SELF-CONCEPT, PERCEIVED PARENTING, AND SOCIAL SUPPORT AMONG ADOLESCENTS WITH INTERNALIZING AND EXTERNALIZING SYMPTOMS

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ABSTRACT

SELF-CONCEPT, PERCEIVED PARENTING, AND SOCIAL SUPPORT AMONG ADOLESCENTS WITH INTERNALIZING AND EXTERNALIZING SYMPTOMS

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The current study investigated the relationship between symptomatology among adolescents and self-concept, perceived parenting behavior, and perceived social support. Examining the effect of maternal and paternal favoritism on adolescent symptom development was another aim of the current study. This work also showed the effects of gender, age, maternal and paternal education level, and socioeconomic status on self-concept, perceived parenting behaviors, perceived social support; and also internalizing and externalizing symptoms. The participants of the current study were 484 middle and high school students (210 male and 262 female) aged between 11 and 18. The data were collected through self-report questionnaires. The results indicated that gender, maternal education level, self-concept, friend support, parental punishment and emotional pressure, and maternal

favoritism predicted internalizing symptoms among adolescents. Also, socioeconomic status, family and friend support, parental physical punishment, and maternal favoritism predicted externalizing symptoms among adolescents. Besides, significant differences were found between adolescents who perceived both their mothers and fathers as favoring one of their children over the others and those who did not perceive favoritism from both of their parents. Several main factors that are likely to influence adolescents' psychological well-being were discussed in the current study. Self-concept, perceived parenting behavior, and perceived social support among adolescents were able to be considered simultaneously. Differential parenting practices and the importance of these practices in adolescent symptom development, together with the perception of social supportive factors and self-concept were highlighted as a result of the current research.

Keywords: Adolescence, self-concept, parenting, social support, internalizing symptoms, externalizing symptoms

ÖZ

İÇSEL VE DIŞSAL SEMPTOMU OLAN ERGENLERDE BENLİK ALGISI, ALGILANAN EBEVEYNLİK TUTUMU VE SOSYAL DESTEK

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Bu çalışma, ergenlerdeki semptomatoloji ile benlik algısı, algılanan ebeveynlik tutumu ve sosyal destek arasındaki ilişkiyi incelemektedir. Bu çalışmanın diğer bir amacı ise, annenin ve babanın kayırmacı davranışlarının ergenlerdeki gelişimine etkisini araştırmaktır. Bu araştırma ayrıca, cinsiyet, yaş, annenin ve babanın eğitim seviyesi ve sosyoekonomik düzeyin benlik algısı, algılanan ebeveynlik tutumu ve sosyal destek algısı ile ergenlerin içsel ve dışsal semptomlarına etkisini göstermektedir. Araştırmaya 210'u erkek, 262'si kız; toplam 484 ortaokul ve lise öğrencisi katılmıştır. Katılımcıların yaşları 11 ile 18 arasında değişmektedir. Veri toplama işlemi özbildirim ölçekleri ile gerçekleştirilmiştir. Araştırma sonuçları, cinsiyet, annenin eğitim seviyesi, benlik algısı, arkadaştan gelen destek, annenin ve babanın cezalandırıcı ve duygusal açıdan baskıcı tutumları ile annenin kayırmacı davranışının ergenlerdeki içselleştirme semptomlarını yordadığını ortaya çıkarmıştır.

Ayrıca, sosyoekonomik statü, aileden ve arkadaşlardan gelen destek, annenin ve babanın fiziksel olarak cezalandırıcı tutumları ile annenin kayırmacı davranışının ergenlerdeki dışsallaştırma semptomlarını yordadığını göstermiştir. Bunların yanı sıra, annesinin ve babasının kardeşler arasında kayırmacı davranış sergilediğini düşünen ergenler ile annesinin ve babasının kardeşler arasında kayırmacı davranış sergilemediğini düşünen ergenler arasında istatistiksel açıdan anlamlı fark bulunmuştur. Bu çalışmada ergenlerin psikolojik sağlıklarını etkileyebilecek çeşitli önemli unsurlar ele alınmıştır. Ergenlerde benlik algısı, algılanan ebeveynlik tutumu ve sosyal destek algısı aynı anda değerlendirilmiştir. Çalışmanın sonucunda, ayrımcı ebeveynlik tutumlarının ve bu tutumların ergenlerin semptom geliştirmesindeki öneminin, sosyal açıdan destekleyici etmenler ve benlik algısı ile birlikte, önemi vurgulanmıştır.

Anahtar kelimeler: Ergenlik, benlik algısı, ebeveynlik tutumu, sosyal destek, içselleştirme semptomları, dışsallaştırma semptomları

To my mother, father,

and sister

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TABLE OF CONTENTS

PLAGIARISM iii

ABSTRACT iv

ÖZ vi

DEDICATION viii

ACKNOWLEDGEMENTS ix

TABLE OF CONTENTS xii

LIST OF TABLES xv

LIST OF FIGURES xvi

1. INTRODUCTION 1

1.1. General Introduction 1

1.2. Psychological Symptomatology in Adolescents 4

1.2.1. Internalizing Symptoms in Adolescents 8

1.2.2. Externalizing Symptoms in Adolescents 9

1.3. Bronfenbrenner's Ecological Model of Child Development 11

1.3.1. Importance of Microsystem 13

1.4. Self-Concept in Adolescents 14

1.4.1. Mastery 15

1.4.2. Self-Esteem 21

1.4.3. Self-Concept and Symptomatology 23

1.5. Parenting and Adolescents 26

1.5.1. Historical approaches on parenting 27

1.5.2. Parenting and Adolescent Development 31

1.5.3. Parenting Behaviors 34

1.5.3.1. Emotional Warmth 35

1.5.3.2. Parental rejection: Punishment, Emotional Pressure, and Physical Punishment 36

1.5.3.3. Overprotection 38

1.5.3.4. Parental Favoritism of a Child over Another 39

1.6. Social Support in Adolescents 40

1.6.1. Social Support as a Protective Factor 41

1.7. Interaction between Self-Concept, Parenting, and Social Support 43

1.8. Aim of the Present Study 44

2. METHOD 48

2.1. Participants 48

2.2. Instruments 51

2.2.1. Socio-Demographic Information Form 51

2.2.2. Achenbach Youth Self Report (YSR; Achenbach & Edelbrock, 1987) 52

2.2.3. Rosenberg Self-Esteem Scale (RSES; Rosenberg, 1965) 54

2.2.4. My Memories of Upbringing for Children (Egna Minnen Beträffande Uppfostran, EMBU-C; Markus, Lindhout, Boer, Hoogendjik, & Arrindell, 2003) 56

2.2.5. Social Support Appraisals Scale (Dubow & Ullman, 1989) 59

2.3. Procedure 60

3. RESULTS 63

3.1. Descriptive and Bivariate Analyses 63

3.1.1. Data Screening and Descriptive Analysis 64

3.1.2. Correlations among the Study Variables 67

3.2. ANOVA Analyses by Demographic Variables 78

3.2.1. ANOVA Analyses by Age and Gender 78

3.2.2. ANOVA Analyses by Parental Education Level 80

3.2.3. ANOVA Analyses by SES Level 86

3.3. Regression Analyses 89

3.3.1. Prediction of Internalizing Symptoms 90

3.3.2. Prediction of Externalizing Symptoms 92

3.4. Role of Parental Favoritism on Internalizing and Externalizing Symptomatology among Adolescents 95

4. DISCUSSION 98

4.1. The Bivariate Analysis among the Study Variables 99

4.2. Effects of Demographic Variables on Study Variables 102

4.3. Predicting Symptomatology among Adolescents 103

4.3.1. Predicting Internalizing Symptoms among Adolescents 104

4.3.2. Predicting Externalizing Symptoms among Adolescents 111

4.4. Role of Parental Favoritism on Symptomatology among Adolescents 118

4.5. Implications of the Current Study 121

4.6. Limitations of the Current Study 122

4.7. Future Directions 124

REFERENCES 126

APPENDICES 162

LIST OF TABLES

Table 3. 1. Means and Standard Deviations of the Study Variables by Gender, Age, and SES Level 65

Table 3. 2. Means and Standard Deviations of the Study Variables by Parental Level of Education 66

Table 3. 3. Pearson Product Moment Correlations among the study Variables 68

Table 3. 4. ANOVA Results for Study Variables by Age 79

Table 3. 5. ANOVA Results for Study Variables by Gender 80

Table 3. 6. ANOVA Results for Study Vatiables by Mother Education Level 84

Table 3. 7. ANOVA Results for Study Variables by Father Education Level..... 86

Table 3. 8. ANOVA Results for study Variables by SES Level..... 89

Table 3. 9. Stepwise regression analysis results for predicting internalizing symptoms among adolescents 92

Table 3. 10. Stepwise regression analysis results for predicting externalizing symptoms among adolescents..... 94

Table 3. 11. Means and Standard Deviations of Maternal and Paternal Favoritism Levels by Symptomatology 96

Table 3. 12. ANOVA Results for Symptomatology by Favoritism..... 97

LIST OF FIGURES

Figure 1. 1. Diagrammatic representation of the difference between efficacy expectations and outcome expectations. 18

Figure 1. 2. The study model 45

Figure 3. 1. Phases of regression analysis for predicting internalizing symptoms among adolescents 91

Figure 3. 2. Phases of regression analysis for predicting externalizing symptoms among adolescents 93

CHAPTER 1

INTRODUCTION

1.1. General Introduction

The current study involves a broad research of adolescents on the basis of Bronfenbrenner's Ecological Theory. Bronfenbrenner talks about five main levels of a child's environment in his theory: microsystem, mesosystem, exosystem, macrosystem and chronosystem (1992). The first level, microsystem, implies the closest social and physical settings, involving home, school, playground, and so on (Bronfenbrenner, 1979). The interactions in this first level occur face-to-face. The significance on this very first stage is that it involves individuals that the adolescent influence, and also individuals that the adolescent is influenced by. Taking the first environmental level of Ecological Theory into account, this study investigates adolescents' self-concept and their perception of parenting and social support by comparing symptomatic adolescents with the non-symptomatic ones.

Symptomatology is defined as individuals' perceptions of any deviation from normal functioning or feeling (Edwards, 2012). Symptoms are previously thought to be coming out of sexual and aggressive drives (Freud, 1916-1917). The reactions of

an individual in front of circumstances, on the other hand, might be seen as a disorder. The age of the individual may determine these reactions (Wicks-Nelson & Israel, 2009). Detection of symptomatology is especially important for an adolescent, since adolescence is a period in which significant changes occur (Compas, Wagner, Slavin, & Vannatta, 1986). Because of the fact that symptoms can also appear in normal children (Lapouse & Monk, 1958; 1959), adolescents should be screened for symptoms. It is important that this screening process gives information about internalizing and externalizing symptoms in adolescents separately, for the symptomatology type to be related to variables such as adolescents' age, socio-cultural environment, self-concept, family type, perceived parenting practices, and perceived social support.

Self-concept is defined as the way a person perceives himself (Shavelson, Hubner, & Stanton, 1976). This very concept involves two core aspects: mastery and self-esteem (Turner, Finkelhor, & Ormrod, 2010). Shavelson et al. suggested that an individual's perception of himself may affect his actions, and his actions may affect his perceptions in turn (1976). Besides, damage in self-concept may explain short-term distress in children and long-term outcomes in adults (Turner et al., 2010). Taking this idea into consideration, with the microsystem level of Ecological Model, it is important to include self-concept into the current study. By comparing and relating the self-concepts of the participants to the other variables, a broader view may be formed to understand the way adolescents think and behave in front of certain situations and in specific environments.

For the socialization of children and adolescents, parents are considered as the primary agents (Darling & Steinberg, 1993). Although children form the closest relationship with their parents, from the beginning of adolescence, they shift their primary attention from their parents to their peers. The essential dilemma of this period is said to be their efforts to gain independence and responsibility taking at the same time (Cole, Cole, & Lightfoot, 2005). Besides, a parental rearing behavior and the way they perceive these behaviors are essential in children's psychosocial development (Main, Kaplan, & Cassidy, 1985; Perris, 1994). For the purpose of the current study, four aspects of parenting; emotional warmth, parental rejection, overprotection, and favoring subject were taken into account as parenting behaviors that have significant affects on children. Besides, psychopathology in children is related to maladaptive parenting (Perris, 1994), and all of the four aspects have been related to symptomatology.

Social support that adolescents get is another factor with great importance for their psychosocial development. Since adolescents spend much time with their peers, they start to perceive higher levels of support from their peers than their parents (Bokhorst, Sumter, &Westenberg, 2009). But still, they are quiet aware of the fact that the highest support comes from their parents. Teachers also play an important role in terms of social support adolescents get (Stewart & Suldo, 2011). Research has showed that social support diminishes life stressors and improves general well-being (Demaray, Malecki, Davidson, Hodgson, & Rebus, 2005).

Previous researches have shown that self-concept, parenting, and social support altogether have significant effects on adolescents (Lau & Leung, 1992;

Sandler, Miller, Short, & Wolchik, 1989). Besides, Bronfenbrenner's Ecological Model also implies that the contexts of home and school are essential in psychosocial development of children (1979). The current study tries to reveal the way of effect in the relationship between symptomatology in adolescent and self-concept, perceived parenting behavior and perceived social support, through investigating these notions. The direct relationship between self-concept, perceived parenting, and perceived social support; and adolescent internalizing and externalizing symptoms were investigated separately. Besides, the effect of one of the parental behaviors, namely favoritism, on adolescent internalizing and externalizing symptomatology were also investigated. Other research questions included the effect of demographic variables (gender, age, maternal and paternal education level, socioeconomic status) on adolescent symptom development, self-concept, perceived parenting and social support. The background information and historical perspectives for the theories and ideas which this research is based on are also given.

1.2. Psychological Symptomatology in Adolescents

Various behaviors that are considered as problematic have gained researchers' attention up to this time. These problem behaviors are termed as many different ways, such as; "abnormal behavior, behavioral disturbance, emotional disorder, psychological deficit, mental illness, psychopathology, maladaptive behavior, and developmental disorder" (Wicks-Nelson & Israel, 2009, p. 2). Besides, a need to distinguishing and categorizing psychopathology from typical behavior has risen for practical reasons, but this categorization brought stigmatization towards people who have psychopathology. (Grand, Lingler, Conner, & Dew, 2009).

Most people think of psychological problems as “atypical, odd, or abnormal”. However, not all behaviors that are considered as atypical or abnormal are problematic. People with high intelligence or who have exceptional athletic skills are favoured, rather than being excluded from the society. For a behavior or thought to be considered as problematic, that behavior or thought should be harmful to the person himself or should disrupt his functionality. Professionals generally decide if there is an abnormality or not, by looking at the person’s actions, the content of the person’s talk, and a specific symptom of the disorder (Wicks-Nelson & Israel, 2009). According to the American Psychiatric Association (APA, 2012), a disorder is:

1. A behavioral or psychological syndrome or pattern that occurs in an individual
2. That reflects an underlying psychobiological dysfunction
3. The consequences of which are clinically significant distress (e.g., a painful symptom) or disability (i.e., impairment in one or more important areas of functioning)
4. Must not be merely an expectable response to common stressors and losses (for example, the loss of a loved one) or a culturally sanctioned response to a particular event (for example, trance states in religious rituals)
5. That is not primarily a result of social deviance or conflicts with society.

The dysfunction that psychopathology or a disorder brings rests within an individual and it prevents the individual to adapt him to the conditions occurring in his life. A disorder may also be seen as the reactions of an individual in front of circumstances. These reactions might differ according to the age of the individual, since behavioral expectations from individuals alter with age (Wicks-Nelson & Israel, 2009).

The issue of age, in terms of behavioral change, gains much importance during adolescence; the stage in which human behavior changes so rapidly. When judging one's behaviors, developmental norms involving "the typical rates of growth, sequences of growth, and forms of physical skills, language, cognition, emotion, and social behavior" are taken into consideration (Wicks-Nelson & Israel, 2009, p. 3). Those behaviors which do not follow these "developmental standards" might easily be considered as atypical, odd, or abnormal; especially when they coexist. However, it must be taken into account that plain symptoms of psychopathology may be observed through behaviors, which then might disrupt functionality (Freud, 1953a). In this sense, it is important to address symptomatology by itself.

Psychological symptoms are described as any deviation from normal feeling or functioning, that are perceived by the individuals themselves (Edwards, 2012). Symptoms are previously thought to be coming out of "reprehended sexual and aggressive drives admixed with ego defenses and superego prohibitions" (Freud, 1916-1917). Freud, as the first clinician and scientist paying attention to psychological symptom formation, seems to address symptomatology as psychopathology in many of his works (Freud, 1953a; 1959; 1962). He viewed symptoms occurring as solutions to the circumstances which individuals perceive as being harmful (Kellerman, 2008). In order to detach ego from harm, people's "forbidden wishes", which Freud believed are usually sexual wishes, come up as symptoms. It follows, then, that every neurotic or psychological symptom arises from these forbidden wishes and repressive forces. In this sense, a symptom might be counted as a perverse form of the psyche (Freud, 1959).

Many other authors following Freud also had attempts to explain the structure and formation of symptoms (Seligman, 1975; Kellerman, 1987; Luborsky, 1996). Brenner (1973) for example, saw symptoms as consequences coming from the failure of ego defenses. Moreover, Luborsky (1996) insisted on symptoms having contexts and he explained symptoms as reactions that a person cannot control, that are distant from personality characteristics, and that are controlled by symptoms themselves. As a matter of fact, Cognitive Behavioral Theories go along with the Psychoanalytical view about symptomatology. Accordingly, the main function of symptoms could be to protect mental health from the harm that failure brings, through various ways. Behavior theorists, on the other hand, have a rather different approach to symptomatology. They explain symptomatic behavior as the social conditioning resulting from an observation of a specific behavior (Bandura & Walters, 1963). Besides, Zigler and Phillips (1960) proposed that "patterns of symptomatic behavior represent the degree to which an individual tends either to resist or to conform to the mores of society" (p. 237).

Symptomatology is of greater importance during the period of adolescence, since this is a stage of life in which dramatic changes occur (Compas et al., 1986). Emphasizing the period of childhood and adolescence, Freud believed that childhood disturbances underlie all symptoms (1959). Also, a recent study indicates that the prevalence of personality disorders in adolescents are high and can be diagnosed during adolescence, in which period personality disorders are notable clinical signs (Hopwood & Grilo, 2010). Consequently, many researches have been done on symptoms of disorders (e.g., Yahav, 2006). Other studies have showed that high incidence of symptoms are not only seen in children having psychiatric problems, but

also in a considerable number of normal children (Lapouse & Monk, 1958; 1959). Even though being initially internalizing or externalizing, these symptoms co-occur in many children (Angold & Costello, 1995). Thus, it is worthwhile to monitor symptoms of adolescents, which might then appear as internalizing or externalizing problems.

1.2.1. Internalizing Symptoms in Adolescents

The conceptual development of internalizing and externalizing problems has first offered by Achenbach (1966). Internalizing problems are naturally latent (Rodriguez, 2011). Internalizing symptoms contain difficulties such as anxiety, psychosomatic complaints, shyness, social regression, withdrawal, low self-esteem, irritability and depression (Dleiden, Vasey, & Brown, 1999). Children with internalizing symptoms are generally neglected. However, they need much attention, since internalizing symptoms are not prominent (Coyle et al., 2003). Since juveniles go through dramatic social and physical changes, the meaning of internalizing symptoms increases during adolescence (Kovacs & Devlin, 1998).

Alongside of causing impairment in current functioning, internalizing problems may also be risk factors for future emotional and behavioral disorders (Reinherz, Paradis, Giaconia, Stashwick, & Fitzmaurice, 2003). Besides, many mental health difficulties seen in adulthood illustrate internalizing problems (Hartung & Widiger, 1998). Among these, anxiety and mood disorders are the most commonly seen internalizing disorders among the U.S. adolescents (Merikangas, 2010). Besides, a research with Turkish adolescent sample showed that the most common

internalizing problems were “nervousness, anxiety, and introversion” (Görker, Korkmazlar, Durukan, & Aydoğdu, 2004, p. 103). Emphasizing the significance of research on internalizing symptomatology in childhood and adolescence, Aronen and Soininen (2000) supposed that depressive symptoms seen in childhood lead to depression and anxiety in young adulthood.

As in many psychological disorders, gender differences seen in internalizing symptomatology. High levels of internalizing symptoms are reported by female adolescents than male adolescents (Wade, Cairney, & Pevalin, 2002). The higher number of stressful life events are reported by more females than males. Females also have more acute reactions in such situations than males (Jose & Ratcliffe, 2004).

Socioeconomic status (SES) is another factor that is related to mental health outcomes (Adler et al., 1994). A research done with adolescents has revealed that social disadvantage is a predictor of increased stress (Goodman et al., 2005). Among adolescents, higher levels of depressive and anxiety symptoms are associated with lower levels of SES (McLeod & Owens, 2004). Low SES is also reasoned as a factor which increases stress (Mendelson, Kubzansky, Datta, & Buka, 2008).

1.2.2. Externalizing Symptoms in Adolescents

Externalizing symptoms involve *a lack of emotional control, interpersonal aggressiveness, and a lack of adherence to societal norms* (Brook, Zhang, Balka, & Brook, 2012, p. 175). When transferred into behaviors, this symptomatic pattern

would lead to low academic competence (Masten et al., 2005) and vulnerability to and persistence of substance use (Stice & Barrera, 1995).

A previous study has showed that early childhood is a critical period for the onset of externalizing behaviors (Alink et al., 2006). Children displaying externalizing behaviors are highly likely to have various problems such as school drop-out, academic underachievement, psychological disorders, substance abuse, aggression, criminality, and delinquency, later in their lives (Moffitt, Caspi, Harrington, & Milne, 2002). Besides, behavior disorders and substance use disorders are the most commonly seen externalizing disorders among adolescents in the U.S. (Merikangas et al., 2010). However, a study within Turkish adolescents has shown that "school failure, nail biting, not getting along well with peers, and sibling rivalry" (Görker et al., 2004, p. 103) are the most common externalizing problems among adolescents (Görker et al., 2004).

Gender differences are seen in externalizing symptomatology, as they are seen in internalizing symptomatology; only this time it is males who have the majority (Maughan, Rowe, Messer, Goodman, & Meltzer, 2004). During childhood and adolescence, the rates of externalizing problems of boys exceed girls (Lewinsohn, Hops, Roberts, Seeley, & Andrews, 1993). This finding may be linked to the fact that neurodevelopmental disorders, which occur early in life, affect males more than females because of their particular vulnerability (Rutter, Caspi, & Moffit, 2003). Besides, the way they express their problems may differ between males and females. Males are more likely to display physical aggression than females (Zalecki & Hinshaw, 2004); which might be counted as an externalizing behavior.

1.3. Bronfenbrenner's Ecological Model of Child Development

The development of adolescents can be investigated through many different aspects. Until this time, various theorists proposed many theories about child and adolescent development (Erikson, 1959; Freud, 1953b; Piaget, 1896/ 1980/ 2007). Although being different from each other, they address similar issues. Among these theories, Bronfenbrenner's Ecology of Human Development Theory is one of the most well recognized theories that illustrates adolescent development comprehensively, and enables adolescents to be evaluated from a wider view.

Bronfenbrenner is said to change the stance in developmental psychology. His ecological perspective has important implications for adolescent development. His idea was that a certain methodology showing basic theoretical assumptions should be selected and the characteristics of the research plan should be determined (Muuss, 1988). Bronfenbrenner developed his ecological model to understand social and learning environments as well as understanding human development. He illustrates *human development* as requiring the interaction of multiple persons in multiple settings with the environment taken into account, rather than a single person being in a single setting and unaware of the environment (1979). He paid much attention to the environment where people live and interact to each other, in his work where he combined theory and empirical work. He gives a comprehensive definition of *the ecology of human development* in his work with the same title. He wrote:

> The ecology of human development involves the scientific study of the progressive, mutual accommodation between an active, growing human being and the changing properties of the immediate settings in which the developing person lives, as this process is affected by relations between the

settings, and by the larger contexts in which the settings are embedded (Bronfenbrenner, 1979, p. 21).

Bronfenbrenner specifies that the developing person is a *growing, dynamic entity;* "the interaction between person and the environment is … characterized by reciprocity" (1979, p. 22); and the environment that is required for the *developmental process* is widened to joint links between multiple settings (1979). His *ecological environment* consists of "nested structures, each inside the next" (1979, p. 3). Thus, all environments are interconnected and support each other (Lau, 2012).

Bronfenbrenner offered four structures, four different environmental subsystems in which people interact both with each other and with the environment itself, and he labeled them as microsystem, mesosystem, exosystem, and macrosystem (1979). Basically, microsystem refers to the closest settings in which people engage in face-to-face interactions. Mesosystem comprises out of the interaction between at least two settings, in which the person actively participates. As the third setting, exosystem consists of two or more environmental layers, as well; albeit the person does not actively exists in exosystem, but affected by the events that occur in (Bronfenbrenner, 1979). Macrosystem, on the other hand, was defined by "the macrosystem refers to consistencies, in the form and content of lower-order systems (micro-, meso-, and exo-) that exists, or could exist, at the level of the subculture or the culture as a whole, along with any belief systems or ideology underlying such consistencies" (Bronfenbrenner, 1979, p. 26).

In his later work, he added a fifth environmental subsystem and labeled it as the chronosystem (Bronfenbrenner, 1992). With this level, he intended to attract

attention to time. Chronosystem basically designates a research model which enables to examine the effect of changes and continuities on people's development in the settings they live in over time (Bronfenbrenner, 1986a).

1.3.1. Importance of Microsystem

The *microsystem* was defined by Bronfenbrenner (1979) as "a pattern of activities, roles, and interpersonal relations experienced by the developing person in a given setting with particular physical and material characteristics" (p. 22). He points to the closest social and physical settings, in his description of the microsystem. Bronfenbrenner (1979) addresses a *setting* in an adolescent's microsystem as "a place where people can readily engage in face-to-face interaction – home, day care center, playground, and so on" (p. 22). This interaction occurs with whom the adolescent has a permanent relationship, who influences the adolescent's life, and also whom the adolescent influences. Family is considered to be the microsystem first in line, for a huge number of adolescents. Generally, family is followed by friends and school. *Siblings* (as a family member), *teachers* (as a school member), *neighbors*, and *social groups* in which adolescents' relationships with members are persistent (Muuss, 1988).

As time and experiences make adolescents change, their microsystems change, too. The importance of specific microsystems may also change, depending on the social settings he or she starts or stops attending to (Muuss, 1988). Above all, it is a part of development itself for an adolescent to change (Eccles et al., 1993). Throughout development, the environments they engage in become more complex.

For the period of adolescence specifically, the peer relationships become more significant. Although the microsystem of peers can be socially rewarding (e.g., status, prestige, friendship, popularity, acceptance) (Muuss, 1988), it can also have negative effects like school drop-out, crime, alcohol and drug use (Office of Educational Research and Improvement, 1988, as cited in Eccles et al., 1993). Muuss pointed out that, for a microsystem to be healthy, the relationships in that microsystem should be reciprocal. Lack of reciprocity decreases the quality of the microsystem (Muuss, 1988).

Bronfenbrenner's Ecology of Human Development Theory presents the ideas comprehensively and gives an in-depth understanding of the processes throughout an individual's developmental change. His theory indicates that there are various settings and levels in a person's life, which modifies or expands as he or she undertakes new roles and engage in different activities throughout his or her development (Sontag, 1996). Bronfenbrenner put parents, peers, and teacher to the first level, the microsystem, of his theory (1977). Pointing to the importance of this micro level environment in a child's development, he showed the effect of extrafamilial processes on intrafamilial processes (Bronfenbrenner, 1986b).

1.4. Self-Concept in Adolescents

Self-concept is basically described as "a person's perception of himself" (Shavelson, Hubner, & Stanton, 1976, p. 411). Shavelson, et al. suggested that environment and significant others influence and shape these perceptions. They also claimed that, the way in which a person perceives himself may explain and predict one's actions, and in turn, his actions affect his perceptions about himself (1976).

Two core aspects for self-concept are specified: *mastery* and *self-esteem* (Turner et al., 2010).

1.4.1. Mastery

Mastery is described as "the extent to which one regards one's life chances as being under one's own control in contrast to being fatalistically ruled" (Pearlin & Schooler, 1978, p. 5). There are several constructs related with mastery: *locus of control* (Rotter, 1966), *personal control* and *self-efficacy* (Bandura, 1982), and *inflexibility* and *fatalism* (Wheaton, 1983). Even though not the same, all these concepts involve the idea that a significant expectation in human functioning and development is that outcomes in life may be caused by people themselves (Turner & Roszell, 1994).

Locus of control – or control of reinforcement – was first introduced by Rotter (1966) which implied whether or not individuals got reinforced in life determine events. There are two dimensions of locus of control, including internal control and external control. Individuals with an internal locus of control have the belief that they have control over the situation they are in. Individuals with an external locus of control on the other hand, believe that events are determined by uncontrollable forces that situations occur outside of their will (Rotter, 1966). People who perceive that they control the events and situation they are in are more likely to behave in a manner that make them better cope with threatening situations, than people who believe that chance or other external forces affect situations (Phares, 1962).

Other constructs related with mastery, personal control and self-efficacy was introduced by Bandura (1982). The significance of control mechanism has also led other theorists to contribute to the literature (Adler, 1956; White, 1959; DeCharms, 1978; Rotter, 1966). Personal control can be explained as the attempt "to exercise control over events that affect people's lives … to produce valued outcomes and to prevent undesired ones" (Bandura, 1992, p. 1). When people are able to exert some control, they may see the future coming events more clearly and they may have the chance to shape that future according to their will by using control. Since it creates many personal and social benefits, people's attempts to control over events in their lives penetrate almost all the things people do. The outcomes of the events become predictable when people can affect them. Also, as people can predict the outcomes, they would be prepared for the things they will go through. Not being able control things that people have negative effects may cause "apprehension, apathy, or despair" (Bandura, 1992, p.1).

Self-efficacy, on the other hand, has rather a different content, though being similar to personal control. Albert Bandura is the first theorist who addressed self-efficacy (1977), which is more than just competence or proficiency for a given task that a person thinks of himself or herself. Bandura explained:

> Efficacy in dealing with one's environment is not a fixed act or simply a matter of knowing what to do. Rather, it involves a generative capability in which component cognitive, social, and behavioral skills must be organized into integrated courses of action to serve innumerable purposes (Bandura, 1982, p. 122).

A capability should be used and shown by acts, for it to be exist and labeled as good or bad. Also, competence should be managed by the use of various skills and it should string along with the changing time and settings (Bandura, 1982). Thus, efficacy itself and perceived self-efficacy might be differentiated from each other. "Perceived self-efficacy refers to beliefs in one's capabilities to organize and execute the courses of action required to manage prospective situations" (Bandura, 1997, p. 2). People tend to have certain beliefs about their self-efficacy. Bandura stated that efficacy beliefs affect people's thoughts, feelings, motivations, and actions (Bandura, 1997). Correctly estimating one's own capabilities has a functional value for a person, since directing behavior according to misjudgments about personal efficacy may cause adverse effects. Whether accurate or wrong, judgments about self-efficacy affect not only activity choices, but also the settings a person chooses to join (Bandura, 1982).

In the course of self-efficacy, *efficacy expectations* and *efficacy beliefs* should be distinguished from each other. Psychological procedures are to form and support self-efficacy expectations. Within this idea, response-outcome expectancies are differentiated from efficacy expectations (Bandura, 1977). Bandura described outcome expectancy as "a person's estimate that a given behavior will lead to certain outcomes", whereas efficacy expectancy is "the conviction that one can successfully execute the behavior required to produce the outcomes" (Bandura, 1977, p. 193). People tend to believe that certain behaviors will cause particular results, but if they strongly have the idea that they may not be able to satisfy the necessities of those particular outcomes, then the information they have does not have an effect on their behavior. People's beliefs about their own effectiveness influence if they are going to

try to strive for a specific situation, and also how much effort they will give for a particular circumstance. Thus, the settings they join are in a way picked by their perception of self-efficacy. Those situations in which people believe their skills are insufficient are labeled as threatening and they are avoided, whereas people take action in situations which they believe that they are capable of coping with things (Bandura, 1977). The difference between efficacy expectations and outcome expectations are shown in Figure 1.

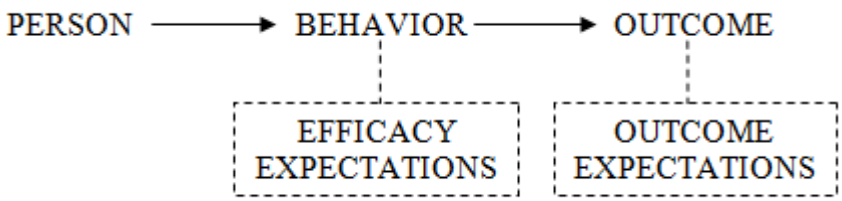

Figure 1. 1. Diagrammatic representation of the difference between efficacy expectations and outcome expectations (Bandura, 1977, p. 193).

Bandura proposed that there are various dimensions that efficacy expectations vary from, which give significant clues about behaviors (1977). *Magnitude* is the first attribute that alters efficacy expectations. In a case where there are different levels of difficulty in multiple tasks, there would be distinct choices of tasks of different individuals, according to their own efficacy expectations. They tend to limit themselves to simpler tasks; or there may be a wide array of difficulty choices among given tasks. A second dimension that efficacy expectations vary accordingly is *generality*. While some tasks require mastery expectations, some others may easily be involved into a situation that a more generalized efficacy would fit. Moreover, efficacy expectations differ in *strength*. Experiences that are disconfirming may

easily be extinguished by weak expectations, although endowed with strong expectations will persist to use their coping strategies, no matter what disconfirming experiences they have (Bandura, 1977).

Efficacy beliefs, on the other hand, are a rather different aspect of self-efficacy. Previous research has found that efficacy beliefs have a significant role in human motivation and accomplishments (Bandura, 1992). Bandura introduced four main forms that affect individual's beliefs about their efficacy (1997). A strong sense of efficacy can best be created by *mastery experiences*. They accurately obtain evidence that if a person can aggregate all the things to be able to be successful (Bandura, 1982). Individuals develop a strong belief via success about their self-efficacy. While self-efficacy is undermined by failure, success strengthens it. But still, failure easily indisposes those who are accustomed to easy successes and quick outcomes (Bandura, 1997). *Vicarious experiences*, which social models provide, is another way to produce and support efficacy beliefs. When individuals observe other people similar to themselves succeeding with enduring efforts, the beliefs of the observing individual form in a way that he or she also has the competence to succeed on a similar task (Bandura, 1986). A third way of reinforcing people's beliefs for them to put effort to succeed is *social persuasion*. Individuals who are verbally induced that they have the aptitude to handle certain activities are prone to put in much effort and maintain it, than people who have doubts about their selves and concentrate on their personal deficiencies when they face with a problem (Litt, 1988; Schunk, 1989). The last way to strengthen personal efficacy beliefs is people's own *physiological and emotional states*. Individuals see the stress reactions and tension in front of a given situation as their vulnerability; they think that they are going to

perform poorly. Similarly, when people feel weariness, pain, and distress during strength requiring activities, they think them as a physical weakness (Ewart, 1992). Besides, Kavanagh and Bower revealed that, mood has a great impact on judgements of self-efficacy. Perceived self-efficacy heightens with positive mood, while it declines with negative mood (1985).

Inflexibility and fatalism are concepts thought as parts of an individual's personal resources, which have effect on coping strategies that a person use in front of stressful situations. Personal resources are thought as different aspects of personality, which are considered as background factors of coping process. Inflexibility is defined as people's preference of certain types of coping mechanisms every stressful situation. In addition, it implies strategy constriction (Wheaton, 1983). "Characteristics such as a belief in external conformity, the rigid application of standards, mistrust and guardedness, and an emphasis on absolutes in value socialization, e.g., neatness and obedience, may in particular represent aspects of inflexibility that have consequences for coping ability" (Wheaton, 1983, p. 211).

Fatalism also suggests a decrease in aptitude in using different coping skills in different situations, but it also implies an extra notion (Wheaton, 1983). Wheaton describes fatalism as "a tendency to believe in the efficacy of environmental rather than personal forces in understanding the causes of life outcomes, including both "success" and "failure" outcomes" (Wheaton, 1983, p. 211). Thus, the most apparent result is that fatalism adds ambiguousness to coping actions (Wheaton, 1983).

A decrease in "overall coping ability" (Wheaton, 1983, p.211) mediates inflexibility effect on psychiatric symptoms. Besides, eventful impairment in tendencies to give effort mediates fatalism effect. Due to the fact that people can increase their effort easier than they can do for their abilities, it is expected that, the effect of sources of stress that are not stable would be more effectively reduced by low levels of fatalism (Wheaton, 1983).

1.4.2. Self-Esteem

The concept of self-esteem has a significant value in the psychology field. This construct has been the point of attention of several researches for years (Rosenberg, Schooler, Schoenbach, & Rosenberg, 1995). Many theorists have proposed definitions for self-esteem. Rosenberg conceptualized the construct as "the evaluation which the individual makes and customarily maintains towards himself or herself: it expresses an attitude of approval or disapproval towards oneself" (1965, p. 5). He proposed that self-esteem is the exhibition of positive or negative attitudes of a person towards another (Rosenberg, 1965). James' definition, on the other hand, includes a person being satisfied or dissatisfied with herself or himself (1963). He claimed that self-esteem "is determined by the ratio of … actualities to … supposed potentialities; … thus, Self-esteem = Success/ Pretentions" (James, 1963, p. 193). Then again, Janis and Field believed that self-esteem is having the sense of social sufficiency (1959). Also, Ziller proposed that self-esteem is determined by how a person perceives his worth, which is specified by the orientation between self and other (1973).

Similar to all these ideas, Coopersmith gave a broad description of self-esteem that unites many definitions about this concept. He wrote:

> The evaluation which the individual makes and customarily maintains with regard to himself: it expresses an attitude of approval or disapproval, and indicates the extent to which the individual believes himself to be capable, significant, successful, and worthy. In short, self-esteem is a personal judgment of worthiness that is expressed in the attitudes the individual holds toward himself (1967, p. 4-5).

Besides, Pope, McHale, and Craighead gave another definition for self-esteem in which they explained the concept via actual self and ideal self. They described self-esteem as a person's appraising senses towards himself or herself, and the feeling that the person is substantially worthy. It is claimed that the distinction between the actual self and the ideal self-evaluates self-esteem. The actual self basically stands for a person's self that is objectively perceived, on the other hand, the ideal self is person's self-type that he or she wants to be (1988). The difference between the actual and ideal self is considered to be a significant criteria among self-esteem (Lynch, La Guardia, & Ryan, 2009). Further, Rosenberg and colleagues (1995) suggested that most of the research done about self-esteem has considered *global self-esteem*, which is basically "the individual's positive or negative attitude toward the self as a totality" (p. 141). Subsequent authors, on the other hand, have emphasized *specific self-esteem*, which implies to more particular facets of self-concept, in their works (Marsh, 1986; Marsh, & Shavelson, 1985).

1.4.3. Self-Concept and Symptomatology

In the development of adolescent symptomatology, a possibly critical factor may be the adolescent's self-concept. Hammen (1988) pointed out that, cognitions about one's self have important effect on developing depression, which involves internalizing symptoms. A possible impairment in self-concept may be an explanation to children's distress that occurs in short-term and adults' long-term outcomes. The development of self-concept is posited to be affected by important stressors. Success and failure that children experience in their social environment and how they perceive other people's ideas about themselves form the development of children's mastery and self-esteem (Turner et al., 2010). On the other hand, a recent study has found that, senses of self-worth of siblings of mentally ill children were not affected by having a mentally ill sibling in their environment (Barnett & Hunter, 2012). The same study linked this finding to having an adequate self-concept as a possible protective factor, emphasizing self-concept as a construct.

An important aspect of self-concept, self-esteem, has found to be related to "juvenile delinquency, academic performance, and psychological depression" (Rosenberg, Schooler, & Schoenbach, 1989, p. 1005). Kaplan (1975) emphasized to research showing negative association between self-esteem and delinquency. Wells and Rankin also referred to similar studies, which "demonstrate a consistent association between evaluative social experiences, self-evaluation, and a variety of delinquent behaviors" (1983, p. 13). Besides, a previous study which revealed the differences between well-adjusted adolescents, stress-resilient adolescents, and

adolescents vulnerable to stress has shown that the level of self-esteem decreases from well-adjusted adolescents to vulnerable ones (Dumont & Provost, 1999).

A huge place is given to the negative relationship between self-esteem and depression in a number of researches (Wylie, 1979; Rosenberg, 1985; Turner et al., 2010). This case is valid for almost all age groups; "children, adolescents, and the aged" (Rosenberg et al., 1989, p. 1005). A study which was done by 2213 tenth grade male students revealed that there is a moderate to high correlation between self-esteem and depressive affect (Bachman, 1970). In a more recent research, it is found that low perceived personal control mediates abuse on internalizing problems of children (Bolger & Patterson, 2001). Also, being victimized by peers verbally in childhood and depression during young adulthood mediate low self-esteem (Benas & Gibb, 2007). Moreover, a work by Rosenberg and his colleagues in 1989 described the two-way relationship between depression and self-esteem well. They pointed out that self-esteem theory proposes that one cause of depression might be low self-esteem. They wrote: "If the desire for positive self-regard is a major motive of human beings, then the frustration of such a motive would almost inevitably be experienced as depressing" (Rosenberg et al., 1989, p. 1007). The same work also suggests that the cause of self-esteem may be depression as well, and this cause has been linked to the principle of consistency. One core aspect of depressive personality as to cognitive therapists (e.g., Beck, Rush, Shaw, & Emery, 1979), is the permeation of negative cognitions. Rosenberg and colleagues describe this as follows:

> The depressed person thinks that the world is a rotten place, that people are selfish, and that the future is hopeless. Consistent with this negative outlook on life is the expectation that the depressed person would also develop

> negative attitudes toward the self – for example, to feel worthless, guilty, and unimportant. If this is so, then it would suggest that depression causes low self-esteem (1989, p. 1007).

Mastery – the other aspect of self-concept related with helplessness, perceived control, fatalism, and self-efficacy – is also connected with depressive symptoms. Research done with various populations has found clear links between mastery and distress symptoms and depression (Aneshansel, 1992; Gecas, 1989, Mirowsky & Ross, 1989; Seligman, 1975; Wheaton, 1983). Even though data has shown that there is a significant relationship between self-concept and problems like delinquency and depression, the situation whether the problems are cause or effect is not clear (Rosenberg et al., 1989).

Research indicates sex differences in self-concept. Previous studies revealed that boys tend to handle the transition to junior high school better than girls (Hirsch & Rapkin, 1987; Simmons, Burgeson, Carlton-Ford, & Blyth, 1987). This situation may be due to the fact that boys mature later than girls and girls' junior high school transition occurs simultaneously with the changes of puberty (Alfeld-Liro & Sigelman, 1998). Along with a high number of changes, a decline in girls' self-esteem is observed. Also, the life stressor that girls encounter during this period is said to be higher than boys (Simmons et al., 1987), even though the number of stressful events for both boys and girls increase from first to second year in high school (Groer, Thomas, & Shoffner, 1992). Moreover, when girls experience various stressors during early adolescence, they cannot recover from the damage until they come to mid-high school (Simmons et al., 1987). Nevertheless, research has also

found that girls experience less adaptation problems than boys, during the transition from junior high to high school. A smaller drop in girls' GPA and girls' better adaptation to new social environments following the transition are the indicators for this difference (Barone, Aguirre-Deandreis, & Trickett, 1991). Thus, boys and girls may be affected differently as the adolescent transitions occur for them at different points in time (Alfeld-Liro & Sigelman, 1998).

1.5. Parenting and Adolescents

Parents are considered as children and adolescents' primary agents for socialization (Baumrind, 1991; Darling & Steinberg, 1993; Maccoby & Martin, 1983). Parenting as a construct is described as a channel through which children are socialized according to the parents' objectives. As the socialization purposes might be particular, they can also be more general (Maccoby & Martin, 1983). Three different facets of parenting should be considered to have an understanding of the influence of parenting on adolescents, or development of children: the objectives that lead to socialization, parenting practices, parenting style. Though used as similar concepts, parenting practices and parenting style should be differentiated from each other. Parenting practices stand for patterns that parents use to make their children reach the objectives leading to socialization, which consider specific situations (Darling & Steinberg, 1993). Parenting style, or emotional climate (Darling & Steinberg, 1993), on the other hand, is conceptualized as "sets of attitudes, goals, and patterns of parenting practices that affect outcomes for children and adolescents" (Wicks-Nelson & Israel, 2009, p. 53).

1.5.1. Historical approaches on parenting

At the beginning of the 20th century, the effect of parenting behavior on child development became a prominent topic for both behavioral theorists and Freudian theory. The point of interest of child behaviorists was the contribution of the congruence of reinforcement in the close environment to the development. Whereas according to Freudian theorists, the primary indicatives of development were coming from human biology and in conflict with the wishes of parents and requirements of the society. Personal differences in child development occur as a consequence of the libidinal needs of the child interacting with the family environment (Darling & Steinberg, 1993).

Since there is an overall consensus about the influence of parenting practices on child development, the way parents treat their child – namely, parenting style – gains importance (Darling & Steinberg, 1993). Previous work done to assess parenting style mainly emphasized three factors which are "the emotional relationship between the parent and the child, the parent's practices and behaviors, and the parent's belief systems" (Darling & Steinberg, 1993, p. 488). Various perspectives offer distinct theories about how parenting influence children and adolescents.

Socialization research which takes psychoanalytic perspective emphasized that child's "psychosexual, psychosocial, and personality development" (Darling & Steinberg, 1993, p. 488) are affected by parent-child emotional relationship. Theorists of psychoanalytic perspective claimed that different parental attributes

reveal individual differences in terms of emotional relationships among children and parents (Darling & Steinberg, 1993). Since parental practices and "more subtle behaviors that give those practices meaning" (Darling & Steinberg, 1993, p. 488) are determined by attitudes, the emotional tone in the family environment, which specifies the relationship between parent and child and also affects the development of the child, gives much importance to parental attitude assessment (Baldwin, 1948; Schaefer, 1959). Nevertheless, researchers have denoted a dilemma at this point. It is an attitude which gives a behavior its meaning, but behavior is the agent for an attitude to be demonstrated (Darling & Steinberg, 1993). Symonds (1939) stated that, "Eventually the child's emotional security does go back to the parents' feelings and attitudes, needs and purposes, but only as they are openly expressed to him in word and action" (p. 154). Regarding this idea, it would be meaningless to study only one of the concepts, without considering the other (Darling & Steinberg, 1993). Schaefer expressed an idea in 1959, in which he suggested the term "molar level". Accordingly, specific parental practices were gathered into groups according to their conceptual categories. These categories were determined by their possible power to make changes in emotional processes (Baldwin, 1948; Schaefer & Bell, 1958). Molar attributes involve "autonomy granting, ignoring, punitiveness, perception of the child as a burden, strictness, use of fear to control, and expression of affection" (Schaefer, 1959, 1965).

Although behaviorist and social learning researchers have also took parental behaviors into account to classify parenting styles, they differ from researchers who take psychoanalytic perspective to their point of attention. Rather than focusing on parental attitudes, they directed their attention on the parental practices (Darling &

Steinberg, 1993). Learning theorists have the idea that children's environment of learning they are exposed to, is the key to change in children's development (Sears, Maccoby & Levin, 1957). They see control as behavioral characteristics underlying physical punishment, masturbation tolerance, outcomes of aggressive acts, failing in the practice of rules, and the rules used in general places that parents perform. Learning theorists, unlike psychoanalytic theorists, used parenting style as a stenography through which they sum up many analysis' results implemented on particular parenting practices (Darling & Steinberg, 1993).

Among the theories of parenting, Baumrind's typology has an important place. According to Baumrind, the core role of parents was to help children maintain their personal integrity on the one hand, and make children socialize through complying with the essential requests of people on the other. She focused on the importance of parental authority during the early years of child development and she extended the parental control construct (Baumrind, 1966). Baumrind pointed to the difference between parental restrictiveness and control, and claimed that control involves more of a parental attitude which demands compliance to include the child in the society and family (Baumrind, 1966; Darling & Steinberg, 1993). She basically proposed three types of parental control: permissive, authoritarian, and authoritative. Authoritative parents have firm control and they expect their child to comply their rules; and are warm, accepting, and they consider the needs of their child. As a result, the children of authoritative parents are generally socially responsible, independent, and have self-confidence (Wicks-Nelson & Israel, 2009). On the other hand, authoritarian parents have "rigid psychological control" (Bugental & Grusec, 2006), and permissive parents are described as being highly responsive

and tolerant, but very low in demanding (Wicks-Nelson & Israel, 2009). Baumrind found that permissive and authoritarian parents, compared to authoritative parents, were less demanding, use less effective communication, and not as nurturing and controlling. She also found that, interestingly, there were no considerable differences between authoritative parents and authoritarian or permissive parents in terms of love and warmth they show towards their child (Baumrind, 1967).

There were some theorists that opposed to Baumrind's theory of parental control, in which she argued that parental values are internalized by children when parents, such as authoritative parents, use external control. Lewis (1981) emphasized the inconsistency between Baumrind's work and attribution theory, according to which internalization is undermined by strong external control (Darling & Steinberg, 1993). Lewis proposed that children experience specific characteristics of authoritative families in which children engage in reciprocal communication with their parents. In such a family environment, parental rules can be modified through debates between the child and the parents. According to Lewis, such an experience that authoritative families present supports children to develop an autonomous and independent sense of self, rather than high controlling feature authoritative families have (Lewis, 1981; Darling & Steinberg, 1993).

After Lewis, Maccoby and Martin (1983) proposed another approach on parenting by merging Baumrind's theory with previous approaches (Darling & Steinberg, 1993). They suggested that parenting style has two functional dimensions, rather than three; these are demandingness and responsiveness. "Demandingness refers to the parent's willingness to act as a socializing agent, whereas

responsiveness refers to the parent's recognition of the child's individuality" (Darling & Steinberg, 1993, p. 492). Both demandingness and responsiveness is high for authoritative parents; but for authoritarian parents, demandingness is high but responsiveness is low. Besides, Maccoby and Martin (1983) divided Baumrind's permissive parenting type into two as indulgent and neglecting. They described indulgent parents as highly responsive but having low demands; whereas both responsiveness and demandingness is low for neglecting parents (Maccoby & Martin, 1983). Figure 2 illustrates the parenting model proposed by Maccoby and Martin (1983).

1.5.2. Parenting and Adolescent Development

Parent-child relationship changes by the time the child get into adolescence and spend more time with their peers than their parents (Cole et al., 2005). Adolescents direct themselves to their peers more than their parents to take advice about managing themselves in various environments (Paikoff & Brooks-Gunn, 1991; Steinberg & Silk, 2002). Although many work about adolescent development point to the changes in adolescents during their developmental period, the parents of adolescents go through some significant changes regarding their age. The parents of adolescents are likely to have much responsibility at their work, and the parents of the parents happens to be aging so they are likely to need help and care. At the same time, the parents of adolescents are likely to have less physical power than before (Cole et al., 2005). Since the time of a child becoming an adolescent is stressful both for the adolescent and the parent, it is highly likely to have conflicts between them (Steinberg & Duncan, 2002).

The essential dilemma of adolescence is thought to be that they are stuck in between the notion of gaining their independence on the one hand, and taking responsibilities on the other. This contradiction is one of the biggest reasons of the conflicts between adolescents and parents (Cole et al., 2005). Laursen, Coy, and Collins have indicated that the conflict between parents and children change throughout the period of adolescence (1998). They reasoned that the conflict is higher during the early adolescence in terms of strength and frequency, but then it decreases. They have linked this decline in conflict to the adolescents' spending less time with their parents and establishing emotional bonds more with their peers than their parents. Besides, conflicts may create intense feelings among adolescents. In a study by Csikszentmihalyi and Larson, adolescents are asked to fill out a form about what they were occupied with just at the moment the beeper they requested to carry was beeped (1984). The adolescents were asked to do this routine for a week. The adolescents in the study reported the experience as highly unfavorable. The most frequent subject of argument between adolescents and their parents are found to be as house work, dating, sports, and economic independence, while the less frequent ones are about politics and religion (Holmbeck, 1996).

Another conflict arising situation is emphasized by Turiel (1998). He pointed out that conflicts may arise at times when adolescents and parents cannot agree on their ideas about personal space. Parents from different cultures tend to act differently towards their children. Previous studies have shown that it is important to give personal space to children according to the parents in Brazil and the United States (Nucci, 1996; Smetana, 1999). On the other hand, when compared to European American families, African American families from middle class have

more of a restrictive attitude about personal judgments of adolescents (Smetana, 2000).

Although many theorists have found clues that lead to conflict between adolescents and their parents, very few of these relationships are damaged out of this reason (Schneider & Stevenson, 1999). A recent study has shown that adolescents who perceive warmth from their families, whose parents have academically high expectations, and who discuss intellectual and academic issues with parents have higher performance in school than adolescents perceive less warmth and involvement from their parents (Juang & Silbereisen, 2002). A study among African American and European American families has revealed that the values of adolescents are highly linked to identifying oneself positively to parents (Jodl, Michael, Malanchuk, Eccles, & Sameroff, 2001). Besides, Fuligni and Eccles (1993) found that children got closer to their peers in cases of when their parents act strictly, or do not take their opinions about familial issues throughout their adolescence development. The same study also indicated that adolescents who are monitored by their parents are less likely to turn to their peers than whose parents do not set rules about times to be outside and do not want to be aware of when they would be at home.

Research implies that parenting style (i.e., Baumrind, 1967; Maccoby & Martin, 1983) also has an effect on adolescent behavior. Accordingly, those adolescents who have higher achievements at school and do not have much trouble in their lives generally have authoritative parents (Steinberg, 2001). Parenting style happens to extend to the friends of the adolescents. Those who have friends whose

parents behave affectively towards their children are also likely to perform better in school (Fletcher, Darling, Steinberg, & Dornbusch, 1995).

In terms of parenting, the roles of mothers have gained much more attention than the roles of fathers throughout history. Mothers have been seen as the primary caregivers for the child development, and they were in charge of all the things about their child. However, from the beginning of the new millennium great emphasis was given to the effects of father in child development (Cabrera, Tamis-LeMonda, Bradley, Hofferth, & Lambd, 2000; Coley, 2001). Research has shown that fathers undertake rather different roles than mothers throughout the development of children. Fathers help children to develop feelings of competition and independence, and also daughters who have effective fathers have healthy sexual identity (Cabrera et al., 2000; Leinonen, Solantaus, & Punamaki, 2003).

1.5.3. Parenting Behaviors

One of the most important factors on children's psychosocial development is parents' rearing behaviors. Thus, maladaptive parenting may cause psychopathology in children (Perris, 1994). Research has shown that parenting involves the participation to the communication of both parent and child (Bell & Chapman, 1986). Besides, it has been revealed that parenting behaviors' mental representations have effects on children (Main et al., 1985). Since the real parental behaviors and the way child perceives those behaviors may vary from child to child, parenting studies should consider the perceptions of children (Markus, Lindhout, Boer, Hoogendijk, & Arrindell, 2003).

1.5.3.1. Emotional Warmth

Parental warmth has been considered as a significant factor in children's psychosocial development. Emotional warmth has been linked to "the quality of the affectional bond between parents and their children, and with the physical and verbal behaviors parents use to express these feelings" (Rohner, Khaleque, & Cournoyer, 2005, p. 305). During the adolescence years, emotional warmth and responsiveness of parents are considered as significant factors in development of children. Authoritative parenting, in which parents' warmth and firm control are high, is thought as the most effective parenting type (Baumrind, 1991). Kerr and Stattin have suggested that adolescents' disclosure level is determined by parents' actions towards them (2000). They argued that previous experiences of adolescents about the parents' reactions to the information and their level of warmth and acceptance are the indicatives of adolescents' disclosure.

Recent research has found that those who experience warmth and positive affect from their parents are less likely to develop externalizing behaviors (Deater-Deckard, Ivy, & Petrill, 2006). In addition, warmth and positive parental involvement serve as protective factors for conduct problems (Klein & Forehand, 2000) and externalizing symptoms (Scaramella, Conger, & Simons, 1999). Besides, disruptive behavior has been linked to inadequate warmth and positive involvement (Strassberg, Dodge, Petitt, & Bates, 1994).

Attachment research also has some implications about the importance of parental warmth for the late childhood and adolescence. Karavasilis, Doyle, and

Markiewicz found that the attachment type of adolescents differ according to parenting style (2003). Those who have parents with “high in warm involvement, psychological autonomy granting, and behavioral monitoring/ control” (Karavasilis et al., 2003, p. 161) were found to have secure attachment.

1.5.3.2. Parental rejection: Punishment, Emotional Pressure, and Physical Punishment

Parental rejection refers to the withdrawal or lack of “warmth, affection, care, comfort, concern, nurturance, support, or simply love that children experience from their parents and other caregivers, …, and behaviors and by the presence of a variety of physically and psychologically hurtful behaviors and emotions" (Rohner et al., 2005, p. 305). It has been shown that four principal expressions make individuals experience parental rejection: “cold and unaffectionate, …, hostile and aggressive, indifferent and neglecting, and undifferentiated rejecting” (Rohner et al., 2005, p. 305). Among these, undifferentiated rejection stands for the thoughts of people that they are not really cared or loved by their parents, although there are not any traces of neglect, aggression, or unaffecting. Rohner (2004) implied that there are warmth, care, support on one hand, and absence of warmth, apathy and neglect, and behaviors that give physical and emotional pain on the other hand, in the extent of parental rejection.

Feelings of rejection and being unloved by parents may arise in children either when the parents are neglecting, or when the children perceive their parents are neglecting. These feelings might also be experienced by children in loving and

warm families. In order to better understand the feelings of a child, whether it is real or perceived; the child's perception of parental rejection should be considered (Rohner et al., 2005). As Kagan points out, "parental rejection is not a specific set of actions by parents but a belief held by the child" (1978, p. 61).

Adolescent children of rejecting parents develop maladaptive mental representations about their environment and themselves, which damages the attachment bond between parent and child leading the child to refuse parental values (Rohner, 2004). Hoeve and colleagues have found that parental rejection, hostility, and neglect are associated with delinquent behaviors (2009). They also found that negative facets of support have stronger connection with delinquency, when compared to inadequate support and warmth. Higher levels of hostility, delinquent behavior and aggression, low self-esteem, emotional instability, and dependency were seen in children of rejecting parents (Palmer & Hollin, 2000; Rohner & Britner, 2002; Russ, Heim, & Westen, 2003; Barnow, Lucht, & Freyberger, 2005).

More generally, parental rejection has been found to be associated with internalizing and externalizing symptoms. Depression in adulthood might occur as a consequence of parental rejection in the childhood (Lefkowitz & Tesiny, 1984). Mothers and fathers who use non-functional, maladaptive parenting aspects are likely to have children with externalizing symptoms (Barnow & Freyberger, 2003; Patterson, Forgatch, Yoerger, & Stoolmiller, 1998). Even though rejection from both mother and father plays a central role in the development of symptomatology in children, the possibility of a child to develop symptoms is higher when the mother is

rejecting than when the father is rejecting (Perris, Jacobson, Lindstorm, Von Knorring, & Perris, 1980; Yahav, 2006).

1.5.3.3. Overprotection

Protective behaviors of parents can take place in a range from neglect to overprotection. Parental overprotection is described as parent's excessive protective behaviors. (Thomasgard, Metz, Edelbrock, & Shonkoff, 1995). A recent research has indicated that "parental overprotection refers to the specific behaviors (e.g., choosing what the child eats or wears, making the child go to sleep at a set time, deciding when the child goes to the bathroom) that a parent engages in despite consideration of the child's developmental stage and need for assistance" (Hullmann et al., 2010, p. 358). Levy proposed that overprotective mothers contact to their children more than others, both physically and socially (1970). She also posited that overprotective parents are extremely concerned about their children and they prevent their children's independent actions. She highlighted the idea that parental overprotection may evoke the feelings of deficiency or non-acceptance in children.

Children with overprotective parents reported that the actions of their parents make them feel they were infantile, highly controlled, and that they do not have a private life (Parker, Tupling, & Brown, 1979). Holmbeck and colleagues have found negative associations between overprotection and behavioral autonomy (Holmbeck et al., 2002). A study by Janssens, Oldehinkel, and Rosmalen (2009) in which they took children report, indicated that parental overprotection is associated with functional somatic symptoms, and that overprotection is a predictor of functional

somatic symptoms. Parental overprotection has been also linked to delinquent behavior, anxiety, depression (Biggam & Power, 1998; Burbach, Kashani, & Rosenberg, 1989; Hudson & Rapee, 2005). Besides, it has been found that both male and female drug abusers reported their parents controlling, apathetic, intrusive, and cold (Schweitzer & Lawton, 2006).

1.5.3.4. Parental Favoritism of a Child over Another

Parental expressions of "affection, intimacy, admiration, and interest" (Bieber, 1977, p. 291) towards a specific child can be thought as the indications of parental favoritism of a child over another. Bieber suggests that children learn who is more preferred by the parents in time and as a result, there would be some consequences for the children. She also implies that, with respect to unique characteristics of each child, parents may act differently towards their children without favoring one over the other (1977).

Favoritism leads to particular personality characteristics in children. Favored child tends to develop grandiosity, and feelings of guilt at the same time. The guilt feelings come from the favored child's idea that because he or she exists, his or her sibling is deprived of their parents' respect, support, and affection (Bieber, 1977). The unpreferred child on the other hand, is likely to feel inferior and hostile to the preferred child; and the unpreferred child also needs to be accepted by his or her parents (Yahav, 2006). Nonetheless, the favored child has needs to know the reasons leading his or her parents to choose him or her. Thus, the child may use his or her power in other areas of life (Bieber, 1977).

Since parents' favoritism disturbs favored children, both preferred and unpreferred children have similar possibilities to develop psychopathology (Bieber, 1977). De-Man, Wong, and Leung have found that negative parenting (e.g., favoritism) is linked to suicidal ideation in adolescents. According to their findings, adolescents who perceived favoritism are more likely to have suicidal thoughts than those who do not perceive favoritism (2003). A similar result has been found by Hui, who also found relations between perceptions of parental favoritism and pathological symptoms (2004).

Birth order is found to affect the parents' preference of a child. Rohde and his colleagues have revealed that the last child of a family with two or three children happens to be the most favored one (Rohde et al., 2003). An explanation might be the fact that younger children get more responsiveness, verbalization, and emotional expression than older children from their parents, which is another finding of the same study. As to the reporting of favoritism, children with higher numbers of siblings were found to report favoritism more accurately than those with few numbers of siblings (Suitor, Sechrist, Steinhour, & Pillemer, 2006).

1.6. Social Support in Adolescents

A significant change is observed in an individual's life, during the adolescence period in which adolescents start to be separated from their parents and they get close to their peers (Collins & Laursen, 2004; Levitt, 2005). This shift in relationships may lead adolescents to perceive higher levels of support from their friends than their parents (Bokhorst et al., 2009). But still, adolescents perceive the highest support from parents. It has been revealed that teacher support also have significant impact on adolescents' lives (Stewart & Suldo, 2011).

Cobb has defined social support as;

1. Information leading the subject to believe that he is cared for and loved.
2. Information leading the subject to believe that he is esteemed and valued.
3. Information leading the subject to believe that he belongs to a network of communication and mutual obligation (1976, p. 300).

Perceived social support, on the other hand, reflects the availability of people's social network to give social support (Cauce, Mason, Gonzales, Hiraga, & Liu, 1994). According to Bronfenbrenner's Ecological Model, both home (including parents) and school contexts (including friends and teachers) have importance on social development of children (1977, 1979, 1986a, 1986b, 1992).

1.6.1. Social Support as a Protective Factor

It is well known that social support weakens stressors in life and helps to improve general well-being (Demaray et al., 2005). Supportive peer relations lead to a decrease in depression and suicidal ideation (Kerr, Preuss, & King, 2006). Also, externalizing symptoms would decrease with higher social support (Stewart & Suldo, 2011; Tandon, Dariotis, Tucker, & Sonenstein, 2013). Previous studies have emphasized the importance of children's mere perception of social support (Haber, Cohen, Lucas, & Baltes, 2007). Even in situations where there is no social support, negative effects of stressful life events are diminished if the child has any perception of social support (Costello, Pickens, & Fenton, 2001).

Gordon (2011) implied that children's perception of social support affects the level of symptom development. Another study pointed out that social support buffers

psychological outcomes, including externalizing symptoms (Wills & Fegan, 2001). Yahav (2006) has revealed that children are likely to develop externalizing symptoms, when they perceive their relationships with their parents as unsupportive. Besides, negative peer relationships are associated with maladaptive behavior in children (Barnow et al., 2005). Those who do not have stable relationships with their peers are likely to have aggressive behavior and externalizing behavior in general (Hymel, Rubin, Rowden, & Lemare, 1990). It has been revealed that adolescents who reported significantly low levels of social support had dysthymic disorder before (Klein, Lewinsohn, & Seeley, 1997). Dishion has exhibited that young adolescents who have psychopathology are more likely to engage in deviant peer groups. His study revealed that, it is more possible for those who exhibit antisocial behaviors at home and at school, and also emotionally distressed to join deviant peer groups and engage in deviant activities (2000).

A recent study has found that perceived social support and psychopathology symptoms are negatively related (Stewart & Suldo, 2011). The findings have shown that support from classmates and teachers predict a decrease in children's internalizing symptoms and an increase in their life satisfaction. However, parental support occurred as the strongest factor in protection from mental health outcomes. Yet another study has proved that children feel assisted and secure when they engage in positive communications with their peers and teachers (Ladd, Birch, & Buhs, 1999). Children's externalizing behavior has been negatively related to teacher support (Baker, 2006). Besides, peer social preference and externalizing behavior has been linked differently from teachers' support (Leflot, van Lier, Verschueren, Onghena, & Colpin, 2011).

1.7. Interaction between Self-Concept, Parenting, and Social Support

In adolescents' perception of their self-esteem, how they perceive their parents' actions towards them and the support they get from their social network have significant effect (Lau & Leung, 1992; Sandler et al., 1989). Previous studies have related parent-child relations with self-concept (Lau & Leung, 1992). In this relation, gender differences lead distinct explanations for male and female adolescents. Parental control affects boys' self-concept more, whereas parental support affects girls' self-concept more (Decovic & Meeus, 1997). It has been found that low self-esteem has an indirect affect on behavioral problems on children, whereas parental and peer rejection is directly related to conduct problems and aggression (Sandler et al., 1989). The indirect effect of self-esteem may be due to the fact that self-esteem itself is affected by parental practices. Decovic and Meeus (1997) revealed that self-concept mediates the relationship between maternal parenting style and peer involvement; whereas paternal parenting was not related to peer involvement or self-concept.

A recent study has found that perceived social support and self-esteem are positively related to each other (Ikiz & Savi-Cakar, 2010). Burke and Weir's study revealed that support from parents and peers are linked to adolescent self-esteem (1979). Self-esteem has been found to be affected mostly by maternal support and acceptance. In the absence of mothers, peer support has a primary influence on self-esteem; whereas paternal support affected adolescent self-esteem less (Decovic & Meeus, 1997; Hoffman, Ushpiz, & Levy-Shiff, 1988). Besides, a study by Dumont and Provost has found positive correlations between self-esteem and community, family, and neighborhood involvement (1999).

Research has implications about the relationship between parenting and social support. Parenting practices are found to mediate the support of adolescents' relatives. The same study showed that once parenting practices are controlled, the effect of kinship support on adolescents has disappeared (Taylor, Casten, & Flickinger, 1993). Ceballo and McLyod have found that the link between parenting behaviors and social support is moderated by the conditions of neighborhood. They have indicated that worse conditions in neighborhood attenuated the positive link between maternal parenting and emotional support. Also, in environments where crime rates are high, the positive impact of social support on parenting has been found to be weak (2002). Support from family and friends leads to positive parent-child relations and preserves from depressive symptoms. Besides, social support and nurturance were found to be positively correlated for mothers (McLyod, 1990). Mothers with higher levels of social environment satisfaction have more positive interaction with their children (Crnic, Greenberg, Robinson, & Ragozin, 1984).

1.8. Aim of the Present Study

The current study aims to explore adolescents with internalizing and externalizing symptoms in terms of their self-concept, perceived parenting behavior and social support. This study also aims to compare the adolescents who have siblings and who do not have any siblings in terms of internalizing and externalizing symptomatology, by parental favoritism. It is also aimed to reveal the effects of age, parental education level, and SES level on adolescents' self-esteem, perception of parenting and social support, and also development in internalizing and externalizing symptoms. A conceptual model is used to test these relationships. Figure 3 shows the model that is tested for this research.

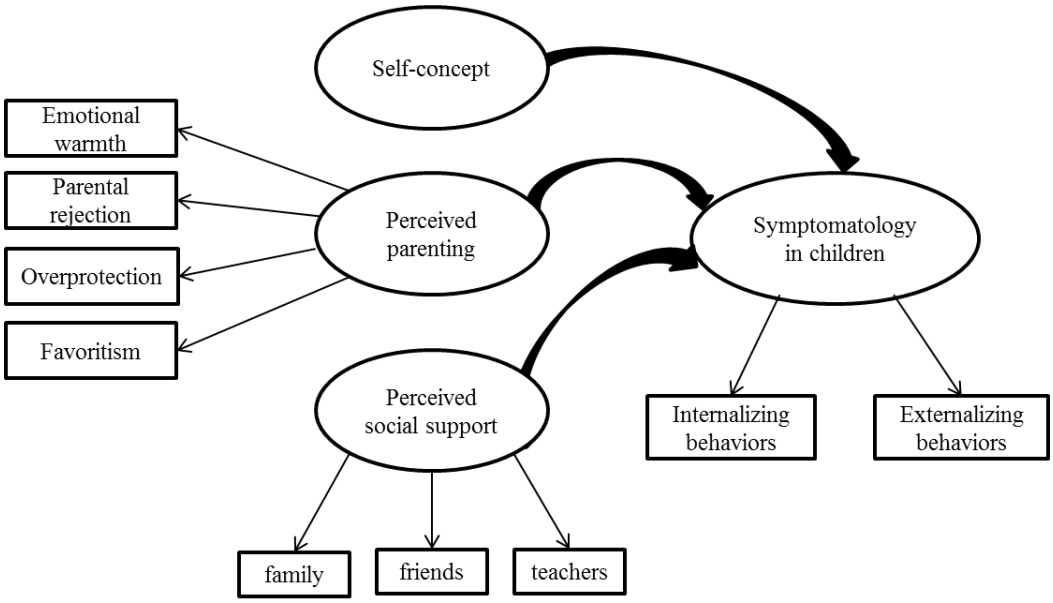

Figure 1. 2. The study model

The constructs introduced above are organized in terms of the effects on adolescents, based on the literature review. The current study intends to test the following hypotheses:

Hypothesis 1: It is predicted that lower self-concept, negative perception of parenting behavior, and lower levels of perceived social support would lead to higher levels of internalizing and externalizing symptomatology.

Hypothesis 2: It is also hypothesized that there is a significant difference between the following groups of children in terms of internalizing and externalizing symptoms:

Group 1: Adolescents who have siblings and perceive parental favoritism (those who had scores above the mean on favoritism sub-scale),

Group 2: Adolescents who have siblings and do not perceive parental favoritism (those who had scores below the mean on favoritism sub-scale),

Group 3: Adolescents who do not have any siblings at all.

Other research questions that are intended to be answered with this study include:

- Are there significant differences between adolescents on different ages in terms of symptomatology, self-concept, perceived parenting behavior and social support they get?
- Are there significant differences between female and male adolescents in terms of symptomatology, self-concept, perceived parenting behavior and social support they get?
- Are there significant differences between parental education level of in terms of adolescent symptomatology, self-concept, perceived parenting behavior and social support?
- Are there significant differences between different socioeconomic levels, in terms of adolescent symptomatology, self-concept, perceived parenting behavior and social support?

In the current study, it is aimed to test the model that was developed to understand the mutual relationship between symptomatology and self-concept, perceived parenting behavior and perceived social support. Along with providing a better understanding of adolescents, it is believed that the results of the study would offer clues for designing appropriate interventions for the amelioration of the psychological functioning of children with internalizing and externalizing behavior. It is intended to enlighten the dynamics under the difference between the perceptions of siblings, by exploring the perspectives of siblings. Since there is not any study to our knowledge that explores the dynamics between a symptom developing children

and a non-symptomatic sibling in terms of individual level and multi-environments in Turkey, the contribution of this study to the field would be of importance.

CHAPTER 2

METHOD

This chapter provides information about the demographic qualities of the participants, the procedure that was followed to conduct the current study, and detailed information about the instruments used in this study.

2.1. Participants

The sample of the current study consisted of 484 adolescents ages between 11 and 18 (M= 13.37, SD=1.55), of whom 210 were male (43.4%), and 262 were female (54.1%). The participants were recruited from two Anatolian high schools [n=34 (7%)], two private high schools [n=34 (7%)], four public middle schools [n=266 (54.9%)], one private middle school [n=88 (18.2%)], and other sources [n=62 (12.8%)]. Adolescents in the last source group of information also attend schools appropriate for their ages, but they were reached personally, rather than being reached via their schools.

Most of the adolescents participated in this study had siblings [n=422 (87.2%)], and 62 (12.8%) of them were single child. 233 (48.2%) of them had siblings older than themselves, and 185 (38.2%) of the siblings are younger than the participants. 218 (45%) of the adolescents in the study had only one sibling, 120 (24.8%) of them had two siblings, and 82 (17.1%) of them had three or more siblings. Only 44 (18.18%) of the adolescents who have siblings turned the sibling questionnaires back. The ages of siblings vary from 0 to 37 (M=15.17, SD=6.89), and 276 (56.6%) of the siblings were between the ages of 11 and 18, as the target population of this study. Among the participant adolescents, 185 (38.2%) of them were the first child of the family, 146 (30.2%) of them were the second child, and 87 (18%) of them were the third child or latter. 5 (1%) of them did not specify their order of sibship.

The adolescents in the study were also asked to complete some information about their parents. The ages of the mothers vary from 29 to 64 (M=40.14, SD=5.64), whereas the fathers' ages were between 30 and 83 (M=44.07, SD=6.48). Educational level of the mothers vary from illiterate (N=47, 9.7%) to higher education (N= 34, 7%). 146 (30.2%) of the mothers were primary school graduates, 70 (14.5%) of them were middle school graduates, 92 (19%) of them were high school graduates, and 83 (17.1%) had bachelor's degree. Fathers' educational levels also vary from illiterate 11 (2.3%) to higher education 40 (8.3%). 133 (27.5%) of the fathers were primary school graduates and 95 (19.6) of them were middle school graduates, 91 (18.8%) of the fathers were high school graduates and 92 (19%) had bachelor's degree. The jobs of the parents also show variance in the current sample. The mothers worked as officers, employees, shopkeepers, engineers, teachers,

doctors, managers, bankers, textile suppliers, or they were self-employed. Among mothers, 304 (62.8%) of them were housewives, 18 (3.7%) of them were retired, and 1 (0.2%) of them was unemployed. Fathers of the adolescents also worked as officers, employees, shopkeepers, engineers, teachers, doctors, managers, bankers, textile suppliers, drivers, suppliers, academicians, or they were self-employed. Among fathers, 12 (2.5%) of them were househusbands, 37 (7.6%) of them were retired, and 3 (0.6%) were unemployed.

Most of the adolescents participated in the current study had intact families 437 (90.3%), and 26 (5.4%) of the adolescents' parents were divorced. There were some differences between the socioeconomic status (SES) of the adolescents' families and the perceptions of adolescents about their SES levels. 153 (31.6%) of the participants were selected from high SES environments, 141 (29.1%) were from middle SES environments, and 190 (39.3%) were from low SES environments. Nevertheless, 59 (12.2%) of the adolescents reported that they were from high SES families, 390 (80.6%) reported that they were from middle SES families, and 33 (6.8%) reported that they were from low SES families.

The adolescents in the study reported that, 89 (18.4%) of them lived in a place other than Istanbul for a long time. The least living outside of Istanbul was 8 months (0.2%), and the longest was 17 years (0.4%). Among them, 45 (8.8%) lived in such a place for more than 5 years. Other than that, 57 (11.8%) of the participants reported that they have seen a mental health professional at least once in their lives. Besides, 18 (3.7%) of the participants were seeing a mental health professional just at the time they completed the questionnaire. The most frequent reason to seeing a

mental health professional among the participants was anger (n= 15, 3.1%). The second most frequent problem were attention deficit (n=10, 2%) and familial issues (n=6, 1.2%). Besides, adolescents who did not have mother or father, and who had mental or cognitive disabilities which would prevent them to answer the questionnaires were excluded from the study.

2.2. Instruments

Adolescents completed a demographic information form, The Achenbach Youth Self Report Questionnaire for identifying level of symptomatology and discovering internalizing and externalizing symptoms, Rosenberg Self-Esteem Scale to understand how they perceive themselves, My Memories of Upbringing for Children (EMBU-C) to have an understanding of their perception of parents and the parents' behaviors towards them, and Social Support Appraisals Scale to understand how they perceive the social support they get.

2.2.1. Socio-Demographic Information Form

The adolescent participants were requested to fill in a socio-demographic information form, as the first instrument for the study (see Appendix D). This form consisted of adolescents' gender, birth date, age, and class. They also reported if they have any siblings, and if they do, they indicated the number of siblings and siblings' ages. Another question on this form asks if they lived in a place other than İstanbul for a long time. The information about their history of seeing a mental health professional was also requested. The information for their mothers' and fathers' ages, level of education, and their jobs were gathered. The last questions on this

questionnaire ask if the mother and father were together, who the adolescent was living with at home, and the adolescents' idea about their level of income.

2.2.2. Achenbach Youth Self Report (YSR; Achenbach & Edelbrock, 1987)

The original form of Achenbach Youth Self Report (YSR) was developed by Achenbach and Edelbrock in 1987. It was developed to screen symptoms of adolescents between the ages 11 and 18, according to the information they give about themselves (Achenbach, 1991). YSR has four pages, in which the first two pages contain demographic questions information and competence items; whereas the last two pages contain items that define behavioral and emotional problems seen in adolescents. The form has 7 competence items and 112 problem items. The last item of the form is an open ended question for the adolescents to add any feelings, thoughts, behaviors, and areas of interest other than the items on the form. Only the problem items were used for the purpose of this study.

Three subscales are acquired from the competence items of YSR: competence, sociability, and school. The competence subscale shows the sportive activities, activities and areas of interest other than sports, and indoors or outdoors works; the sociability subscale shows the club memberships and relationships with peers and siblings; and the school subscale shows the school success, school relate problems, and participation in school activities. These subscales form the *total competence score*. Problem scores, on the other hand, constitute two subscales as *internalizing* and *externalizing*. Internalizing subscale is generated from the total scores of anxiety/ depression, social introversion/ depression, and somatic problems

subtests. Then again, externalizing subscale is generated from the total score of *disobedience to the rules, and aggressive acts* subtests. Other than these, there are three more subtests in the test, *social problems, thought problems, and attention problems,* which are included neither in internalizing nor in externalizing subscales. The total scores from these subtests also included, when the total score of YSR is computed. Besides, subtests that are coherent to DSM are also obtained from YSR: mood disorder, anxiety disorder, somatization disorder, attention deficit – hyperactivity disorder, oppositional defiant disorder and conduct disorder. Achenbach and Rescorla added three more subtests to YSR in 2007: obsessive-compulsive disorder, post-traumatic stress disorder, and positive characteristics.

YSR is a self-report form, which the adolescents are expected to complete themselves. The wording of YSR is in the first person. Adolescents score the problem items from 0 to 2, where 0 stands for "not true", 1 stands for "somewhat or sometimes true", and 2 stands for "very true or often true". The sum of competence, sociability, and school subscale scores generate total competence score; and the sum of internalizing and externalizing subscale scores, together with the sum of obsessive-compulsive disorder, post-traumatic stress disorder, and positive characteristics scores generate total problem score (Erol & Şimşek, 2010). The demographic information are not scored. Some of the problem items (items 2, 9, 29, 40, 46, 56d, 56h, 58, 66, 70, 77, 79, 83, 84, 85, 100, 105) have also explanation parts where adolescents are expected to explain their answers. Those items are scored according to the adolescent's explanation's relevance with the item.

Internal consistencies and test-retest correlation coefficients were obtained both for the original form and the Turkish form of YSR, to show the level of relationship of each item with another, and to reflect the differences in the ordering. Cronbach alpha internal consistency coefficients of competence subscale of the original YSR form have shown variance between .55 and .75. Test-retest reliability Pearson correlation coefficient for the same subscale was .89. For the social introversion/ depression and social problems, Cronbach alpha coefficient was found <.75, and for the DSM – coherent subtests, Cronbach alpha was between .67 and .83. Test-retest reliability Pearson correlation coefficients for the total problem score was .87 (Erol & Şimşek, 2010).

Turkish standardization study of YSR was conducted by Erol, Arslan, and Akçakın in 1995 (see Appendix E). Test-retest reliability Pearson correlation coefficient of the Turkish form of the 1991 YSR form was .81 for total competence, and .82 for total problem subscale. Cronbach alpha internal consistency coefficient of the 2001 YSR form of competence subscale of the Turkish form of YSR was .92, and the test-retest reliability Pearson correlation coefficient was .88 for the same subscale. Cronbach alpha internal consistency coefficient of total problem subscale was .95, and the test-retest reliability Pearson correlation coefficient was .87 (Erol & Şimşek, 2010).

2.2.3. Rosenberg Self-Esteem Scale (RSES; Rosenberg, 1965)

Rosenberg Self-Esteem Scale (RSES) was developed by Morris Rosenberg in 1965. It was developed to measure individuals' self-reported global self-esteem and

self-worth. These concepts are obtained by assessing positive and negative attitudes towards the self. The target population of the scale is identified as adolescents, whereas it has been shown in the following years that the scale was also appropriate for adults (Farran, 2004). The scale consists of 10 items. Although the scale has been designed as a Guttman scale originally, it is scored as a Likert scale at the present time. The scale is scored on a 4-point scale where 3 stands for strongly agree and 0 stands for strongly disagree. Items 1,2,4,6, and 7 are scored according to the given coding system, and the items 3, 5, 8, 9, and 10 are scored reversed. The self-esteem score is obtained by summing the points of each item and individuals with higher self-esteem get higher scores on the scale. The highest score that can be obtained from the scale is 30. Cronbach alpha internal consistency coefficient for this scale differed between .77 and .88 for different samples and test-retest reliability Pearson correlation coefficient differed between .82 and .88 (Rosenberg, 1986).

Rosenberg Self-Esteem Scale was adapted to Turkish by Çuhadaroğlu (1986) (see Appendix F). She applied the scale to adolescents aged between 15 and 18 twice. The second application was one month after the first one. As a result, test-retest reliability Pearson correlation coefficient of the scale was found between .46 and .89. (Çuhadaroğlu, 1986). The Cronbach alpha internal consistency coefficient for this subscale was found to be as .88 for the Turkish sample, as well as the USA sample (Schmitt & Allik, 2005). To test the validity of the scale, eight students were randomly selected from the sample, who were interviewed to rank their level of self-esteem. The scale was found to be as valid (Çuhadaroğlu, 1986).

2.2.4. My Memories of Upbringing for Children (Egna Minnen Beträffande Uppfostran, EMBU-C; Markus, Lindhout, Boer, Hoogendjik, & Arrindell, 2003)

The original scale of My Memories of Upbringing (EMBU) was developed to assess adults' perception of parental rearing behaviors (Perris et al., 1980). The previously occurring 14 aspects of EMBU were later reduced to four core aspects: rejection, emotional warmth, overprotection, and favoring subject (Arrindell, Emmelkamp, Brilman, & Monsma, 1983; Arrindell & van der Ende, 1984). Further studies have shown that the first three dimensions fit in various cultures, but favoring subject has a rather poor replicability; so the studies suggested that this dimension is culture-specific (Arrindell et al., 1994).

The actual perception of parental rearing was needed to be assessed in order to the recalled memories of parenting (Arrindell, Emmelkamp, Brilman, & Monsma, 1983). This need contributed to the development of an adolescent version (EMBU-A; Castro, Toro, Arrindell, Van der Ende, & Puig, 1990; Gerlsma, Arrindell, Van der Veen, & Emmelkamp, 1991) and a child version (EMBU-C; Castro, Toro, Van der Ende, & Arrindell, 1993) by doing several modifications on the adult version of EMBU. Muris and his colleagues conducted studies by using EMBU-C (Muris, Muris, Bögels, Van der Kamp, & Van Oosten, 1996; Muris, Bosma, Meesters, & Schouten, 1998) as modified by Castro et al. (1993) and found that some of the subscales of both the adult and child versions of EMBU had weak internal consistencies. Even though there is also an adolescent version of EMBU, since ages of the adolescents in the current study range between 11 and 18, EMBU-C was used

in the current study, rather than using EMBU-A. It was intended to be made sure that all the participants in the current study see the same version of questions. Besides, EMBU-A did not include one of the subscales, favoring subject, which was intended to be measured.

The recent child form of EMBU-C was modified by Markus, Lindhout, Boer, Hoogendjik, and Arrindell (2003). It measures the participants' perception of emotional warmth, rejection, overprotection and favoring subject of their parents, which also named the subscales of the scale. The target population of the scale is children between ages 7 and 13. The scale has 52 items which consists 4 subscales. The language of the scale is on first-person and all the questions are asked both for mother and father. The children were requested to mark their answers for their mother and their father separately on a 4-point Likert scale (1= No, never, 2= Yes, sometimes, 3= Yes, often, 4= Yes, nearly always).

The Cronbach's alpha internal consistency coefficients for father emotional warmth, rejection, overprotection, and favoring subject were .89, .84, .64, and .54. The Cronbach's alpha coefficients for mother emotional warmth, rejection, overprotection, and favoring subject were .87, .83, .67, and .58. Parents were rated similarly on distinct scales by children. The Pearson correlation of rejection was found to be as .70, .86 for emotional warmth, .81 for overprotection, and .83 for favoring subject. The Pearson correlation of maternal emotional warmth was found between .39 and .68, maternal rejection was between .32 and .59, maternal overprotection was between .30 and .47, and maternal favoritism between .42 and .59. Pearson correlation of paternal emotional warmth was found between .36 and

.74, paternal rejection between .31 and .62, paternal overprotection between .31 and .47, paternal favoring subject between .41 and .54.

The adaptation study of EMBU-C in Turkey was done by Gökler-Danışman and Cüre (submitted) (see Appendix G). The Turkish form of the scale has 50 items which compose 5 subscales: emotional warmth, punishment and emotional pressure, physical punishment, overprotection and intrusiveness and favoritism. The questions are also asked both for mother and father in the Turkish form. The children were requested to mark their answers for their mother and their father separately on a 4-point Likert scale (1= No, never, 2= Yes, sometimes, 3= Yes, often, 4= Yes, nearly always). Besides, the favoritism items (2, 6, 17, 44, 49) are rated on a 5-point Likert scale (0= Not applicable option is added to those items). Items number 8 and 43 are coded reversed for the Turkish version of the scale.

The Cronbach's alpha internal consistency coefficients for the Turkish form of mother emotional warmth, punishment and emotional pressure, physical punishment, overprotection and intrusiveness, and favoritism were .94, .72, .82, .65 and .55, respectively. The Cronbach's alpha coefficients for father emotional warmth, rejection, overprotection, and favoritism were .95, .77, .87, .71 and .69, respectively. Parents were rated similarly on distinct scales by children. The Pearson correlation of maternal emotional warmth was found between .41 and .78, maternal punishment and emotional pressure between .40 and .63, maternal physical punishment between .63 and .74, maternal overprotection and intrusiveness between .59 and .72, and maternal favoritism between .53 and .79. On the other hand, the Pearson correlation of paternal emotional warmth was found between .50 and .81,

paternal punishment and emotional pressure between .52 and .64, paternal physical punishment between .71 and .77, paternal overprotection and intrusiveness between .62 and .75, and paternal favoritism between .53 and .82 (Gökler-Danışman & Cüre, submitted).

2.2.5. Social Support Appraisals Scale (Dubow & Ullman, 1989)

The Social Support Appraisals Scale, developed by Dubow and Ullman (1989), was used to assess children's and adolescents' perception of social support they get from their families, friends, and teachers. The scale has originally developed as 31 items, but later Dubow and colleagues reviewed the scale. The last version of the scale took its final form as 41 items with the additions of questions about social support from classmates and teachers (Dubow, Tisak, Causey, Hryshko, & Reid, 1991). The scale has 3 subscales: friend support, family support, and teacher support. The target population of the scale was third, fourth, and fifth grade children. The children were requested to mark their answers on a 5-point Likert scale, where 1 stands for never, and 5 stands for always. The Cronbach alpha internal consistency coefficient of the total scale was .93. The Cronbach alpha internal consistency coefficient of 19-item peer support subscale was .88, for 12-item family support subscale the Cronbach alpha coefficient was .92, and for 10-item teacher support subscale the Cronbach alpha coefficient was .86.

The Social Support Appraisals Scale was adapted to Turkish by Gökler (2007) (see Appendix H). The scale was applied to 358 children and adolescents aged between 9 and 17 (M= 10.9). The sample was recruited from families from

three different socioeconomic statuses. The sample also included a clinical group in which participants had various psychological complaints. The Cronbach alpha internal consistency coefficient for this scale was found to be as .93 for the Turkish sample. The Cronbach alpha internal consistency coefficients for the subscales of the scale were found .89 for friend support, .86 for family support, and .88 for teacher support. To test the consistency of the scale through time, the scale was given to 68 children and adolescents for a second time, two weeks after the first application. As a result, test-retest reliability coefficient for the whole scale was found to be as .49 ($p < .001$), and the split-half reliability coefficient of the scale was .82.

2.3. Procedure

The field work of the current study has started by taking permission for the application. The research proposal, the instruments that were planned to use and the list of schools (middle and high schools) in which the research was going to be applied were submitted to the Bahçeşehir University Scientific Research and Publication Ethics Committee (see Appendix A). After taking approval from this committee, to apply the questionnaires in schools, the same files of documents were submitted to the Turkish Ministry of Education.

By the time the approval for the application of the questionnaires from the Turkish Ministry of Education has been received, the principles of the schools on the list were contacted and their permissions were taken for the application. The data collection process was started in November, 2013 for the current study, and ended at the beginning of March, 2014. With the cooperation of the principal and the school counselors, the available classes were determined for the application. None of the

12th grade students were included in the study, as the directors of the schools requested, due to the university entrance exams.

The administrators of three out of eight of these schools preferred to have the adolescents complete the questionnaires at school in available course hours. In the other five schools, the questionnaires were given to the students for them to complete at home and bring them back. Besides, questionnaires were given also for the siblings of the students in those five schools. Those students who completed the questionnaires at home were given an informed consent letter to their parents, which contained communication information of the researcher and the advisor (see Appendix B). This letter informed the parents about the importance of their children's participation in the study, that all the information gathered would be in confidentiality. All sets of questionnaires were initiated with an informed consent for the participants (see Appendix C) and socio-demographic form, but the order of preceding questionnaires was determined by applying counterbalance technique.

The beginning of the application of the questionnaires was the same for all the schools, whether they were to complete them at school or at home. In each school, the researcher entered the classes one by one, with a school counselor or with the principle, and explained the study's purposes, subjects, and the importance of their participation. The students were told to bring the questionnaires back in one week and deliver them to their school counselor or principle. Since this was a volunteer work, the researcher asked for those who wanted to participate in the study, after finishing her explanation. The students were also asked if they had any

questions about the study, and those who had were answered before going out of the class.

CHAPTER 3

RESULTS

The analyses of the study are provided in three separate sections. The first section includes descriptive analyses and bivariate correlations of the variables in the study. In the second section, the results of the regression analyses of the study variables (gender, age, parental education levels, family SES levels; self-esteem; friend, family, and teacher support; emotional warmth, punishment and emotional pressure, physical punishment, overprotection and intrusiveness, and favoritism) and internal external symptomatology are presented. The last section gives the ANOVA results of the effect of maternal and paternal favoritism on internalizing and externalizing symptomatology among children with and without siblings.

3.1. Descriptive and Bivariate Analyses

This section provides information about the descriptive qualities of the variables of the study. To have an understanding between the associations of the variables, bivariate correlations among age, gender, SES level, educational level of mother and father, internalizing and externalizing symptom levels of the participants, self-esteem, social support; friend, family and teacher support; and emotional

warmth, punishment/ emotional pressure, physical punishment, overprotection/ intrusiveness and favoritism for mothers and fathers were performed.

3.1.1. Data Screening and Descriptive Analysis

All variables were screened for the accuracy of data entry to eliminate any errors, prior to analysis. The data was also screened for the fit between the distributions of the variables and if the assumptions of multivariate analysis were confirmed. To treat missing data, number 999 was entered to the empty cells for the demographic variables in the study (age, gender, SES levels of the family, educational levels of mothers and fathers). For the study variables which were self-esteem, social support, friend support, family support, teacher support, emotional warmth, punishment/ emotional pressure, physical punishment, overprotection/ intrusiveness and favoritism, the mean values of the series were used to treat missing data. For internalizing symptom and externalizing symptom variables on the other hand, the mean values of each participant were used to treat missing data. As proposed in the manual of the scale that assesses symptomatology (YSR; Erol & Şimşek, 2010), scales that have missing values more than 8 items were excluded from the study (N= 35). The normality, linearity, and homoscedasticity assumptions were met. The means and standard deviations of the study variables for the two age groups, both genders, and SES levels can be seen in Table 3.1. Also, Table 3.2 shows the mean differences and standard deviations for parental education levels.

Table 3. 1. Means and Standard Deviations of the Study Variables by Gender, Age, and SES Level

	Gender				Age				SES Level					
	Female		Male		Middle School		High School		Low		Middle		High	
	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD
Self-Esteem	21.07	5.33	20,95	5.07	21.38	4.85	20.35	5.62	19.86	4.87	21.72	4.86	21.50	5.76
Total Social Support	163.12	23.86	160.64	24.42	162.97	24.90	160.46	22.88	153.10	24.24	167.47	22.93	167.56	21.49
Friend Support	74.26	12.43	73.81	12.95	73.72	13.10	74.15	12.04	69.63	12.54	76.08	12.46	77.23	11.39
Family Support	50.87	8.82	50.57	8.37	51.50	8.42	49.79	8.78	47.50	8.99	52.83	7.23	52.82	8.09
Teacher Support	37.99	7.64	36.27	8.11	37.76	8.25	36.53	7.30	35.96	7.33	38.56	7.65	37.51	8.48
Maternal Emotional Warmth	76.12	13.98	75.77	13.09	78.51	11.98	72.73	14.67	72.93	13.35	77.04	13.33	78.67	13.32
Paternal Emotional Warmth	72.60	16.34	73.17	14.82	75.42	13.96	69.79	16.97	70.68	15.34	72.78	15.93	75.84	15.25
Maternal Punishment and Emotional Pressure	18.18	4.27	18.49	4.71	18.17	4.62	18.58	4.35	19.27	4.32	17.76	3.92	17.77	5.04
Paternal Punishment and Emotional Pressure	16.63	4.59	18.00	5.00	17.03	4.92	17.53	4.72	18.30	4.94	16.71	4.12	16.45	5.11
Maternal Physical Punishment	9.62	3.17	9.95	3.13	9.81	3.28	9.78	3.09	10.77	3.58	9.19	2.74	9.16	2.78
Paternal Physical Punishment	9.07	3.01	10.19	3.75	9.41	3.19	9.77	3.70	10.38	3.89	9.22	3.22	8.89	2.74
Maternal Overprotection and Intrusiveness	14.13	3.25	13.73	3.66	14.20	3.51	13.69	3.32	14.00	3.07	14.54	3.31	13.41	3.88
Paternal Overprotection and Intrusiveness	12.53	3.58	12.52	3.63	12.67	3.58	12.33	3.61	12.89	3.38	12.86	3.84	11.75	3.52
Maternal Favoritism	7.80	2.44	7.70	2.24	7.73	2.45	7.87	2.34	8.06	2.54	7.59	2.14	7.60	2.44
Paternal Favoritism	8.13	2.91	7.91	2.87	8.06	3.08	8.02	2.62	8.42	3.08	7.76	2.73	7.74	2.66
Internalizing Symptoms	18.39	10.05	15.12	9.35	16.91	9.63	17.38	10.43	19.85	10.28	16.40	9.71	14.38	9.01
Externalizing Symptoms	11.24	8.19	12.48	9.49	11.51	9.36	12.61	8.56	13.67	10.47	10.37	8.09	11.41	7.47

Table 3. 2. Means and Standard Deviations of the Study Variables by Parental Level of Education

	Maternal Education Level						Paternal Education Level					
	Low		Middle		High		Low		Middle		High	
	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD
Self-Esteem	20.00	4.71	21.31	5.31	22.00	5.77	20.40	4.71	20.70	5.14	21.88	5.87
Total Social Support	154.44	23.37	167.76	23.25	165.96	23.09	156.65	25.41	162.72	24.15	166.03	21.28
Friend Support	70.13	12.77	76.66	11.57	76.19	12.32	71.01	13.58	74.36	12.11	76.11	11.75
Family Support	48.28	8.80	52.31	8.02	52.89	8.18	48.99	8.56	50.77	8.98	52.90	7.68
Teacher Support	36.02	7.31	38.79	7.25	36.88	9.06	36.64	7.66	37.59	7.56	37.02	8.64
Maternal Emotional Warmth	72.22	13.67	78.73	12.49	78.34	13.41	73.14	13.15	76.13	14.33	78.60	12.48
Paternal Emotional Warmth	68.70	16.43	75.31	14.25	76.71	14.34	68.94	15.69	73.12	15.97	76.36	14.57
Maternal Punishment and Emotional Pressure	18.97	4.39	18.25	4.35	17.36	4.67	18.71	4.63	18.37	4.20	17.74	4.68
Paternal Punishment and Emotional Pressure	17.88	4.67	17.25	4.96	16.00	4.74	17.41	4.49	17.70	5.14	16.30	4.66
Maternal Physical Punishment	10.56	3.61	9.39	2.76	8.96	2.44	10.26	3.56	9.93	3.16	9.07	2.63
Paternal Physical Punishment	10.20	3.70	9.16	3.23	8.95	2.81	9.99	3.53	9.66	3.61	8.95	2.91
Maternal Overprotection and Intrusiveness	14.03	3.70	14.79	3.06	12.76	3.16	14.16	3.63	14.33	3.38	13.24	3.30
Paternal Overprotection and Intrusiveness	12.43	3.71	13.17	3.37	11.64	3.57	12.16	3.74	13.08	3.43	11.92	3.64
Maternal Favoritism	7.99	2.38	7.30	2.31	7.87	2.39	7.77	2.25	7.87	2.52	7.47	2.28
Paternal Favoritism	8.18	3.03	7.90	2.95	7.75	2.32	8.05	2.95	8.09	3.02	7.74	2.57
Internalizing Symptoms	19.35	9.74	16.99	10.16	13.68	9.21	18.55	9.62	17.81	10.04	15.02	9.92
Externalizing Symptoms	13.24	10.35	11.17	8.43	11.05	7.17	12.59	10.51	11.94	8.32	11.56	7.95

3.1.2. Correlations among the Study Variables

Bivariate Pearson Product Moment Correlation analyses were performed to calculate the estimates between the study variables. Table 3.3 shows the Pearson correlation coefficients and levels of significance of these variables.

Pearson correlation results showed that, age was positively correlated with SES level, parental education level, and externalizing symptoms. On the other hand, age was negatively correlated with total social support, family support, teacher support, and parental emotional warmth. The results suggested that as adolescents got older, their SES level, their parents' educational level, and their externalizing symptom levels increased. However, younger adolescents perceived more social support, family support, teacher support, and parental emotional warmth. Age was not correlated with internalizing symptom, self-esteem, friend support, parental physical punishment, parental physical punishment, paternal overprotection and intrusiveness, and parental favoritism ($p > .05$).

According to the correlation results, SES level was positively correlated with age, parental education, self-esteem, total social support, friend support, family support, and parental emotional warmth. In other respects, SES level was found to be negatively correlated with internalizing and externalizing symptoms, parental punishment and emotional pressure, parental physical punishment, paternal overprotection and intrusiveness, and paternal favoritism. These results showed that, SES levels increased as age of adolescents, education levels of parents, self-esteem,

Table 3. 3. Pearson Product Moment Correlations among the study Variables

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21
1. Age		.17**	.11*	.11*	.03	.10*	-.07	-.01	-.11*	-.15**	-.10*	-.17**	-.17**	.03	.03	-.02	.08	-.05	-.01	.06	.07
2. SES Level			.67**	.64**	-.23**	-.11*	.14**	.26**	.27**	.09	.26**	.18**	.14**	-.15**	-.16**	-.22**	-.19**	-.06	-.13**	-.08	-.10*
3. Mother Education				.76**	-.20**	-.07	.16**	.21**	.22**	.07	.21**	.18**	.17**	-.14**	-.16**	-.21**	-.17**	-.11*	-.08	-.04	-.07
4. Father Education					-.12**	-.01	.11*	.15**	.18**	.02	.15**	.16**	.18**	-.08	-.10*	-.15**	-.15**	-.10*	-.03	-.01	-.05
5. Internalizing Symptom						.66**	-.43**	-.41**	-.37**	-.30**	-.45**	-.30**	-.27**	.44**	.40**	.43**	.33**	.05	.00	.31**	.23**
6. Externalizing Symptom							-.29**	-.30**	-.39**	-.32**	-.40**	-.29**	-.24**	.33**	.33**	.41**	.38**	-.03	-.04	.30**	.21**
7. Self-Esteem								.47**	.51**	.47**	.58**	.46**	.44**	-.33**	-.29**	-.37**	-.32**	.11*	.19**	-.17**	-.18**
8. Friend Support									.51**	.51**	.87**	.35**	.27**	-.28**	-.28**	-.34**	-.22**	.04	.06	-.29**	-.25**
9. Family Support										.53**	.80**	.66**	.55**	-.35**	-.36**	-.48**	-,458**	.17**	.21**	-.25**	-.29**
10. Teacher Support											.78**	.39**	.36**	-.26**	-.26**	-.33**	-.33**	.11*	.19**	-.24**	-.22**
11. Total Social Support												.55**	.46**	-.36**	-.36**	-.46**	-.39**	.12*	.17**	-.31**	-.30**
12. Maternal Emotional Warmth													.65**	-.34**	-.24**	-.55**	-.41**	.37**	.32**	-.20**	-.25**
13. Paternal Emotional Warmth														-.24**	-.33**	-.33**	-.56**	.21**	.50**	-.16**	-.13*
14. Maternal Punishment/ Emotional Pressure															.63**	.65**	.43**	.21**	.05	.40**	.33**
15. Paternal Punishment/ Emotional Pressure																.48**	.62**	.09*	.11*	.33**	.30**
16. Maternal Physical Punishment																	.57**	-.02	-.05	.37**	.42**
17. Paternal Physical Punishment																		-.08	-.10*	.27**	.29**
18. Maternal Overprotection/ Intrusiveness																			.47**	.04	-.03
19. Paternal Overprotection/ Intrusiveness																				.03	.05
20. Maternal Favoritism																					.58**
21. Paternal Favoritism																					

** Correlation is significant at the 0.01 level (2-tailed).

* Correlation is significant at the 0.05 level (2-tailed).

total social support, friend support, family support, and parental emotional warmth increased. On the contrary, as SES level decreased, internalizing and externalizing symptoms increased, and adolescents perceived higher levels of parental punishment and emotional pressure, parental physical punishment, paternal overprotection and intrusiveness, and paternal favoritism. SES level was not found to be correlated with teacher support, maternal overprotection and intrusiveness, and maternal favoritism ($p > .05$).

Results indicated that, education levels of mothers and fathers were positively correlated with age, SES level, self-esteem, total social support, friend support, family support, and parental emotional warmth. Mothers' education levels and fathers' education level were positively correlated with each other. On the other hand, mother and father education levels were negatively correlated with internalizing symptom, paternal punishment and emotional pressure, parental physical punishment, and maternal overprotection and intrusiveness. Mothers' level of education was also negatively correlated with maternal punishment and emotional pressure. Accordingly, as the education levels of both parents (separately) increased, the SES level of families, self-esteem of adolescents, adolescents' perception of social support, friend support, family support, and parental emotional warmth increased. Also, results indicated that education levels of mother and father increase or decrease together. Besides, as the education level of mothers and fathers decreased, internalizing symptom levels of adolescents, their perception of paternal punishment and emotional pressure, parental physical punishment, and maternal overprotection and intrusiveness increased. Also, as education level of mother increased, adolescents perceived less maternal punishment and emotional pressure.

Maternal and paternal education levels were not correlated with externalizing symptoms, teacher support, paternal overprotection and intrusiveness, and parental favoritism ($p > .05$). Education level of father was also not correlated with maternal punishment and emotional pressure ($p > .05$).

According to the results, internalizing symptom was negatively correlated with SES level, mothers' and fathers' educational level; self-esteem; total social support; friend, family, and teacher support; and parental emotional warmth. On the other hand, internalizing symptom was found to be positively correlated with externalizing symptom, parental punishment and emotional pressure, parental physical punishment, and parental favoritism. Similarly, externalizing symptom was found to be negatively correlated with SES level, self-esteem; total social support; friend, family, and teacher support; and parental emotional warmth. Externalizing symptom was positively correlated with age, internalizing symptom, parental punishment and emotional pressure, parental physical punishment, and parental favoritism. Bivariate correlation results showed that, as adolescents had higher SES homes, higher educated parents, higher self-esteem, and perceived much social support (including family, friend, and teacher support) and parental emotional warmth, both the level of internalizing and externalizing symptomatology among adolescents decreased. On the other hand, as they perceived much parental punishment and emotional pressure, parental physical punishment, and parental favoritism, the level of both internalizing and externalizing symptom adolescents report increased. Other than that, as the level of parental education increased, the level of internalizing symptomatology among adolescents decreased, whereas, the externalizing symptom levels increased with age. There were no significant

correlations between internalizing symptom and age, and overprotection and intrusiveness; whereas externalizing symptom was not significantly correlated with parental education level, and overprotection and intrusiveness.

Pearson correlation results indicated that, self-esteem was positively correlated with SES level, parental level of education, total social support; friend, family, and teacher support; parental emotional warmth; and parental overprotection and intrusiveness. With any increase in these variables, adolescents' self-esteem increased, too. Self-esteem was negatively correlated with internalizing and externalizing symptoms, parental punishment and emotional pressure, parental physical punishment, and parental favoritism. Accordingly, increase in these variables may have led to reduction in adolescents' self-esteem. There were no significant correlations between self-esteem and age ($p > .05$).

Results also specified that, total social support was positively correlated with SES level, parental education level, self-esteem, friend support, family support, parental emotional warmth, and parental overprotection and intrusiveness. Total social support negatively correlated with age, internalizing and externalizing symptoms, parental punishment and emotional pressure, parental physical punishment, and parental favoritism. According to the correlation coefficients, as SES level, parental education level, self-esteem, friend support, family support, parental emotional warmth, and parental overprotection and intrusiveness increase, social support adolescents perceive increased, too. On the other hand, as adolescents perceived higher levels of social support, they also perceived less internalizing and externalizing symptoms, parental punishment and emotional pressure, parental

physical punishment, and parental favoritism. Total social support was found to be not correlated with teacher support ($p > .05$).

Correlation results showed that, friend support was positively correlated with SES level, parental education level, self-esteem, total social support, family support, teacher support, and parental emotional warmth. With any increase in these variables, adolescents were more likely to perceive higher friend support. Friend support was negatively correlated with internalizing and externalizing symptoms, parental punishment and emotional pressure, parental physical punishment, and parental favoritism. Accordingly, increase in these variables may have led to reduction in adolescents' perception of friend support. Friend support was not correlated with age and parental overprotection and intrusiveness ($p > .05$).

Pearson correlation results indicated that, family support was positively correlated with SES level, parental education level, self-esteem, total social support, friend support, teacher support, parental emotional warmth, and parental overprotection and intrusiveness. With any increase in these variables, adolescents were more likely to perceive much more support from their families. Family support was negatively correlated with age, internalizing and externalizing symptoms, parental punishment and emotional pressure, parental physical punishment, and parental favoritism. Accordingly, increase in these variables may reduce adolescents' perception of family support.

Results showed that, teacher support was positively correlated with self-esteem, total social support, friend support, family support, parental emotional

warmth, and parental overprotection and intrusiveness. With any increase in these variables, adolescents were more likely to perceive higher support from their teachers. Teacher support was negatively correlated with age, internalizing and externalizing symptoms, parental punishment and emotional pressure, parental physical punishment, and parental favoritism. Increase in these variables may decrease adolescents' level of teacher support perception ($p > .05$).

According to the results, parental (both maternal and paternal) emotional warmth were positively correlated with SES level, parental education level, self-esteem, total social support, friend support, family support, teacher support, and parental overprotection and intrusiveness. Besides, maternal emotional warmth was positively correlated with paternal emotional warmth; and paternal emotional warmth was positively correlated with maternal emotional warmth. With any increase in these variables, adolescents were more likely to perceive higher parental emotional warmth. Maternal and paternal emotional warmth were negatively correlated with age, internalizing and externalizing symptoms, parental punishment and emotional pressure, parental physical punishment, and parental favoritism. Accordingly, as these variables increase, adolescents' perception of parental emotional warmth might have been decreased.

Pearson correlation results showed that, both maternal and paternal punishment and emotional pressure were positively correlated with internalizing and externalizing symptoms, parental physical punishment, overprotection and intrusiveness of mothers, and parental favoritism. Paternal punishment and emotional pressure was also positively correlated with overprotection and intrusiveness of

fathers. Besides, maternal punishment and emotional pressure and paternal punishment and emotional pressure were positively correlated with each other. On the other hand, maternal and paternal punishment and emotional pressure were negatively correlated with SES level, educational level of mother; self-esteem; total social support; friend, family, and teacher support. Paternal punishment and emotional pressure was also negatively correlated with educational level of father. Bivariate correlation results showed that, as adolescents perceived higher punishment and emotional pressure both from their mother and fathers, their report of internalizing and externalizing symptoms, perception of parental physical punishment, overprotection and intrusiveness of mothers, and parental favoritism increased. Also, as adolescents' perception about their father as being punishing and emotionally oppressive increased, their perception of mothers' punishment and emotional pressure, and overprotection and intrusiveness of fathers increased, too. Similarly, as adolescents perceived their mothers as being more punishing and emotionally oppressive, their perception about fathers being punishing and emotionally oppressive increased. On the other hand, as SES level, educational level of mother; self-esteem of adolescents; total social support; friend, family, and teacher support that adolescents perceived decreased, they perceived less punishment and emotional pressure from their mothers and fathers. Besides, as the educational level of father decreased, adolescent perception of punishment and emotional pressure from father increased. Both maternal and paternal punishment and emotional pressure were not correlated with age ($p > .05$).

According to the correlation results, maternal physical punishment and paternal physical punishment were positively correlated with internalizing and

externalizing symptoms, parental punishment and emotional pressure, and parental favoritism. Besides, maternal physical punishment and paternal physical punishment were positively correlated with each other. On the other hand, maternal physical punishment and paternal physical punishment were negatively correlated with SES level; educational level of mothers and fathers; self-esteem; total social support; family, friend, and teacher support; and maternal and paternal emotional warmth. Paternal physical punishment was also found to be negatively correlated with paternal overprotection and intrusiveness. These results indicated that, as adolescents perceived higher levels of maternal and paternal physical punishment, their internalizing and externalizing symptoms, along with their perception of parental punishment and emotional pressure, and parental favoritism increased. Also, as adolescents' perception of maternal physical punishment increase, they perceived more paternal physical punishment; and as their perception of paternal physical punishment increase, they perceived more maternal physical punishment. In other respects, as SES level; educational level of mothers and fathers; self-esteem; total social support; family, friend, and teacher support; and maternal and paternal emotional warmth increase, adolescents' perception of maternal and paternal physical punishment decreased. Also, as adolescents perceived lower levels of physical punishment from their fathers, their perception of paternal overprotection and intrusiveness decreased. Both maternal physical punishment and paternal physical punishment were not correlated with age and maternal overprotection and intrusiveness. Maternal physical punishment was not correlated also with paternal overprotection and intrusiveness ($p > .05$).

Pearson correlation results indicated that, maternal and paternal overprotection and intrusiveness were positively correlated with self-esteem, total social support, family support, teacher support, maternal and paternal emotional warmth, and paternal punishment and emotional pressure. Besides, maternal overprotection and intrusiveness and paternal overprotection and intrusiveness were positively correlated with each other. On the other hand, maternal overprotection and intrusiveness was negatively correlated with maternal and paternal education levels, whereas paternal overprotection and intrusiveness was negatively correlated with paternal physical punishment and SES level. Accordingly, as adolescents had higher self-esteem; and as they perceived higher social support, family support, teacher support, maternal and paternal emotional warmth, and paternal punishment and emotional pressure, they perceived higher maternal and paternal overprotection and intrusiveness. Also, as their perception of maternal overprotection and intrusiveness increased, their perception of paternal overprotection and intrusiveness; and as their perception of paternal overprotection and intrusiveness increased, their perception of maternal overprotection and intrusiveness increased, too. On the contrary, as adolescents had parents with lower levels of education, they perceived higher levels of maternal overprotection and intrusiveness; whereas as they had lower levels of SES and as they perceived lower levels of paternal physical punishment, their perception of paternal overprotection and intrusiveness increased. Maternal paternal overprotection and intrusiveness was not correlated with age, SES level, internalizing and externalizing symptoms, friend support, parental physical punishment, and parental favoritism ($p > .05$). Paternal overprotection and intrusiveness was not correlated with age, parental education level, internalizing and externalizing

symptoms, friend support, maternal punishment and emotional pressure, maternal physical punishment, and parental favoritism ($p > .05$).

Correlation results indicated that, maternal favoritism and paternal favoritism both positively correlated with internalizing and externalizing symptoms, parental punishment and emotional pressure, and parental physical punishment. Maternal favoritism and paternal favoritism were also positively correlated with each other. In other respects, maternal and paternal favoritism were negatively correlated with self-esteem; total social support; friend, family, and teacher support, and parental emotional warmth. Paternal favoritism was also negatively correlated with SES level. According to these results, as adolescents perceived their parents favor one of their children over the other more, their level of internalizing and externalizing symptoms, parental punishment and emotional pressure, and parental physical punishment increase. Besides, as adolescents perceived more maternal favoritism, their perception of paternal favoritism increased, and as adolescents perceived more paternal favoritism, their perception of maternal favoritism increased, too. On the other hand, as adolescents had higher levels of self-esteem; perceived higher social support; friend, family, and teacher support, and parental emotional warmth, their perception of maternal and paternal favoritism decreased. Also, as adolescents' SES level increased, their perception of paternal favoritism decreased. Maternal and paternal favoritism were not correlated with age, parental education level, and parental overprotection and intrusiveness ($p > .05$). Maternal favoritism was also not correlated with SES level ($p > .05$).

3.2. ANOVA Analyses by Demographic Variables

The significance of the mean differences of the study variables by age, gender, educational level of mothers and fathers, and SES level were examined by one-way ANOVAs. The current study comprises of adolescents between the ages 11 and 18. This age range was categorized according to the educational level they were in at the time of the current study. The first age category involves middle school students (ages between 11-13and the second age category involves high school students (ages between 14-18). Also, parental educational levels were categorized as low (illiterate, literate, and primary school graduates), middle (middle and high school graduates), and high (college graduates or above) education levels, before performing analyses.

3.2.1. ANOVA Analyses by Age and Gender

Results showed that there were significant mean differences in self-esteem [$F(1, 482)= 4.61$, $p< .05$], family support [$F(1, 482)= 4.74$, $p< .05$] and maternal and paternal emotional warmth [$F(1, 482)= 22.75$, $p< .01$; $F(1, 482)= 16.02$, $p< .01$] by age. Those who were in middle school ($M= 21.38$, $SD= 4.85$) had higher self-esteem than those in high school ($M= 20.35$, $SD= 5.62$). Adolescents who continued to middle school ($M= 51.50$, $SD= 8.42$) also perceived much support from their families than those in high school ($M= 49.79$, $SD= 8.78$). Besides, those in middle school perceived more maternal emotional warmth ($M= 78.51$, $SD= 11.98$) and more paternal emotional warmth ($M= 75.42$, $SD= 13.96$) than those in high school ($M= 72.73$, $SD= 14.67$; $M= 69.79$, $SD= 16.97$; for maternal and paternal emotional warmth respectively). On the other hand, social support generally, and friend and teacher support that adolescents perceive to get, and punishment and emotional

pressure, physical punishment, overprotection and intrusiveness, and favoritism that adolescents perceive from their parents did not differ according to age ($p > .05$). Table 3.4 shows the ANOVA results by age.

Table 3. 4. ANOVA Results for Study Variables by Age

	df	*F*	η^2	*CI (95%)*	*p*
Self-Concept	1	4.61	.01	20.45 - 21.39	.03
Social Support Total	1	1.304	.00	159.71 - 164	.25
Friend Support	1	.14	.00	72.78 - 75.04	.71
Family Support	1	4.74	.01	49.97 - 51.51	.03
Teacher Support	1	2.94	.01	36.51 - 37.91	.09
Maternal Emotional Warmth	1	22.75	.05	74.73 - 77.15	.00
Paternal Emotional Warmth	1	16.02	.03	71.53 - 74.32	.00
Maternal Punishment and Emotional Pressure	1	.97	.00	17.95 - 18.75	.33
Paternal Punishment and Emotional Pressure	1	1.25	.00	16.82 - 17.68	.26
Maternal Physical Punishment	1	.01	.00	9.51 - 10.08	.92
Paternal Physical Punishment	1	1.29	.00	9.26 - 9.88	.26
Maternal Overprotection and Intrusiveness	1	2.64	.01	13.66 - 14.28	.11
Paternal Overprotection and Intrusiveness	1	1.08	.00	12.20 - 12.84	.30
Maternal Favoritism	1	.36	.00	7.56 - 8.02	.55
Paternal Favoritism	1	.02	.00	7.76 - 8.32	.88
Internalizing Symptoms	1	.27	.00	16.23 - 18.01	.60
Externalizing Symptoms	1	1.79	.00	11.19 - 12.80	.18

One-way ANOVA analysis of the variables by gender showed that, teacher support [$F(1, 470)= 5.60$, $p< .05$], paternal punishment and emotional pressure [$F(1, 470)= 9.53$, $p< .01$], paternal physical punishment [$F(1, 470)= 12.89$, $p< .01$], and internalizing symptoms [$F(1, 470)= 13.12$, $p< .01$] have significant mean differences. According to these results, girls ($M= 37.99$, $SD= 7.64$) perceive much support from their teachers than boys ($M= 36.27$, $SD= 8.11$). On the other hand, boys ($M= 18.00$, $SD= 5.00$) perceive much more punishment and emotional pressure from their fathers than girls ($M= 16.63$, $SD= 4.59$). Boys ($M= 10.19$, $SD= 3.75$) also perceive much

more physical punishment from their fathers than girls (*M*= 9.07, *SD*= 3.01). Also, girls (*M*= 18.39, *SD*= 10.05) reported more internalizing symptoms than boys (*M*= 15.12, *SD*= 9.35). In other respects, self-esteem, social support, friend support, family support, parental emotional warmth, maternal punishment/ emotional pressure, maternal physical punishment, and overprotection/ intrusiveness and favoritism that adolescents perceive from their parents did not differ by gender (*p*> .05). Table 3.5 shows the ANOVA results by gender.

Table 3. 5. ANOVA Results for Study Variables by Gender

	df	*F*	η^2	*CI (95%)*	*p*
Self-Concept	1	.06	.00	20.54 - 21.49	.81
Social Support Total	1	1.23	.00	159.83 - 164.20	.27
Friend Support	1	.15	.00	72.91 - 75.20	.70
Family Support	1	.14	.00	49.96 - 51.51	.71
Teacher Support	1	5.6	.01	36.51 - 37.94	.02
Maternal Emotional Warmth	1	.08	.00	74.74 - 77.19	.78
Paternal Emotional Warmth	1	.15	.00	71.43 - 74.27	.70
Maternal Punishment and Emotional Pressure	1	.56	.00	17.92 - 18.72	.45
Paternal Punishment and Emotional Pressure	1	9.53	.02	16.81 - 17.68	.00
Maternal Physical Punishment	1	1.29	.00	9.48 - 10.05	.26
Paternal Physical Punishment	1	12.89	.03	9.26 - 9.88	.00
Maternal Overprotection and Intrusiveness	1	1.58	.00	13.64 - 14.27	.21
Paternal Overprotection and Intrusiveness	1	.00	.00	12.20 - 12.85	1.00
Maternal Favoritism	1	.18	.00	7.53 - 7.99	.67
Paternal Favoritism	1	.60	.00	7.75 - 8.31	.44
Internalizing Symptoms	1	13.12	.03	16.04 - 17.82	.00
Externalizing Symptoms	1	2.32	.01	11.00 - 12.59	.13

3.2.2. ANOVA Analyses by Parental Education Level

Results of one-way ANOVAs showed that, there were significant mean differences in self-esteem [*F*(2, 469)= 6.00, *p*< .01], social support [*F*(2, 469)= 16.93, *p*< .01], friend support [*F*(2, 469)= 15.30, *p*< .01], family support [*F*(2, 469)=

14.99, $p < .01$], teacher support [$F(2, 469) = 5.76$, $p < .01$], emotional warmth from mother [$F(2, 469) = 13.23$, $p < .01$], emotional warmth from father [$F(2, 469) = 13.08$, $p < .01$], punishment and emotional pressure from mother [$F(2, 469) = 4.78$, $p < .01$], punishment and emotional pressure from father [$F(2, 469) = 5.57$, $p < .01$], physical punishment from mother [$F(2, 469) = 11.63$, $p < .01$], physical punishment from father [$F(2, 469) = 6.61$, $p < .01$], overprotection and intrusiveness from mother [$F(2, 469) = 12.30$, $p < .01$], overprotection and intrusiveness from father [$F(2, 469) = 6.25$, $p < .01$], favoritism from mother [$F(2, 469) = 3.61$, $p < .05$] by mothers' educational level, internalizing symptoms [$F(2, 469) = 12.23$, $p < .01$], and externalizing symptoms [$F(2, 469) = 3.17$, $p < .05$]; in terms of maternal education levels.

Adolescents who had low educated mothers ($M = 20.00$, $SD = 4.71$) reported lower self-esteem than whose mothers had middle ($M = 21.31$, $SD = 5.31$) or high education levels ($M = 22.00$, $SD = 5.77$). Adolescents whose mothers had low education ($M = 70.13$, $SD = 12.77$) also perceived much less friend support than whose mothers had middle education levels ($M = 76.66$, $SD = 11.57$) or whose mothers were highly educated ($M = 76.19$, $SD = 12.32$). Those with highly educated mothers ($M = 52.89$, $SD = 8.18$) and those with mothers who had middle education ($M = 52.31$, $SD = 8.02$) reported higher family support than those with low educated mothers ($M = 48.18$, $SD = 8.80$). Adolescents whose mother had middle education ($M = 38.79$, $SD = 7.75$) reported much teacher support than those with low educated mothers ($M = 36.02$, $SD = 7.31$). Similarly, adolescents with low educated mothers ($M = 154.44$, $SD = 23.37$) perceived less social support in general than whose mothers had middle education ($M = 167.76$, $SD = 23.25$) and whose mothers were highly educated ($M = 165.96$, $SD = 23.09$).

Educational levels of mothers were also found to be effective on their parental behaviors towards their children. Adolescents who had low educated mothers (*M*= 72.22, *SD*= 13.67) reported lower emotional warmth from their mothers than whose mothers had middle (*M*= 78.73, *SD*= 12.49) or high education levels (*M*= 78.34, *SD*= 13.41). Those with low educated mothers (*M*= 68.70, *SD*= 16.43) reported to receive less emotional warmth also from their fathers than whose fathers had middle (*M*= 75.21, *SD*= 14.25) or high education levels (*M*= 76.71, *SD*= 14.34). Moreover, adolescents with low educated mothers (*M*= 18.97, *SD*= 4.39 for maternal punishment; *M*= 17.88, *SD*= 4.67 for paternal punishment) perceived much more punishment and emotional pressure from both of their parents than whose mothers were highly educated (*M*= 17.36, *SD*= 4.67 for maternal punishment; *M*= 16.00, *SD*= 4.74 for paternal punishment).

The difference among adolescents for physical punishment has a slight difference by maternal education level. Adolescents whose mothers had low education (*M*= 10.56, *SD*= 3.61 for maternal physical punishment; *M*= 10.20, *SD*= 3.70 for paternal physical punishment) reported much more physical punishment from their parents than those with mothers who had middle education (*M*= 9.39, *SD*= 2.76 for maternal physical punishment; *M*= 9.16, *SD*= 3.23 for paternal physical punishment) and whose mothers were highly educated (*M*= 8.96, *SD*= 2.44 for maternal physical punishment; *M*= 8.95, *SD*= 2.81 for paternal physical punishment). Interestingly, while adolescents whose mothers had higher education levels (*M*= 12.76, *SD*= 3.16) reported less overprotection and intrusiveness from their mothers than those with low educated mothers (*M*= 14.03, *SD*= 3.70) and whose mothers had middle education (*M*= 14.79, *SD*= 3.06); whereas those with mothers who had

middle education levels (*M*= 13.17, *SD*= 3.37) reported more overprotection and intrusiveness from their fathers than only those with highly educated mothers (*M*= 11.64, *SD*= 3.57). Adolescents of low educated mothers (*M*= 7.99, *SD*= 2.38) also reported much favoritism from their mothers among siblings than whose mothers had middle education (*M*= 7.30, *SD*= 2.31).

Besides, adolescents whose mothers were less educated (*M*= 19.35, *SD*= 9.74) reported higher levels of internalizing symptoms than those with middle (*M*= 16.99, *SD*= 10.16) or high (*M*= 13.68, *SD*= 9.21) education levels. Even though the results showed significant mean differences also in externalizing symptoms in terms of mothers' level of education; according to Post Hoc results, none of the maternal education levels diverged from another education level. On the other hand, paternal favoritism that adolescents perceive did not differ by mothers' educational level ($p > .05$). Table 3.6 shows the ANOVA results by mothers' education level.

One-way ANOVA results by paternal educational level showed that, there were significant mean differences in social support [$F(2, 459)= 5.61$, $p< .01$], friend support [$F(2, 459)= 6050$, $p< .01$], family support [$F(2, 459)= 7.26$, $p< .01$], emotional warmth from mother [$F(2, 459)= 5.72$, $p< .01$], emotional warmth from father [$F(2, 459)= 7.99$, $p< .01$], punishment and emotional pressure from father [$F(2, 459)= 3.44$, $p< .05$], physical punishment from mother [$F(2, 459)= 5.23$, $p< .01$], physical punishment from father [$F(2, 459)= 3.36$, $p< .05$], overprotection and intrusiveness from mother [$F(2, 459)= 4.20$, $p< .05$], overprotection and intrusiveness from father [$F(2, 459)= 4.70$, $p< .05$], and internalizing symptoms [$F(2, 459)= 4.91$, $p< .01$].

Table 3. 6. ANOVA Results for Study Variables by Mother Education Level

	df	*F*	η^2	*CI (95%)*	*p*
Self-Concept	2	6.00	.03	20.47 - 21.41	.00
Social Support Total	2	16.93	.07	159.64 - 163.99	.00
Friend Support	2	15.30	.06	72.71 - 74.99	.00
Family Support	2	14.99	.06	50.01 - 51.57	.00
Teacher Support	2	5.76	.02	36.47 - 37.89	.00
Maternal Emotional Warmth	2	13.23	.05	74.72 - 77.17	.00
Paternal Emotional Warmth	2	13.01	.05	71.51 - 74.33	.00
Maternal Punishment and Emotional Pressure	2	4.78	.02	17.92 - 18.73	.01
Paternal Punishment and Emotional Pressure	2	5.57	.02	16.77 - 17.65	.00
Maternal Physical Punishment	2	11.63	.05	9.49 - 10.05	.00
Paternal Physical Punishment	2	6.61	.03	9.23 - 9.45	.00
Maternal Overprotection and Intrusiveness	2	12.30	.05	13.67 - 14.29	.00
Paternal Overprotection and Intrusiveness	2	6.25	.03	12.17 - 12.82	.00
Maternal Favoritism	2	3.61	.02	7.50 - 7.96	.03
Paternal Favoritism	2	.75	.00	7.72 - 8.28	.47
Internalizing Symptoms	2	12.23	.05	16.25 - 18.06	.00
Externalizing Symptoms	2	3.17	.01	11.18 - 12.82	.04

Adolescents who had low educated fathers (*M*= 71.01, *SD*= 13.58) reported lower friend support than whose fathers had middle (*M*= 74.36, *SD*= 12.11) or high education levels (*M*= 76.11, *SD*= 11.75). Adolescents whose fathers had low education (*M*= 48.99, *SD*= 8.56) also perceived much less family support than whose fathers had high education (*M*= 52.90, *SD*= 7.68). Similarly, adolescents with low educated fathers (*M*= 156.65, *SD*= 25.41) perceived less social support in general than whose fathers were highly educated (*M*= 166.03, *SD*= 21.28).

Educational levels of fathers were found to be effective on different parental dimensions. Adolescents who had low educated fathers (*M*= 73.14, *SD*= 13.15) reported lower emotional warmth from their mothers than whose fathers had high education levels (*M*= 78.60, *SD*= 12.48). Those with low educated fathers (*M*= 68.94, *SD*= 15.69) reported to receive less emotional warmth also from their fathers

than whose fathers had middle (*M*= 73.12, *SD*= 15.97) or high education levels (*M*= 76.36, *SD*= 14.57). Moreover, adolescents with fathers who had middle education (*M*= 17.70, *SD*= 5.14) perceived more punishment and emotional pressure from their fathers than whose fathers were highly educated (*M*= 16.30, *SD*= 4.66). Once again, adolescents whose fathers had high education (*M*= 9.07, *SD*= 2.63) reported less physical punishment from their mothers than those with fathers who had low (*M*= 10.26, *SD*= 3.56) and middle (*M*= 9.93, *SD*= 3.16) education levels. Adolescents whose fathers had low education levels (*M*= 9.99, *SD*= 3.53) reported much more physical punishment from their fathers than those with highly educated fathers (*M*= 8.95, *SD*= 2.91).

A similar path was found in overprotection and intrusiveness, in terms of fathers' level of education. Adolescents whose fathers had higher education levels (*M*= 13.24, *SD*= 3.30 for maternal overprotection and intrusiveness; *M*= 11.92, *SD*= 3.64 for paternal overprotection and intrusiveness) reported less overprotection and intrusiveness from their parents than those with fathers who had middle education levels (*M*= 14.33, *SD*= 3.38 for maternal overprotection and intrusiveness; *M*= 13.08, *SD*= 3.43 for paternal overprotection and intrusiveness). Besides, adolescents whose fathers were highly educated (*M*= 15.02, *SD*= 9.92) reported lower levels of internalizing symptoms than those with low (*M*= 18.55, *SD*= 9.62) or middle (*M*= 17.81, *SD*= 10.04) education levels. On the other hand, self-esteem, teacher support, maternal punishment and intrusiveness and parental favoritism that adolescents perceive did not differ by fathers' educational level ($p > .05$). Table 3.7 shows the ANOVA results by fathers' education level.

Table 3. 7. ANOVA Results for Study Variables by Father Education Level

	df	*F*	*η²*	*CI (95%)*	*p*
Self-Concept	2	3.09	.01	20.46 - 21.42	.05
Social Support Total	2	5.61	.02	159.56 - 163.95	.00
Friend Support	2	6.05	.03	72.65 - 74.96	.00
Family Support	2	7.26	.03	50.03 - 51.60	.00
Teacher Support	2	.60	.00	36.41 - 37.85	.55
Maternal Emotional Warmth	2	5.72	.02	74.65 - 77.14	.00
Paternal Emotional Warmth	2	7.99	.03	71.29 - 74.17	.00
Maternal Punishment and Emotional Pressure	2	1.65	.01	17.89 - 18.71	.19
Paternal Punishment and Emotional Pressure	2	3.44	.02	16.77 - 17.65	.03
Maternal Physical Punishment	2	5.23	.02	9.50 - 10.08	.01
Paternal Physical Punishment	2	3.36	.01	9.25 - 9.87	.04
Maternal Overprotection and Intrusiveness	2	4.20	.02	13.65 - 14.28	.02
Paternal Overprotection and Intrusiveness	2	4.70	.02	12.13 - 12.79	.01
Maternal Favoritism	2	.90	.01	7.51 - 7.97	.41
Paternal Favoritism	2	.49	.00	7.71 - 8.28	.61
Internalizing Symptoms	2	4.91	.02	16.34 - 18.16	.01
Externalizing Symptoms	2	.47	.00	11.22 - 12.85	.63

3.2.3. ANOVA Analyses by SES Level

Results of one-way ANOVA of the variables by socioeconomic statuses (SES) of the families included in this study showed that, self-esteem [$F(2, 481)= 6.61$, $p< .01$], social support [$F(2, 481)= 22.65$, $p< .01$], friend support [$F(2, 481)= 19.70$, $p< .01$], family support [$F(2, 481)= 24.19$, $p< .01$], teacher support [$F(2, 481)= 4.65$, $p< .05$], emotional warmth from mother [$F(2, 481)= 8.54$, $p< .01$], emotional warmth from father [$F(2, 481)= 4.72$, $p< .01$], punishment and emotional pressure from mother [$F(2, 481)= 6.63$, $p< .01$], punishment and emotional pressure from father [$F(2, 481)= 7.62$, $p< .01$], physical punishment from mother [$F(2, 481)= 15.29$, $p< .01$], physical punishment from father [$F(2, 481)= 9.35$, $p< .01$], overprotection and intrusiveness from mother [$F(2, 481)= 3.99$, $p< .05$],

overprotection and intrusiveness from father [$F(2, 481)= 5.22$, $p< .01$], internalizing symptoms [$F(2, 481)= 13.94$, $p< .01$], and externalizing symptoms [$F(2, 481)= 6.00$ $p< .01$] have significant mean differences.

According to these results, those who live in low SES homes ($M= 19.86$, $SD= 4.87$) had lower self-esteem levels than those who live in middle ($M= 21.72$, $SD= 4.86$) or high SES level homes ($M= 21.50$, $SD= 5.76$). Similarly, adolescents who had low SES families ($M= 153.10$, $SD= 2.24$) perceived less social support than who had middle ($M= 167.47$, $SD= 22.93$) or high ($M= 167.56$, $SD= 21.49$) SES families. Adolescents who lived in low SES environments ($M= 69.63$, $SD= 12.54$ for friend support; $M= 47.50$, $SD= 8.99$ for family support) perceived less friend and family support than those who lived in middle ($M= 76.08$, $SD= 12.46$ for friend support; $M= 52.83$, $SD= 7.23$ for family support) and high ($M= 77.23$, $SD= 11.39$ for friend support; $M= 52.82$, $SD= 8.09$ for family support) SES environments. As to the perception of teacher support they get, adolescents who lived in middle SES settings ($M= 38.56$, $SD= 7.76$) perceived much support from their teachers than adolescents who lived in low SES settings ($M= 35.96$, $SD= 7.33$).

Socioeconomic statuses of families were also found to be effective on different parental behaviors. Adolescents who lived in low SES families ($M= 72.93$, $SD= 13.35$) reported lower emotional warmth from their mothers than who had middle ($M= 77.04$, $SD= 13.33$) or high ($M= 78.67$, $SD= 13.32$) SES levels. Those with low SES families ($M= 70.68$, $SD= 15.34$) reported to receive less emotional warmth also from their fathers than who lived in high SES families ($M= 75.84$, $SD= 15.25$). Moreover, adolescents who had low SES families ($M= 19.27$, $SD= 4.32$ for

maternal punishment and emotional pressure; *M*= 18.30, *SD*= 4.94 for paternal punishment and emotional pressure) perceived more punishment and emotional pressure from both of their parents than whose families had middle (*M*= 17.76, *SD*= 3.92 for maternal punishment and emotional pressure; *M*= 16.71, *SD*= 4.12 for paternal punishment and emotional pressure) or high (*M*= 17.77, *SD*= 5.04 for maternal punishment and emotional pressure; *M*= 16.45, *SD*= 5.11 for paternal punishment and emotional pressure) SES levels.

Once again, adolescents whose families had low SES levels (*M*= 10.77, *SD*= 3.58 for maternal physical punishment; *M*= 10.38, *SD*= 3.89 for paternal physical punishment) reported more physical punishment from their parents than those with middle (*M*= 9.19, *SD*= 2.74 for maternal physical punishment; *M*= 9.22, *SD*= 3.22 for paternal physical punishment) and high (*M*= 9.16, *SD*= 2.78 for maternal physical punishment; *M*= 8.89, *SD*= 2.74 for paternal physical punishment) SES level families. Adolescents who lived in middle SES families (*M*= 14.54, *SD*= 3.31) perceived their mothers as being more overprotective and intrusive than those lived in high SES families (*M*= 13.41, *SD*= 3.88). Besides, adolescents who had high SES families (*M*= 11.75, *SD*= 3.52) perceived their fathers as less overprotective and intrusive than those lived in low (*M*= 12.89, *SD*= 3.38) and middle (*M*= 12.86, *SD*= 3.84) SES families.

Adolescents who lived in low SES environments (*M*= 19.85, *SD*= 10.28) reported higher levels of internalizing symptoms than those who lived in middle (*M*= 16.40, *SD*= 9.71) or high (*M*= 14.38, *SD*= 9.01) SES environments. Besides, those who were from middle SES families (*M*= 10.37, *SD*= 8.09) reported less

externalizing symptoms than whose families had lower SES level (*M*= 13.67, *SD*= 10.47). In other respects, parental favoritism that adolescents perceive did not differ by the SES levels of adolescents' families (*p*> .05). Table 3.8 shows the ANOVA results by fathers' education level.

Table 3. 8. ANOVA Results for study Variables by SES Level

	df	*F*	*η²*	*CI (95%)*	*p*
Self-Concept	2	6.61	.03	20.45 - 21.39	.00
Social Support Total	2	22.65	.09	159.71 - 164.00	.00
Friend Support	2	19.70	.08	72.78 - 75.04	.00
Family Support	2	24.19	.09	49.97 - 51.51	.00
Teacher Support	2	4.65	.02	36.51 - 37.91	.01
Maternal Emotional Warmth	2	8.54	.03	74.73 - 77.15	.00
Paternal Emotional Warmth	2	4.72	.02	71.53 - 74.32	.01
Maternal Punishment and Emotional Pressure	2	6.63	.03	17.95 - 18.75	.00
Paternal Punishment and Emotional Pressure	2	7.62	.03	16.82 - 17.68	.00
Maternal Physical Punishment	2	15.29	.06	9.51 - 10.08	.00
Paternal Physical Punishment	2	9.35	.04	9.26 - 9.88	.00
Maternal Overprotection and Intrusiveness	2	3.99	.02	13.66 - 14.28	.02
Paternal Overprotection and Intrusiveness	2	5.22	.02	12.20 - 12.84	.01
Maternal Favoritism	2	1.94	.01	7.56 - 8.02	.15
Paternal Favoritism	2	2.83	.01	7.76 - 8.32	.06
Internalizing Symptoms	2	13.94	.06	16.23 - 18.01	.00
Externalizing Symptoms	2	6.00	.02	11.19 - 12.80	.00

3.3. Regression Analyses

The first hypothesis was tested by using two stepwise regressions. The variables that are included in the regression analyses were determined by the prior correlation analyses. Those variables which were correlated to symptomatology were included in regression. In the first regression analysis, demographic factors of gender, age, parental education levels, family SES levels; self-esteem; perceived social support from friends, family, and teachers; and parenting variables of

emotional warmth, punishment and emotional pressure, physical punishment, overprotection and intrusiveness, and favoritism were used as predictors, and level of internalizing symptoms was the predicted variable. On the other hand, in the second regression model, the predictors were remained as constant but the predicted variable was the level of externalizing symptoms.

3.3.1. Prediction of Internalizing Symptoms

A multiple stepwise regression analysis was performed to evaluate the prediction degree of demographic characteristics, self-concept, parenting and social support on internalizing symptoms. The scores from Achenbach Youth Self Report (YSR) were considered as the predicted (dependent) variable. First, the demographic variables (gender, age, SES level, mother education level, father education level), and then other study variables (self-concept, maternal and paternal emotional warmth, maternal and paternal punishment and emotional pressure, maternal and paternal punishment and emotional pressure, maternal and paternal physical punishment, maternal and paternal overprotection and intrusiveness, maternal and paternal favoritism, friend support, family support, and teacher support) were included in the regression analysis as two separate groups. Figure 3.1 shows the steps in this regression analysis. This method enabled the predictor variables to explain their contribution to the variance in internalizing symptoms among adolescents.

Phases of Regression Analysis for Predicting Internalizing Symptoms
Predicted Variable
Internalizing Symptoms
Predictor Variables
Demographic Variables (gender, age, SES level, mothers' education level, fathers' education level)
Self-Concept
Parenting (maternal and paternal emotional warmth, maternal and paternal punishment and emotional pressure, maternal and paternal physical punishment, maternal and paternal overprotection and intrusiveness, maternal and paternal favoritism)
Social Support (support from friends, family, teachers)

Figure 3. 1. Phases of regression analysis for predicting internalizing symptoms among adolescents

The stepwise regression analysis showed that, seven out of nineteen predictors, namely maternal education level, gender, self-esteem, friend support, maternal punishment and emotional pressure, paternal punishment and emotional pressure, and maternal favoritism, predicted internalizing symptoms. Table 3.9 shows the unstandardized regression coefficients (B), standardized regression coefficients (ß), R^2, and adjusted R^2 for the predictor variables, and R for the proposed model. The model in the current analysis was significant, $F(7, 380)= 32.28$, $p< .001$. The predictor variables explained 36% of the variance in internalizing symptoms.

Table 3. 9. Stepwise regression analysis results for predicting internalizing symptoms among adolescents

Predictor Variable	B	ß	R^2	Adjusted R^2
Maternal Education Level	-2.59**	-.20	.04	.04
Gender	-3.73**	-.19	.08	.07
Maternal punishment and emotional pressure	.92**	.40	.24	.23
Self-concept	-.57**	-.30	.32	.31
Paternal punishment and emotional pressure	.44**	.21	.34	.33
Friend support	-.14**	-.18	.36	.35
Maternal favoritism	.44*	.10	.37	.36
R= .61*				

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

The direction and size of the relationships imply that those with mothers who had higher education levels reported less internalizing symptoms. Also, boys were less likely to develop internalizing symptoms than girls. Besides, those who had higher self-concept and higher friend support reported less internalizing symptoms than those who had lower self-esteem and friend support. On the other hand, adolescents whose mothers and fathers were more punishing and emotionally oppressive, and whose mothers favored one of her children, reported more internalizing symptoms than whose mothers and fathers were less punishing and emotionally less oppressive, and whose mothers used less favoritism.

3.3.2. Prediction of Externalizing Symptoms

A multiple stepwise regression analysis was performed to evaluate the prediction degree of demographic characteristics, self-concept, parenting and social support on externalizing symptoms. The scores from Achenbach Youth Self Report (YSR) were considered as the predicted (dependent) variable. First, the demographic

variables (gender, age, SES level, mother education level, father education level), and then other study variables (self-concept, maternal and paternal emotional warmth, maternal and paternal punishment and emotional pressure, maternal and paternal punishment and emotional pressure, maternal and paternal physical punishment, maternal and paternal overprotection and intrusiveness, maternal and paternal favoritism, friend support, family support, and teacher support) were included in the regression analysis as two separate groups. Figure 3.2 shows the steps in this regression analysis. This method enabled the predictor variables to explain their contribution to the variance in externalizing symptoms among adolescents.

Phases of Regression Analysis for Predicting Externalizing Symptoms
Predicted Variable
Externalizing Symptoms
Predictor Variables
Demographic Variables (gender, age, SES level, mothers' education level, fathers' education level)
Self-Concept
Parenting (maternal and paternal emotional warmth, maternal and paternal punishment and emotional pressure, maternal and paternal physical punishment, maternal and paternal overprotection and intrusiveness, maternal and paternal favoritism)
Social Support (support from friends, family, teachers)

Figure 3. 2. Phases of regression analysis for predicting externalizing symptoms among adolescents

The stepwise regression analysis showed that, six out of nineteen predictors, namely SES level, maternal physical punishment, family support, paternal physical punishment, maternal favoritism, and friend support predicted externalizing symptoms. Table 3.10 shows the unstandardized regression coefficients (B), standardized regression coefficients (ß), R^2, and adjusted R^2 for the predictor variables; and R for the proposed model. The model in the current analysis was significant, $F(6, 404)= 22.14$, $p< .001$. The predictor variables explained 24% of the variance in externalizing symptoms.

Table 3. 10. Stepwise regression analysis results for predicting externalizing symptoms among adolescents

Predictor Variable	B	ß	R^2	Adjusted R^2
SES level	-1.28*	-.11	.01	.10
Maternal physical punishment	1.07***	.38	.15	.15
Family support	-.27***	-.26	.21	.20
Paternal physical punishment	.43**	.17	.22	.22
Maternal favoritism	.49**	.13	.24	.23
Friend support	-.09*	-.12	.25	.24
R= .50*				

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

The direction and size of the relationships imply that adolescents who lived in higher SES families were less likely to develop externalizing symptoms than those lived in lower SES homes. Also, adolescents who had higher family and friend support reported less externalizing symptoms than those who had lower family and friend support. Besides, adolescents whose mothers and fathers used more physical punishment, and whose mothers favored one of the children in the family reported

more externalizing symptoms than whose mothers and fathers used less physical punishment, and whose mothers used less favoritism.

3.4. Role of Parental Favoritism on Internalizing and Externalizing Symptomatology among Adolescents

The significance levels of the mean differences of internalizing and externalizing symptomatology in adolescents by maternal and paternal favoritism were screened by performing one-way ANOVAs. Prior to ANOVA analyses, favoritism variables both for mothers and fathers were transformed into categorical variables. Among adolescents who had siblings, those who rated favoritism above the mean (M= 7.79 for maternal favoritism, M= 8.04 for paternal favoritism) were labeled as exposed to favoritism, and those who rated favoritism below the mean were labeled as not exposed to favoritism. On the other hand, adolescents who did not have any siblings were used as controls. Table 3.11 shows means and standard deviations of maternal and paternal favoritism levels by symptomatology.

Results showed that there were significant mean differences in internalizing symptoms [$F(2, 477)= 16.10$, $p< .01$] and externalizing symptoms [$F(2, 477)= 14.14$, $p< .01$] by maternal favoritism. The strength of the relationship between maternal favoritism and internalizing symptom was weak, with $\eta^2= .06$, 95% confidence limits from 16.20 to 18.00; and the relationship between maternal favoritism and externalizing symptom was also weak with $\eta^2= .06$, 95% confidence limits from 11.18 to 12.80. Adolescents who perceived their mothers favoring one children over the other (M= 20.09, SD= 10.33) were more likely to develop internalizing symptoms than those who did not perceive their mothers as favoring one of her children (M= 15.37, SD= 9.28), and those who do not have any siblings (M= 13.92,

SD= 9.19). Similarly, adolescents who perceived their mothers favoring one children over the other (*M*= 14.52, *SD*= 9.59) were more likely to develop externalizing symptoms than those who did not perceive their mothers as favoring one of her children (*M*= 9.98, *SD*= 8.04), and those who do not have any siblings (*M*= 11.27, *SD*= 8.65).

Table 3. 11. Means and Standard Deviations of Maternal and Paternal Favoritism Levels by Symptomatology

		N	M	SD
Internalizing Symptoms	Favoring mother	195	20.09	10.33
	No favoring mother	223	15.37	9.28
	No siblings	62	13.92	9.19
Externalizing Symptoms	Favoring mother	195	14.52	9.59
	No favoring mother	223	9.98	8.04
	No siblings	62	11.27	8.65
Internalizing Symptoms	Favoring father	211	19.25	10.60
	No favoring father	211	15.92	9.12
	No siblings	62	13.92	9.19
Externalizing Symptoms	Favoring father	211	13.55	9.50
	No favoring father	211	10.66	8.42
	No siblings	62	11.27	8.65

According to the results by paternal favoritism, there were also significant mean differences in internalizing symptoms [$F(2, 481)= 9.87$, $p< .01$] and externalizing symptoms [$F(2, 481)= 5.74$, $p< .01$]. The strength of the relationship between paternal favoritism and internalizing symptom was weak, with $\eta^2= .04$, 95% confidence limits from 16.23 to 18.01; and the relationship between paternal favoritism and externalizing symptom was also weak with $\eta^2= .02$, 95% confidence limits from 11.19 to 12.80. Adolescents who perceived their fathers favoring one children over the other (*M*= 19.25, *SD*= 10.60) were more likely to develop

internalizing symptoms than those who did not perceive their fathers as favoring one of his children (*M*= 15.92, *SD*= 9.12), and those who do not have any siblings (*M*= 13.92, *SD*= 9.19). Besides, adolescents who perceived their fathers favoring one children over the other (*M*= 13.55, *SD*= 9.50) were more likely to develop externalizing symptoms than those who did not perceive their fathers as favoring one of his children (*M*= 10.66, *SD*= 8.42). The differences between those who did not have any siblings (*M*= 11.27, *SD*= 8.65) and those who perceived paternal favoritism or those who did not perceive favoritism were not significant, on the development of externalizing symptoms. Table 3.12 shows the ANOVA results for symptomatology by maternal and paternal favoritism.

Table 3. 12. ANOVA Results for Symptomatology by Favoritism

		df	*F*	η^2	*CI (95%)*	*p*
Maternal Favoritism	Internalizing Symptoms	2	16.10	.06	16.20 - 18.00	.000
	Externalizing Symptoms	2	14.14	.06	11.18 - 12.80	.000
Paternal Favoritism	Internalizing Symptoms	2	9.87	.04	16.23 - 18.01	.000
	Externalizing Symptoms	2	5.74	.02	11.19 - 12.80	.003

Multivariate Analysis of Variance (MANOVA) was performed between favoritism (maternal and paternal) and symptomatology (internalizing and externalizing) to see the interaction effect of maternal and paternal favoritism on internalizing and externalizing symptomatology. MANOVA results showed that, there were not any interaction effects of maternal and paternal favoritism on neither internalizing nor externalizing symptomatology development on adolescents ($p>$ .05).

CHAPTER 4

DISCUSSION

The primary goal of the current study was to examine the relationships between self-concept, perceived parenting, and perceived social support, together with internalizing and externalizing symptoms. It was also aimed to reveal the differences between the perceptions of parenting and states of symptomatology among adolescents who had and who did not have siblings. Taking Bronfenbrenner's Ecological Model (1977/ 1979/ 1992) into consideration, the present study focused on adolescents' microsystem, in which their self-concept, families, and social environments were the points of attention. Adolescents' perceptions about themselves, their families, friends, and teachers were assessed via self-esteem, parenting, and social support scales. Their levels of internalizing and externalizing symptomatology were also checked. The analyses were focused on the relationship and predictions among these concepts, to be able to have an understanding of the relationships between them. The effect of perception of favoritism on symptomatology was also analyzed. This chapter discusses the results of the analyses of the current study. The last sections of this chapter indicate the implications of the

currents study, and limitations and suggestions for future research were also presented.

4.1. The Bivariate Analysis among the Study Variables

The bivariate analysis of the current study showed that demographic variables were not correlated with all of the study variables. Age was not correlated with any of the parenting dimensions except parental emotional warmth; whereas it was correlated with all of the social support types, except friend support. Age was not correlated also with self-esteem and internalizing symptoms. SES level, on the other hand, was found to be correlated with all of the study variables except teacher support, maternal overprotection and intrusiveness, and maternal favoritism. Besides, educational level of parents were found to be correlated with most of the study variables, except externalizing symptoms, teacher support, paternal overprotection and intrusiveness, and parental favoritism. Fathers' educational level was also not correlated with maternal punishment and emotional pressure. The correlations between variables which had significant correlations were on expected directions.

Self-esteem was correlated with all of the study variables and all the correlations were as in the expected direction. Gecas and Schwalbe (1986) have found that while support from parents and their participation mostly affected girls' self-esteem, boys were mostly affected by parental control, in terms of self-esteem. Besides, Herz and Gullone (1999) also found a relationship between self-esteem and parenting, supporting the current results. Nevertheless, there is evidence showing the cultural difference in the relationship between self-esteem and parenting. A previous study has shown that, specific behavioral aspects of parenting behavior were not

related to self-esteem in German adolescents, while they were in the adolescents from the United States; implying that American and German adolescents differ in their perceptions of meaning of specific parent-adolescent relationships (Barber, Chadwick, & Oerter, 1992).

The positive correlations among the similar parenting practices implied that these variables were reliable. Since the correlations of most of the parenting practices went in accordance both with mothers and fathers, it could be implied that adolescents perceived their mothers' and fathers' behaviors similarly towards themselves. Nevertheless, overprotection and intrusiveness was not significantly correlated with maternal physical punishment and parental (both maternal and paternal) favoritism. Besides, paternal overprotection and intrusiveness was not correlated with maternal punishment and emotional pressure; whereas, maternal overprotection and intrusiveness was not correlated with paternal physical punishment. These results suggested that adolescents' perceptions differed in overprotection and intrusiveness practice of parenting. All of the parenting dimensions were also correlated with internalizing and externalizing symptoms among adolescents, except parental overprotection and intrusiveness. Adolescents' perceptions of their parents' differential treatment in emotional warmth was found to be associated with both internalizing and externalizing symptoms, as in the current study (Berkien, Louwerse, Verhulst, & van der Ende, 2012); whereas the current study also found associations between parental overprotection and externalizing symptoms, unlike the current study.

The currents study has revealed that social support dimensions (friend, family, teacher support; and social support in general) had positive correlations among themselves, which implied the reliability of these variables. Social support factors were also correlated with all of the parenting dimensions, except overprotection and intrusiveness. This difference might have been occurred out of the unstable character of overprotection and intrusiveness for the Turkish culture. While some of the participants perceived this dimension as a negative parenting aspect, reports of a number of participants implied that this was a positive parenting aspect for them. Family, friend, and teacher support; and social support totally were correlated with internalizing and externalizing symptoms. Social support from family, friends, and other adults were found to be supportive in mental health outcomes, mostly in low socioeconomic environments (Wight, Botticello, & Aneshensel, 2006).

These results also imply the fact that overprotection and intrusiveness practice of parenting was not correlated with considerable number of variables, which might suggest the sensitivity of this dimension to the cultural differences. Although the questions that assess overprotection and intrusiveness have negative connotations in Western cultures (Finnegan, Hodges, & Perry, 1998), this aspect of parenting is generally considered as positive and caring parenting styles in Turkish culture. A work by Özkan (1993) showed that overprotection was seen as an aspect of caring.

4.2. Effects of Demographic Variables on Study Variables

Many studies have previously tested for age effect on self-esteem (Zimmerman, Copeland, Shope, & Dielman, 1997), family support (Ostrander, Weinfurt, Nay, 1998), and parental emotional warmth (Berkien et al., 2012). Besides, Bayraktar, Sayıl, and Kumru (2009) have indicated that age is a factor that should be investigated in self-esteem researches. The findings of the current study showed that, age significantly affected self-esteem, family support, and parental emotional warmth. Accordingly, middle school students had higher self-esteem, perceived much family support, and perceived much emotional warmth from their parents, than high school students.

Gender differences were found between teacher support, paternal punishment and emotional pressure, and paternal physical punishment. Accordingly, girls perceived much teacher support, less punishment and emotional pressure from their fathers, and less physical punishment from their fathers than boys did. A previous study has also indicated that girls perceived higher levels of teacher support than boys (Reddy, Rhodes, & Mulhall, 2003). On the other hand, among adolescents who have exposed to traumatic events, boys perceived much paternal rejection than girls (Punamäki, Qouta, & Sarraj, 1997). Gershoff (2002) has found that male gender was more associated with parental physical punishment and aggression.

The current study findings showed that, mothers' educational level significantly affected self-esteem, friend support, family support, teacher support, social support in general, parental emotional warmth, parental punishment and emotional pressure, parental physical punishment, parental overprotection and intrusiveness, and maternal favoritism. By fathers' educational level on the other

hand, the results showed that, there were significant differences between friend support, family support, social support in general, parental emotional warmth, paternal punishment and emotional pressure, parental physical punishment, and parental overprotection and intrusiveness. Previous studies have shown that parental education was significantly related to parental warmth and parental discipline (e.g., Pinderhughes, Nix, Foster, & Jones, 2001).

The results of the current study showed that, there were significant differences between self-esteem, friend support, family support, teacher support, social support in general, parental emotional warmth, parental punishment and emotional pressure, parental physical punishment, and parental overprotection and intrusiveness, in terms of SES levels of the participated families. Lower SES levels generally led to worse self-esteem, perception of worse social support and worse perception of parenting (lower levels of emotional warmth; and higher levels of parental punishment and emotional pressure, parental physical punishment, and parental overprotection and intrusiveness). Hashima and Amato (2008) have found negative relationships between social support and punitive behavior of parents, when families earned low income.

4.3. Predicting Symptomatology among Adolescents

Adolescence is a period that teenagers go under several crucial life-long changes. This period can bring many important results via the changes adolescents go through. Research suggests that there is a high prevalence rate in symptoms seen among adolescents, and adolescence is an important period for detecting symptoms of future problems like personality disorders (Hopwood & Grilo, 2010). Besides, a previous study showed that a high proportion of children had psychiatric symptoms,

without having psychiatric disorders (Lapouse & Monk, 1959). In light of these information, a central purpose of the current study was to determine the prediction of several demographic characteristics, namely; self-esteem, perceived parenting and perceived social support on internalizing and externalizing symptoms. In order to test this hypothesis, all the information were gathered from adolescents themselves. Adolescents reported their perceptions about each parent separately.

To test the proposed hypothesis, two stepwise regression analyses were run for the study variables; the predicted variables were changed between the analyses. The direct relationship of age, gender, SES level, parental education level, self-esteem, perceived parenting (emotional warmth, punishment and emotional pressure, physical punishment, overprotection and intrusiveness, favoritism) and perceived social support (friend support, family support, teacher support) with internalizing symptoms were tested in the first analysis. The second analysis, on the other hand, tested the direct relationship of age, gender, SES level, parental education level, self-esteem, perceived parenting (emotional warmth, punishment and emotional pressure, physical punishment, overprotection and intrusiveness, favoritism) and perceived social support (friend support, family support, teacher support) with externalizing symptoms.

4.3.1. Predicting Internalizing Symptoms among Adolescents

The results of the current study showed that maternal education level, gender, maternal punishment and emotional pressure, self-concept, paternal punishment and emotional pressure, friend support, and maternal favoritism predicted internalizing

symptoms among adolescents. Accordingly, adolescents with mothers who had lower education levels reported higher internalizing symptoms. Female adolescents were at a higher risk for developing internalizing symptoms than male adolescents. Besides, better self-concept and friend support predicted lower levels of internalizing symptoms; whereas, higher levels of maternal and paternal punishment and emotional pressure, and maternal favoritism predicted higher levels of internalizing symptoms. Age and overprotection and intrusiveness were not included in the regression analysis, since the correlation results that were previously done showed that they were not related to internalizing symptomatology in adolescents.

The current study has found that maternal education level predicted internalizing symptoms among adolescents. Previous studies showed relationship between internalizing symptoms and parental education level (Boe, Overland, Lundervold, & Hysing, 2012; Eamon & Zuehl, 2001; Hudson & Rapee, 2005; Yahav, 2006). Eamon and Zuehl's study has revealed that maternal education had a negative relationship with depressive symptoms (2001), confirming the current study results. Also, Zhang (2014) revealed that maternal education level was negatively related to internalizing symptoms among female children, which was in line with the findings of the current study. Besides, a recent study has shown that parental educational level predicted externalizing symptoms more than internalizing symptoms (Boe et al., 2012).

Previous findings were in line with previous studies saying that internalizing symptoms were more common among female than male adolescents (Wade et al., 2002; Crawford, Cohen, Midlarsky, & Brook, 2001). An explanation for this

difference might be the fact that females exposed to stressful life events more than males, and females reveal acute reactions in stressful situations more than males (Jose & Ratcliffe, 2004). Also, even though it was previously found that, adolescents who live in more disadvantaged environments are more prone to have higher stress levels (Goodman et al., 2005), and low SES levels were associated with higher levels of depressive and anxiety symptoms (McLeod & Owens, 2004); according to the current study, SES level was not a predictor of internalizing symptoms. Confirming the current findings, Mendelson and colleagues (2008) reported that SES level do not have an interactive effect on internalizing symptoms; whereas their study also showed that, gender also did not have an interactive effect on internalizing symptoms, contrary to the current findings. Their study also included that the female subgroups that had the lowest level of household income were at a high risk on developing internalizing symptoms. These inconsistencies between the previous and the current findings might imply the cultural differences in internalizing symptom development among adolescents, and that the importance of further studies to elaborate on this topic.

Self-concept was found to be as another predictor of internalizing symptoms, in the current study. Many researches have also pointed out the negative relationship between self-esteem and depression, which is an aspect of internalizing symptoms (Wylie, 1979; Rosenberg, 1985; Turner, Finkelhor, & Ormrod, 2010). Besides, Rosenberg and colleagues (1989) proposed that depression might be caused by low self-esteem. A study by McDonald and colleagues (2005), in which they found negative relationship with self-esteem and internalizing symptoms among Mexican American adolescents, also confirmed the current findings. Besides, Barnett and

Hunter (2012) have proposed that adequate levels of self-concept might have been thought as a protective factor, after they found that adolescents' self-concept was not affected by living with a mentally ill sibling. Taking the importance of self-concept for internalizing symptom development among adolescents into consideration, and since there is little evidence showing the relationship between self-esteem and internalizing symptoms cross-culturally (Portes & Zady, 2002), the current findings among Turkish youth would also contribute to cross-cultural literature.

It was expected social support to predict internalizing symptoms, in the current study. Social support included support from friends, family, and teachers; and their predictions on internalizing symptoms were tested separately, rather than using a whole social support score. The results showed that friend support predicted internalizing symptoms among adolescents. These findings paralleled with the findings of Kerr and colleagues (2006), whose study revealed that depression and suicidal ideation decrease with supportive relationships with peers. Another study showed a similar result that diminished internalizing symptoms are predicted by classmate support (Stewart & Suldo, 2011). Also, positive communication with peers imposes a feeling of security (Ladd et al., 1999). Besides, although Newman, Newman, Griffen, O'Connor, and Spas (2007) found that parent support and peer support were both highly associated with internalizing symptoms in adolescents, family support was not a predictor of internalizing symptoms, according to the current study. Even though previous studies have also addressed to the effect of family support on adolescents' internalizing symptoms as being more effective than peer support (Furman & Buhrmester, 1992; Helsen, Vollebergh, & Meeus, 2000), a more recent study showed that they have similar levels of importance (Bokhorst et

al., 2009). Yet, the results of the current study have revealed that friend support predicted internalizing symptoms, whereas family support did not. This might be due to the fact that adolescents become closer to their friends, during the transition to and development in adolescence (Cole et al., 2005). Also, even though previous findings highlighted the importance of teacher support (Stewart & Suldo, 2011; Ladd et al., 1999), the current study findings showed that teacher support was not a predictor of internalizing symptoms. Perception of lower levels of teacher support might be related with the transition that adolescents go through (Bokhorst et al., 2009); especially with their change from middle to high school, who composed a high proportion of the current study sample.

The current study proposed that parental (both maternal and paternal) punishment and emotional pressure, which are rejecting parenting behaviors, would predict internalizing symptoms among adolescents. The results confirmed the proposed hypothesis. Previous findings also confirmed this result. Lefkowitz and Tesiny (1984) have found that those who perceived parental rejection during their childhood might develop depression in adulthood. Also, being on the same direction with the current study, other studies have shown that those who perceived rejection from their parents happened to be much introvert and emotionally disturbed (Önder & Gülay, 2007), more likely to have depression (Akse, Hale III, Engels, Raaijmakers, & Meeus, 2004), more prone to develop internalizing behaviors (Rohner & Britner, 2002; Rohner et al., 2005), and more inclined to have psychopathological symptoms in a more general sense (Roelofs, Meesters, Huurne, Bamelis, & Muris, 2006).

A suggestion of the current study was maternal and paternal favoritism predicting internalizing symptoms among adolescents. According to the results, maternal favoritism predicted internalizing symptoms. Those who perceive much favoritism from their mothers had higher levels of internalizing symptoms. Previous studies on favoritism also supported this finding that suicidal thoughts are more common among adolescents who perceive favoritism (De-Man, Wong, & Leung, 2003). Hui also found associations between pathological symptoms and perceiving favoritism from parents (2004). Besides, Yahav (2006) showed that internalizing behaviors are observed among children who perceive their parents as favoring one of the siblings. Although all these studies included the relationship between internalizing symptoms and favoritism towards both parents, according to the findings of the current study, only maternal favoritism predicted internalizing symptoms. Harris and Howard (1985) showed that perceiving parental favoritism would lead to depressive feelings in adolescents. This finding also highlighted maternal favoritism, leaving paternal favoritism in the second place, similar to the findings of the current study.

In the current study, internalizing symptoms were not only hypothesized to be related with parental punishment and emotional pressure, and maternal favoritism, as parenting dimensions; but also with parental emotional warmth, parental physical punishment, and paternal favoritism. Even though the study by Muris, Meesters, and van den Berg (2003), in which they found that emotional warmth predicted internalizing symptoms also included adolescents in similar age ranges with the current study (between ages 12 and 18), the vast majority of their study participants were Caucasian; so, the biggest difference might have been occurred out of cultural

differences. Besides, while half of the participants on their study were from middle SES level, the current study had rather an equivalent distribution among low (39.3%), middle (29.1%), and high (31.6%) SES levels; so, the distribution of different SES environments in these two samples might also has caused some difference. Also, physical punishment from parents might lead to externalizing symptoms, more than internalizing ones (Bordin et al., 2009). Yahav (2006) has found that children perceived their fathers, rather than their mothers, as showing favoritism; unlike the current study findings. The relation between favoritism and internalizing symptom is effected highly from cultural differences (Markus et al., 2003). Since most of the mothers in the current study were housewives, mothers in the current sample could spend more time with their children than fathers (62.8%). Besides, the attachment issues considerably differ between mother-child and father-child dyads (Bowlby, 1969/ 1997); which might be the reason for paternal favoritism did not predict internalizing symptoms.

The current study revealed that, in the absence of the predictor variables, adolescents might still have had internalizing symptoms. This finding might be an implication of the biological basis of symptom development among adolescents. Accordingly, a male adolescent whose mother had high education level; and also who had better self-concept, high levels of friend support, who perceived little or no punishment and emotional pressure from both of their parents, and who did not perceive any favoritism among his siblings from his mother would still develop internalizing symptoms, as a result of his predisposition.

4.3.2. Predicting Externalizing Symptoms among Adolescents

The results of the current study showed that SES level, family support, friend support, maternal and paternal physical punishment, and maternal favoritism predicted externalizing symptoms among adolescents. According to the study results, adolescents from lower socioeconomic statuses were more likely to develop externalizing symptoms than those from higher socioeconomic statuses. Besides, higher family and friend support predicted lower levels of externalizing symptoms; whereas, higher levels of maternal and paternal physical punishment, and maternal favoritism predicted higher levels of externalizing symptoms. Parental educational level and overprotection and intrusiveness were not included in the regression analysis, since the correlation results that were previously done showed that they were not related to externalizing symptomatology in adolescents.

The current research found that SES level predicted externalizing symptoms. The results of the current study were in line with previous evidence showing that those who lived in lower SES homes had higher levels of externalizing symptoms (Keiley, Bates, Dodge, & Pettit, 2000; Keiley, Lofthouse, Bates, Dodge, & Pettit, 2003). Besides, a recent study has also shown that the economic level of family was related to externalizing symptoms, and parenting practices and parents' emotional well-being mediated this relationship (Bøe et al., 2013). Moreover, McLoyd, Jayaratne, Ceballo, and Borquez (1994) have revealed that living in more disadvantaged families was not only related with externalizing behavior problems, but also with internalizing behavior problems among children, and they have also found that this relationship was mediated by punishing behaviors, including corporal

punishment; which highlights the importance of the current study. Although current finding about SES level predicting externalizing symptoms are in line with previous studies that were conducted in other nations, studies with Turkish samples argued against these findings (Seven, 2007; Baydar, Küntay, Gökşen, Yağmurlu, & Cemalcılar, 2010). Seven (2007) indicated that SES level did not directly affect neither externalizing nor internalizing behaviors among 6-year-old children that were attending kindergarten. Similarly, Baydar and colleagues (2010) have found that SES level was not an environmental factor that was related with externalizing symptoms in 3-year-olds. The inconsistency between previous studies with Turkish samples and the current study results might have been occurred out of the age differences between these studies. Besides, the intervening variables might have changed the direction of the SES level's prediction on externalizing symptoms.

It was hypothesized that age would predict externalizing symptoms among adolescents. The results of the current study did not support the proposed hypothesis. Accordingly, age was not a predictor of externalizing symptoms. Previous researches also do not have direct indications about age predicting externalizing symptoms in adolescence. Delinquent children with externalizing behaviors would have problems like substance abuse, violence, delinquency, and criminality; whereas delinquent adolescents with externalizing behaviors were found to have substance dependence, mental health problems, financial problems, property offense and impulsive personality traits as adults (Moffit et al., 2002). A recent study by Choe, Stoddard, and Zimmerman (2014) also showed that age predicted externalizing symptoms at an older age, but not during adolescence. These studies specified that age predicted future externalizing symptoms via other variables like previous delinquency or

family conflict, rather than predicting during adolescence. Age should be considered with the concept of time, in which many changes occur in an individual's life. Taking this notion into account, age might have been left behind by some other variables, for the prediction of externalizing symptoms among adolescents.

Similar with internalizing symptoms, it was expected social support to also predict externalizing symptoms, in the current study. The prediction of family, friend, and teacher support on externalizing symptoms were tested separately. The results showed that family and friend support predicted externalizing symptoms among adolescents. These findings paralleled with the previous findings in which researchers found that family support and externalizing symptoms were negatively related (Kerr et al., 2006), and that conflict with parents was also related to externalizing symptoms (Barrera, Chassin, & Rogosch, 1993). Even though the current study also revealed that friend support predicted externalizing symptoms among adolescents and they were negatively related; Kerr and colleagues' (2006) work has shown that higher levels of peer support would lead to higher levels of externalizing symptoms. They also discussed that they did not make a distinction between prosocial and antisocial peers, in terms of social support from peers, which might have had affected the relationship between peer support and externalizing symptoms.

Barrera and colleagues (1993) found that externalizing symptoms in adolescents were not related with friend support. They argued that peer support was not effective on controlling problematic behavior. Nevertheless, this finding was about participants' same-sex best friends, unlike the current study, which might have

caused the difference. A previous study has also argued that those with higher levels of aggression would also had more aggressive friends, which may explain the positive relationship between friend support and externalizing symptoms in that study (Cairns, Cairns, Neckerman, Gest, Gariepy, 1988). Even though the importance of teacher support was implied in previous research (Stewart & Suldo, 2011; Ladd et al., 1999), teacher support did not predict externalizing symptoms in the current study, as in internalizing symptoms. This non significance might share the same reason with the non-significant association between teacher support and internalizing symptoms; that as adolescents grow older, the change in their ideas and perceptions make adolescents closer to their friends, rather than their families and teachers (Cole et al., 2005).

The current study findings showed that physical punishment of mothers and fathers predicted externalizing symptoms among adolescents. Accordingly, those who perceived their mothers and fathers as physically punishing would have higher levels of externalizing symptoms. This finding was confirmed by a recent study conducted by Deardorff and her colleagues (2013), in which they found positive association between pubertal timing and externalizing symptoms of Mexican American girls who reported their mothers as harshly punishing. Nevertheless, since Deardorff et al. (2003) did not include perceptions about paternal punishment to their study, which restricts the adolescent functioning to be understood in a broader sense (Forehand & Nousiainen, 1993), a comparison between two parents could not be done, as it was done in the current study. Gershoff (2002) specified in her meta-analysis that corporal punishment has predicted externalizing behavior problems of children on several years later. Also in another study, a decrease in parental physical

punishment was related to lower levels of externalizing symptoms (Kerr, Lopez, Olson, & Sameroff, 2004). Kerr and colleagues (2004) indicated that this finding was supported for boys only. They have also found that, paternal physical punishment did not predicted externalizing symptoms of boys. The reverse of this relationship was also revealed by Richmond and Stocker (2008), in which study they found that in time, externalizing behaviors of adolescents predicted mothers' hostile behaviors. Another study has also found that exposure to parental physical punishment was associated with higher levels of externalizing behavior problems among European American adolescents, while physical punishment was associated with lower levels of externalizing behaviors among African American adolescents (Lansford, Deater-Deckard, Dodge, Bates, & Pettit, 2004). The variety among results of the relationship between parental physical punishment and externalizing symptoms among adolescents shows traces of gender and cultural differences on this subject, which would need further elaboration.

One of the suggestions of the current study was maternal and paternal favoritism predicting externalizing symptoms among adolescents. According to the results, maternal favoritism predicted externalizing symptoms. Those who perceive much favoritism from their mothers had higher levels of externalizing symptoms, as regression analysis by internalizing symptoms also showed. A previous study on parental differential treatment supported this finding that children who were less favored by their mothers and who had a same sex sibling expressed high levels of violent behaviors and vandalism (Scholte, Engels, Kemp, Harakeh, & Overbeek, 2007). The same study included that externalizing behavior effect of parental favoritism decreased for participant daughters aged 13 to 15, who reported better

relationships with their siblings. Yahav (2006), on the other hand, has found that paternal favoritism was effective on children's externalizing behaviors, rather than maternal favoritism, as opposing to the current study findings. He offered that, this situation was caused by the negative perceptions of symptomatic children about their parents, as an explanation to this finding. Nevertheless, the same study also indicated that, symptomatic (both internalizing and externalizing) siblings reported that their non-symptomatic siblings were more favored by both their mothers and fathers. Similarly, the non-symptomatic siblings reported that their symptomatic siblings were less favored by both parents (Yahav, 2006). Although his study and the current study have different findings, Yahav (2006) pointed out that further research should be done to expand on this issue.

In the current study, externalizing symptoms were not only hypothesized to be related with physical punishment and favoritism, as parenting dimensions; but also with parental emotional warmth, and punishment and emotional pressure. However, emotional warmth, and punishment and emotional pressure did not predict externalizing symptoms. Although some of the previous study findings are contradictory to the current findings (Berkien et al., 2012; Yahav, 2006), there are also studies which had findings in line with the current study (Barnow et al., 2005). Barnow and colleagues (2005) have found that parental emotional warmth did not predict externalizing symptoms, which is in line with the current study finding. Though this study sample was composed of adults, it might act as a supportive evidence for the current study results. Besides, this might be an indicator of the validity of this result not only for adolescents, but also for adults.

Punishment and emotional pressure also did not predict externalizing symptoms. The current study proposed that parental (both maternal and paternal) punishment and emotional pressure, which are rejecting parenting behaviors, would predict externalizing symptoms among adolescents. The results did not confirm the proposed hypothesis. Accordingly, punishment and emotional pressure from both parents did not predict externalizing symptoms. Previous findings showed that parental rejection was a risk factor for adolescents to develop externalizing disorders (Wassermann, Miller, Pinner, & Jaramillo, 1996). Muris and colleagues (2003) have also found positive associations between rejection from fathers and mothers and externalizing symptoms. Besides, another study has shown that, those who perceived rejection from their parents were more likely to show externalizing behaviors and they were more prone to substance abuse (Rohner et al., 2005). Even though previous study results and the results of the current study do not support each other, this inconsistency might have been due to the fact that the current research investigated a very specific aspect of parental rejection, namely, punishment and emotional pressure, unlike previous studies.

It was hypothesized that self-concept would predict externalizing symptoms. The results falsified the proposed hypothesis. It was found that self concept did not predict externalizing symptoms among adolescents. Previous researches have highlighted the negative relationship between self-esteem and juvenile delinquency, which is an aspect of externalizing symptoms (Kaplan, 1975; Rosenberg et al., 1989). A study by Schwartz and colleagues (2006), also found negative relationship between self-concept and externalizing symptoms among Hispanic adolescents. Another study has indicated that, negative self-concept was strongly related to

externalizing behaviors, among adolescents on the age of 15 and 16, more than younger or older adolescents (Ybrandt, 2008). Even though there is much evidence that self-concept and externalizing symptoms are related, there are also studies showing the contrary, which are in line with the current study results. Egan and Perry's (1998) study, in which they have indicated that self-concept was not related to externalizing behaviors, was supported by the current research results. Although the inconsistency across the findings about the relationship between self-concept and externalizing symptoms might have been occurred out the cultural differences and confounding factors, it also implies the need of further research on this area.

The current study revealed that, in the absence of the predictor variables, adolescents might still have had externalizing symptoms. This finding might also be an implication of the biological basis of symptom development among adolescents, as in the internalizing symptoms' findings. Accordingly, an adolescent living in a higher SES environment, who had high levels of family and friend support, who perceived little or no physical punishment from his or her mother and father, and who did not perceive any favoritism among his siblings from his or her mother would still develop externalizing symptoms, as a result of his predisposition.

4.4. Role of Parental Favoritism on Symptomatology among Adolescents

A significant difference in terms of internalizing and externalizing symptoms were expected between adolescents who had siblings and perceived parental favoritism, who had siblings and did not perceive parental favoritism, and who did not have siblings at all. The results showed that, there were significant differences between adolescents who perceived favoritism from their parents, and who did not perceive favoritism from their parents and who did not have any siblings, in terms of

internalizing symptoms. Moreover, there was also significant difference between those who perceived favoritism from their parents and those who did not perceive favoritism, in terms of externalizing symptoms. Besides, while there was a significant difference also between adolescents who perceived maternal favoritism and those without siblings in terms of externalizing symptoms; there was not any significant difference between adolescents who perceived paternal favoritism and those without siblings in terms of externalizing symptoms.

The current study showed consistent results with the previous findings. There are a number of studies which showed the significant relationship between parental favoritism and internalizing and externalizing symptoms among children and adolescents (e.g., Berkien et al., 2012; Feinberg, Solmeyer, & McHale, 2012; Meunier et al., 2012; Scholte et al., 2007; Yahav, 2006). The traces of internalizing and externalizing symptoms are highly likely to be observed in children and adolescents whose parents favor one of the children in the family (Feinberg & Hetherington, 2001; Shanahan, McHale, Crouter, & Osgood, 2008). Previous studies have found that the level of depression (Feinberg & Hetherington, 2001; Shanahan et al., 2008), and antisocial and delinquent behavior (Tamrouti-Makkink, Dubas, Gerris, & van Aken, 2004) were higher among non-preferred children. Also, a study by McHale, Updegraff, Shanahan, Crouter, and Killoren (2005) has shown that depression and risky behavior were significantly associated with being disfavored. Besides, the opposite of this case was also supported by other studies. It was also found that symptomatic children reported higher levels of differential parenting behaviors towards themselves and their siblings (Berkien at al., 2012; Yahav, 2006).

Since the current study findings included that perception of favoritism from both parents may lead to higher levels of internalizing and externalizing symptoms, the current findings were supported by the studies mentioned above. A different result that have been occurred out of the variance analysis in this research, which was not explained in previous research, was that there was not a significant difference between those who had siblings and perceived paternal favoritism, and those who never had any siblings, in terms of externalizing symptoms. This result contradicts with what was expected at the beginning, especially considering the importance of fathers on externalizing behaviors of adolescents. However, this result might be reflecting some traces from previous research which was indicated that high levels of violence and vandalism were mostly seen in younger brothers among same-sex sibling dyads, who perceived that they were less favored by their mothers, but not fathers (Scholte et al., 2007).

Another study has shown a contradictory result, which found that externalizing problems of those who were more favored were declined over time (Richmond, Stocker, & Rienks, 2005). Richmond and colleagues (2005) explained this result the tenderness of children to any change in parenting behaviors towards themselves and also to their siblings. On the other hand, Bieber (1977) has proposed that parental favoritism leads to development of certain personality characteristics in children. This perception makes the favored child feel like he or she is unique and grandiose, while feelings of inferiority and hostility might evoke in un-preferred child (Bieber, 1977). Since the current study did not differentiate the favoritism results between those who perceived to be favored and those who perceived that another sibling was favored, considering Bieber's (1977) ideas, perception of

favoritism might have evoked adaptive feelings and thoughts about the favored children's own selves; which might then led to decrease in their externalizing symptoms. If that was also the case for the current study, that might then explain the indifference between those who had siblings and perceived paternal favoritism, and those who never had any siblings, in terms of externalizing symptoms.

4.5. Implications of the Current Study

The current study gathered the main factors in adolescents' lives which might affect adolescents' psychological well-being. This research enabled one to observe the effects of these factors; namely, self-concept, perceived parenting, and perceived social support; on adolescents' well-being at the same time. Although being mostly similar, the current results also had slight differences with previous research, which might have been an implication of the cultural differences between West and Turkey.

The most salient finding in general, might be the fact that adolescents' perceptions differentiated between maternal and paternal parenting, by some aspects of parental behaviors. This result implies the differential parenting behaviors of mothers and fathers to their children. Parents should notice that their behaviors serve as role models to children, and they should also realize how their children are affected by their treatment towards them. Taking into consideration the fact that congruent parenting would lead to better child outcomes (McHale et al., 2002); mothers and fathers should act in similar ways to their children.

It has been revealed in the results of the current study that, even in the absence of the predictor variables, there has been still a chance for adolescents to develop internalizing or externalizing symptoms. This probability was higher for

internalizing symptoms, which might suggest that the inheritance of internalizing symptoms was higher than externalizing symptoms. Besides, when predictors were considered, the difference between internalizing and externalizing symptoms mainly rose from age, gender, maternal physical punishment, and paternal punishment and emotional pressure, predicting internalizing and externalizing symptoms differently. Since emotional and physical punishment might lead to symptomatology among adolescents, parents should be careful to their punishing behaviors. Educating parents about how to behave towards their children might be helpful for regulating their reactions.

Another prominent finding of this research was the effect of favoritism of parents on adolescents' symptom development. Since adolescents were highly affected by both their mothers' and fathers' favoritism, parents should behave similarly to their children, taking their children's distinct needs into consideration. Parents should realize that their differential treatment of their children might give the children harm, leading to mental health issues. With their congruent and similar behaviors towards their children, the parental reasons of sibling rivalry would decrease, which might lead to better family environments. These issues might be highlighted in family, couple, and individual therapies; and also those who experience difficulties in regulating intrafamilial relationships might be encouraged to take therapeutic help.

4.6. Limitations of the Current Study

The present study has contributed to the current literature by presenting possible factors that adolescents might have been influenced in developing symptomatology, considering the possible factors simultaneously. The current

research also has revealed some important implications in symptomatology related with sibling and parenting dynamics. Nevertheless, the study current study has several limitations. First of all, the data gathering process was not able to be fully controlled. Since most of the presidents of the schools did not permit the scales to be filled out in class times, the participants took the scales home and they turned them back in a week. To be able to eliminate any bias, all the participants were informed, all the scales were examined before data entry and only those with consistent answers were included in the study. Besides, the data was analyzed for finding out any inconsistencies between the answers of those who completed the questionnaires at home or in class. The results showed that there were significant differences between these two groups of adolescents, in terms of maternal overprotection and intrusiveness; and friend, family and teacher support. Accordingly, those who completed the questionnaires scored higher in all these aspects, which points to significant differences between the answers of those who completed the questionnaires at school and in class.

Another limitation may be that the current study only analyzed the direct effects or the direct relationships of the variables. However, there might have been confounding factors, or mediators and moderators between these study variables, which were not controlled for in the current study. Taking confounding, mediator, and moderator variables into consideration would enable this study to have a broader view to adolescent symptomatology.

Many studies have also shown the importance of sibling relationships for the development of internalizing and externalizing symptoms (e.g., Feinberg et al., 2012;

Richmond et al., 2005; Scholte et al., 2007; Shanahan et al., 2008). For the current study, although it was attempted to gather data from sibling pairs aged between eleven and eighteen, because only forty-two questionnaires were fully returned from sibling pairs, those data could not be analyzed. Besides, because sibling pairs could not be studied in terms of differential parenting (especially in terms of favoritism), age and gender differences also could not be evaluated, even though previous studies have highlighted the importance of considering gender and age differences in terms of differential parental treatment (e.g., Tamrouti-Makkink et al., 2004).

4.7. Future Directions

In light of the results of the current study, and also taking the limitations of the present research into consideration, several suggestions for future work arose. The center of attention of the current study was perceived parenting and adolescent psychological consequences. While studying the relationship between different parenting dimensions and symptomatology, future research should examine the correlations between these variables. Overprotection and intrusiveness aspect of parenting was happened to be not correlated with many other parenting aspects. Although this should also have reflected a negative side of parenting as physical punishment or punishment and emotional pressure, overprotection and intrusiveness was not related with these aspects for mothers. However, there were significant differences between maternal overprotection and intrusiveness, and friend, family, and teacher support scores of adolescents those who completed the forms at home and in class. The reason for this difference should be investigated, which might give significant clues about parent-adolescent relationships. Since previous work included that overprotection was related with other parenting dimensions and symptomatology

(e.g., Yahav, 2006), this aspect of parenting may be included in a more in depth research in the future, controlling for the cultural differences.

Future research should also consider confounding factors, and mediators and moderators while looking at cause and effects or associations between variables, to have a wider view of the concepts. Besides, since sibling studies are highly significant in studying differential parenting including favoritism, sibling pairs should be included in future research in these areas. Further, to be able to make comparisons between different perceptions of participants with different demographic characteristics, data should be gathered not only from adolescent participants, but also from parents, siblings, teachers, and even from neighbors. This may also enable researchers to have an understanding of real parenting behavior and real social support that adolescents get, which may again enable one to compare these values and make deductions.

Working with adolescents ideally requires working with different settings that adolescents spend most of their time like home, school, friend environments; as Bronfenbrenner suggested in his microsystem (1977/ 1979/ 1992). Such a work would present a more comprehensive approach to adolescents' well-being, which may facilitate to interfere in maladaptive conditions. To be able to produce such a work reliably, there should be multiple reporters and researchers included in the study. With the effort of multiple researchers in theory and field, a highly effective study would be produced, which might contribute to the field well.

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