THE ROLE OF CHILDHOOD EXPERIENCES AND MATERNAL REFLECTIVE FUNCTIONING ON MATERNAL SELF-EFFICACY SKILLS

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DECLARATION OF ORIGINALITY

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ABSTRACT

The Role of Childhood Experiences and Maternal Reflective Functioning on Maternal Self-Efficacy Skills

The influence of maternal reflective functioning in the relationship between adverse and benevolent childhood experiences, and maternal self-efficacy was examined in this study. The sample comprised 155 mothers at least having one child aged 12-36 months. Data were collected by utilizing a demographic form, the Patient Health Questionnaire-Depressive Symptoms (PHQ-9), the Adverse Childhood Experiences (ACEs) Questionnaire, the Benevolent Childhood Experiences (BCEs) Scale, the Parental Reflective Functioning Questionnaire-Short Form (PRFQ-SH), and the Self-Efficacy for Parenting Tasks Index-Toddler Scale (SEPTI). PROCESS Procedure for SPSS Version 4.2 was used to investigate two mediational models. The first model was not tested because ACEs had no significant relationship with maternal self-efficacy. In the second model, while the "Pre-Mentalizing Modes (PM)" dimension of maternal reflective functioning partially mediated the relationship between BCEs and maternal self-efficacy (b = .807, 95% CI [.165, 1.507]), the other two dimensions of maternal reflective functioning did not mediate the relationship. The study demonstrates that with the increase in the mother's BCEs, mentalization skills that support the mother's interaction with the child's world increase, and thus, maternal self-efficacy increases. The implications based on preventive and intervention-oriented programs and services for psychological counselors and professionals working with new mothers were evaluated.

ÖZET

Annelerin Öz yeterlik Becerilerinde Çocukluk Deneyimleri ve Anne İçsel Düşünme İşlevinin Rolü

Bu çalışma, olumsuz ve olumlu çocukluk deneyimleri ile anne öz yeterliği arasındaki ilişkide annenin içsel düşünme işlevinin rolünü araştırmayı amaçlamıştır. Örneklem 12 ila 36 ay arasında en az bir çocuğu olan 155 anneden oluşmuştur. Veriler, demografik form, Hasta Sağlık Anketi-9, Çocukluk Çağı Olumsuz Yaşantılar Ölçeği, Çocukluk Çağı Olumlu Yaşantılar Ölçeği, Ebeveyn İçsel Düşünme İşlevselliği Ölçeği ve Anne Babalık Becerilerinde Özyeterlik Ölçeği kullanılarak toplanmıştır. İki aracı modeli araştırmak için "PROCESS macro" eklentisinin SPSS için düzenlenen 4.2 versiyonu kullanılmıştır. İlk model test edilememiştir çünkü olumsuz çocukluk deneyimleri ile anne öz yeterliği arasında anlamlı bir ilişki bulanamamıştır. İkinci modelde annenin içsel düşünme işlevselliğinin "Zihinselleştirme Öncesi Modlar" boyutu (b = .807, 95% CI [.165, 1.507]), annenin olumlu çocukluk deneyimleri ile öz yeterliği arasındaki ilişkiye kısmen aracılık ederken diğer iki boyutu bu ilişkiye aracılık etmemiştir. Bu çalışma, annenin olumlu çocukluk deneyimlerinin artmasıyla birlikte annenin çocuğun dünyası ile etkileşimini destekleyecek zihinselleştirme becerilerinin arttığını ve dolayısıyla annenin öz yeterliliğinin yükseldiğini göstermektedir. Psikolojik danışmanlar ve yeni annelerle çalışan profesyoneller için önleyici ve müdahale odaklı programlara ve hizmetlere dayalı çıkarımlar değerlendirilmiştir.

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ABBREVIATIONS

ACEs: Adverse Childhood Experiences

BCEs: Benevolent Childhood Experiences

CMS: Certainty about Mental States

IC: Interest and Curiosity

PM: Pre-Mentalizing Modes

CHAPTER 1

INTRODUCTION

Childhood adversity appears in the literature as a public health problem because it accompanies the possibility of many mental health problems occurring in a child or an adolescent exposed to adverse experiences and also accompanies the possibility of evolving into psychopathology later in adulthood (Panagou & Macbeth, 2022). Adverse childhood experiences (ACEs) consist of neglect, three types of abuse, and five types of household dysfunction, which are experienced between the ages of 0-18 (Rowell & Neal-Barnett, 2022). Types of abuse may occur physically, sexually, and emotionally (Rowell & Neal-Barnett, 2022). Household dysfunction includes the situations having divorced or separated parents, witnessing domestic violence, or living with family members with criminal behavior, substance abuse problems, or mental illness (Rowell & Neal-Barnett, 2022). Based on this definition of ACEs, it can be stated that these experiences have the potential to form the basis for the public health problem (Panagou & Macbeth, 2022).

As a result of some research studies, connections have been established between these adverse experiences and physical and mental difficulties, negative behaviors, and interpersonal relationships (Chau, Dryer, & Brunton, 2023; Huffhines, Bublitz, Coe, Seifer, & Parade, 2022; Rowell & Neal-Barnett, 2022). Moreover, in the study of Anda et al. (2006), researchers determined that affective disturbances, substance use and abuse, the level of perceived stress, difficulty in anger management, impaired memory of childhood, somatic problems, and perpetrating intimate partner violence increase when exposing to ACEs. Another study argued that exposures to ACEs may accompany continuous abnormalities

associated with mental health, the immune system, and metabolism (Danese et al., 2009). Also, these exposures may increase the risk of diseases associated with age (Danese et al., 2009).

In addition to the within-generation influence of childhood adversity, the intergenerational influence of adverse experiences in childhood is one of the issues in the literature stated as another dimension of the problem that needs to be considered for public health (Letourneau et al., 2019). When looking at the studies in the literature about the intergenerational influence of childhood adversity, it can be said that researchers focus on the relationality of the ACEs of the mother, who is generally described as the main caregiver, and the well-being of the offspring. Although the number of longitudinal studies focusing on this relationship is limited, there are studies indicating that maternal ACEs are a potential risk for the health and development of the child, accompanied by social, emotional, and behavioral problems and difficulties emerging from the relationship between parent and child (Shih et al., 2023).

When mentioning childhood adversities and their possible influences on adulthood, there is a possibility of looking at the other side of the coin. Benevolent childhood experiences (BCEs) constitute a resource for making sense of the interaction of risk and resilience in different developmental trajectories of individuals (Narayan, Atzl, Merrick, Harris, & Lieberman, 2020). Compared to negative experiences in literature, researchers have just begun to consider BCEs with the study of Lieberman, Padrón, Van Horn, and Harris (2005). This concept includes security, safety, and support, which are perceived, and favorable living conditions in the 0-18 age period (Zhu, Zhang, & Anme, 2023). Regarding the perspective of developmental psychopathology, BCEs, like ACEs, may create intergenerational

influences and act as a buffer; however, more research studies should be conducted to strengthen this hypothesis because this concept is overlooked in the literature (Zhu et al., 2023). When considering both a few studies and the conflicting results in the literature, studies investigating the relationship between maternal BCEs and the mother's mental health will be critical.

In the review paper of Panagou and Macbeth (2021), researchers studied the underlying mechanisms between childhood adversity and mental health problems, and they argued that emotional dysregulation is one of the pathways. Emotion regulation is a skill that changes and develops throughout life by being affected with internal and external processes (Morris, Silk, Steinberg, Myers, & Robinson, 2007). It refers to becoming aware of an emotion, interpreting and naming its effects, and responding to it adaptively (Gratz & Roemer, 2004). The development of emotional regulation skills begins with the attachment established with the parent (Thomas et al., 2017). When emotionally available, parents can better understand and meet the offspring's needs (Slade, Grienenberger, Bernbach, Levy, & Locker, 2005). The offspring internalizes the responses of the parent to positive or negative situations encountered in her/his daily routine and begins to model the parent's emotion regulation skills (Morris, Criss, Silk, & Houltberg, 2017). As the offspring gets older, this process, which starts with modeling by the parent, first turns into co-regulation and then self-regulation (Thomas et al., 2017). Qualified parent-child interaction, a source for this process, supports the individual's development cognitively, emotionally, and socially and helps them demonstrate adaptive functioning (Luyten, Nijssens, Fonagy, & Mayes, 2017b).

Parents’ sensitivity and their internal states related to their own parents determine the characteristics of attachment in the interaction between them and their

child in early childhood (Sümer, Lubiewska, Aran, Głogowska, & Żegleń, 2024). Parental sensitivity has direct and indirect associations in the literature that focus on the intergenerational transmission of attachment. However, statistical data show that the mediator role of parental sensitivity in the relationship between the attachment of the parent and the attachment of the infant may be insufficient, which is called the "transmission gap" (Sümer et al., 2024). At this point, parents' reflective functioning emerges as another mediator for the transmission mechanism of attachment in terms of internal states related to their attachment figures (Sümer, 2024). Moreover, in the study of Zeegers, Colonnesi, Stams, and Meins (2017), researchers argued that mothers' reflective functioning predicted mother-child attachment better when compared to the sensitivity of mothers.

Reflective functioning, also known as mentalizing, represents an intentional comprehension process that extends to the inner states of both the individual and other individuals (Allen, Fonagy, & Bateman, 2008), and emotion regulation skills nurture this metacognitive capacity (Crugnola, Ierardi, Bottini, Verganti, & Albizzati, 2019). Children are programmed to experience the world by watching their parents. However, when parents consciously look at the world through their offspring's eyes and adaptively reflect what they understand back to their offspring, through this, they contribute to their offspring's mentalization capacity, which is parental reflective functioning (PRF) (Ordway, Webb, Sadler, & Slade, 2015).

The positive or negative inferences about the offspring's behavior that the parents filter through their mentalization process are related to the behavior they have developed toward their child (Cunningham & Renk, 2018). At this point, how parents perceive themselves and what they think about their capacity to fulfill their parenting roles may affect their bond with their children. When Bandura's self-

efficacy theory is interpreted through parenting, it can be inferred that parents' belief that having the skills necessary to fulfill their parenting roles may be a prerequisite for success in these roles, which is parenting self-efficacy (Cunningham & Renk, 2018).

1.1 Significance of the study

In a world where there are many problems affecting societies, such as wars, migrations, being in refugee status, social exclusion, natural disasters, and poverty, there are some unseen and unheard difficulties that, when shed light on individuals, affect them and their environment, and even may influence the generations after them (Letourneau et al., 2019). It is not unexpected that children exposed to these difficulties early in life may not cope with the stress they experience because they may not have that capacity yet (Rowell & Neal-Barnett, 2022). When the necessary protective factors are not available for the child, there is a risk that their cognitive, emotional, and social development may be disrupted (Fonagy, Campbell, & Luyten, 2023). While ACEs sometimes bring the risk of depression, post-traumatic stress disorder, behavioral disorders, substance misuse, and suicidal ideation during the periods of childhood and adolescence, the possibility of psychopathology is encountered later in adulthood (Panagou & Macbeth, 2022). Psychopathology that ACEs pave the way may manifest itself with depressive disorders, anxiety, psychosis, substance misuse, suicidal ideation, self-harm (Panagou & Macbeth, 2022), and even internet gaming disorder (Ma et al., 2024).

From the developmental psychopathology perspective, just as different reasons produce the same results, which is equifinality, there are also situations where the exact causes make different results, which is multifinality (Cicchetti &

Rogosch, 1996). For this reason, the influence of ACEs on everyone, even within the same family, is unique, and this influence occurs when many elements come together, such as the individual's biological mechanism and temperament and the interaction of risk conditions and protective factors for that person (Sameroff, 2010).

Also, in the review paper of Panagou and Macbeth (2022), researchers stated that based on fundamental research and epidemiological data, the worldwide prevalence rate of childhood adversity is in the 29-38% range. While this points to a growing public health problem, the intergenerational influence of this issue has slowly begun to take its place in literature. Studies based on this influence have mainly focused on the relationality between the childhood adversity of the mother and the mental health of the child by using various mediating variables such as mothers' mental health conditions (Doi, Fujiwara, & Isumi, 2021; Kumar et al., 2018; Letourneau et al., 2019; Shih et al., 2023) and parenting skills (Luo et al., 2023). Many studies have concluded that children having mothers who experienced childhood adversity might develop internalizing or externalizing behaviors (Doi et al., 2021; Letourneau et al., 2019; Luo et al., 2023; Sauvé et al., 2022; Shih et al., 2023). At this point, research on the underlying mechanism of ACEs and the mother's cognitive, emotional, and social skills affecting the parenting experience may help develop preventive studies in the field.

Maternal reflective functioning represents an interaction in which the mother's mentalization ability supports the offspring's mentalization capacity (Smaling, Huijbregts, Van der Heijden, Van Goozen, & Swaab, 2016). This metacognitive function, also nourished by emotion regulation skills, has been investigated in a limited number of research in Turkey (Arıkan, Acar, & Üstündağ-Budak, 2020; Sümer et al., 2024). On the contrary, this concept is encountered more

intensively in international literature. However, it has been observed that the number of studies in which maternal reflective functioning is combined with maternal self-efficacy, and BCEs is more limited compared to ACEs.

While parenthood may be a source of happiness for the individual, it also requires a new identity, new responsibilities to be managed, and adaptation to new conditions (Chasson & Taubman-Ben-Ari, 2023a). While the mental and physical change of the parent, who is generally the mother because the mother carries the baby on her body and is the primary caregiver, is a researched subject, the situation of the mother who experiences parenting with baggage from the past or the mother-to-be who is preparing to experience motherhood has taken its place in the literature as more specific topics (Christie et al., 2017). The stress brought on by a new identity during the prenatal and postnatal period may trigger the mother, especially those exposed to ACEs, and put them in a riskier position in terms of mental health (Christie et al., 2017). In a process where the offspring's needs are placed at the center, the mother's mental and physical functionality plays a significant role in realizing the parenting skills (Chasson & Taubman-Ben-Ari, 2023a). The mother's beliefs, which influence her expectation of parenting performance, have become a concept that stands out and may be associated with the mother's internal states (Coleman & Karraker, 2003).

Peripartum depression stands out as a common mental health problem during the transition to parenthood. There are studies in the literature showing that the effects of this mental problem, which is diagnosed based on symptoms noticed in the prenatal period or within four weeks after birth, last up to a year (Radoš et al., 2024). As a reflection of these effects on the parent-child relationship, it has been found that mothers with ACEs had much more difficulty in establishing an emotional bond with

their offspring in the first year compared to mothers who were not exposed to these experiences (Fuchs, Möhler, Resch, & Kaess, 2015). Since the current study focuses on maternal childhood experiences, mothers with children at least 12 months constituted one of the inclusion criteria of the sample to alleviate the effect of peripartum depression, whose prevalence is considerable, on the sample. After birth, the first three years, when the bond the baby establishes with the primary caregiver, are important for the baby's healthy development (Bowlby, 1958). At this point, the mother's perception of self, the offspring, and the relationship with the offspring constitute the factors that determine parenting skills (Fonagy et al., 2023). It is thought that examining self-efficacy, which lays the groundwork for success regarding parenting skills in the ages of 1 and 3, when the mother needs to be physically and mentally active, may support studies and programs focusing on the first years of early childhood.

In conclusion, no study that combines all the current study's concepts, ACEs, BCEs, maternal reflective functioning, and maternal self-efficacy, has been encountered in international literature and Turkey. This represents one of the unique parts of the study. On the other hand, considering the peripartum depression period, which mothers experience during the transition to parenthood in the 14-18% range in review studies (Radoš et al., 2024), and the importance of the first three years of life for attachment, mothers with at least a 12-36-month-old child were determined as the sample. It is noteworthy that the number of studies examining self-efficacy with this sample group in Turkey is limited, and there is only an adapted tool that can measure maternal self-efficacy during this period. Therefore, examining self-efficacy in this sample group may contribute to the recognition of the needs of mothers in this period, which is the other unique part of the study. Looking at the mother's cognitive

and psychosocial sources from perspectives of adverse and benevolent childhood experiences may offer researchers a perspective on making sense of the mother's efficacy expectancy about parenting skills. The outcomes of the current study may contribute to designing comprehensive and preventive counseling services and programs that help improve the mother's cognitive, social, and emotional skills to develop mother-child interaction.

1.2 Purpose of the study

The current study explores how maternal reflective functioning helps associate adverse childhood experiences (ACEs) and benevolent childhood experiences (BCEs) with maternal self-efficacy. Based on this aim, the research questions are listed as follows:

1. When considering the demographic characteristics of the sample;
    a. Are the mother's current age, the age of being a mother, and the child's age related to the study variables?
    b. Do the levels of the study variables differentiate regarding having another child, the child's gender, the mother's opinion on whether the time spent with the child is sufficient, and socioeconomic status?
2. Is there a relationship among adverse and benevolent childhood experiences, maternal reflective functioning, and maternal self-efficacy?
3. Does maternal reflective functioning mediate the relationship between adverse childhood experiences and maternal self-efficacy?
4. Does maternal reflective functioning mediate the relationship between benevolent childhood experiences and maternal self-efficacy?

CHAPTER 2

LITERATURE REVIEW

2.1 Adverse childhood experiences (ACEs)

Felitti and colleagues (1998) introduced this framework to the literature by conducting a study investigating the relationship between abuse in childhood and risky behaviors for health and disease in adulthood. Since health behaviors and lifestyle factors may be a risk for cases that result in morbidity and mortality, how devastating experiences in childhood leaves a mark on adult health has become a research subject (Felitti et al., 1998). Researchers divided childhood adversity exposed between the ages of 0-18 into two categories: abuse and household dysfunction. Three types of abuse, which were physical, emotional, and sexual, and household dysfunction, including substance abuse, mental illness, violent behavior towards mother or stepmother, and criminal behavior, created the first definition of ACEs (Felitti et al., 1998).

According to the consequences of this study, obtained from 8,506 participants, 52.1% of whom were women, 79.4% of whom were European American, and whose average age was 56.1 years, childhood adversities associated with health risk factors for disorders that may result in death in adulthood and in severe disease conditions (Felitti et al., 1998). These risk factors for adults having various ACEs were related to mental health (e.g., depressive symptoms, addiction to alcohol and illicit drugs, suicidal attitude), lifestyle conditions (e.g., smoking, physical inactivity, and having more than 50 intercourse partners), and physical health (e.g., obesity and sexually transmitted diseases) (Felitti et al., 1998). While the diversity of adversities exposed to during childhood increases, it is noticeable that

there is an increase in diseases of the heart, lung, liver, skeletal, cancer, and even thoughts about having poor health conditions (Felitti et al., 1998).

Besides the influences of childhood adversity on lifestyle factors, risky behaviors for health, and disease conditions in adulthood, their influences on more singular conditions, such as alcoholism and depression, have also been the subject of other research studies (Anda et al., 2002; Chapman et al., 2004). Anda et al. (2002) conducted their work by adding three categories, which were witnessing domestic violence, having divorced or separated parents, and living with suicidal household members, to the definition of Felitti et al. (1988) and removing one category, which is battered mother, from this definition. They aimed to examine whether having one or two parents having severe alcohol problems was linked to eight other conditions that cause childhood adversity and whether childhood adversity was related to the risk of alcoholism and depression in adulthood, based on having or not having an alcohol-abusing parent.

According to the data obtained from 9,300 adults who were included in the study, one-fifth of adults who had a parent with alcohol abuse have a significantly higher risk of experiencing the other eight childhood adversities (Anda et al., 2002). Compared to the other group who did not have a parent with alcohol problems, alcoholism was more common in adults who had a parent with alcohol problems (Anda et al., 2002). According to the result of this study, while the variety of ACEs increased, alcoholism and depression increased, and no differences were found between groups, which were determined in terms of whether having a parent with alcohol abuse or not (Anda et al., 2002). On the other hand, depression was widespread in adults who had alcohol-abusing parents because of the risk of being subjected to more childhood adversities in the home environment (Anda et al., 2002).

While being subjected to mental health problems, addiction, and suicidal attitudes in the home environment was significantly higher when the alcoholic parent was the mother, no significant difference was found when the alcoholic father was included in this model (Anda et al., 2002).

In studies examining the relationality between childhood adversity and psychiatric disorders, psychiatric disorders occur more commonly in individuals exposed to abuse and trauma compared to individuals of the same age who did not (Chapman et al., 2004). Post-traumatic stress disorder (PTSD), borderline personality disorder, dissociative symptoms, and depression are among these psychiatric disorders (Chapman et al., 2004). Chapman and colleagues (2004) designed their study by adding one category, parental separation or incarceration, to the definition of childhood adversity in the study of Felitti et al. (1998) and focused on the relationality between the diversity of childhood adversity and the risk of depressive disorders. They aimed to control the effect of living in the same house with someone with mental illness on the risk of depression in the period of adulthood due to genetic predisposition. It has been determined that individuals who are exposed to emotional abuse in their childhood are at risk for having depressive disorders throughout life (Chapman et al., 2004). They found that as childhood adversity diversified, depression experienced by participants throughout their lives and depression experienced by participants during the period they participated in the study were likely to occur (Chapman et al., 2004). When the control condition, which was living in the same house with someone with mental illness, was added to the model, the relationality between the diversity of ACEs and depressive disorders weakened slightly, but it was still substantial (Chapman et al., 2004).

The risk that the possible consequences of difficulties one experienced in childhood, extending into adulthood, may create adverse situations for one's child has led to research not being limited to within-generation but also gaining an intergenerational perspective. When looking at the concept of ACEs from an intergenerational perspective, the mother, who is generally the main caregiver, becomes the subject of many studies considering this perspective in literature (Doi et al., 2021; Letourneau et al., 2019; Zhu et al., 2023). Therefore, maternal ACEs took their place in the literature to express the adverse situations the mother was exposed to between the ages of 0-18 (Luo et al., 2023). They have been studied with the mother's biological mechanism, mental health, physical health, and parenting (Christie et al., 2017).

The bond between the mother and the child, established through biological mechanisms in the prenatal period, begins to give way to psychosocial dynamics after birth (Doi et al., 2021). The fetus that falls into the mother's womb is in a position that affects and is affected by the mother's bodily functions (Doi et al., 2021). Especially during critical periods for the development of the offspring, the mother's lifestyle, health of the body, and physical and psychological well-being determine the conditions to which the offspring is exposed in the womb (Doi et al., 2021). The stress the mother experiences due to the difficulties may also be one of the determinants of these conditions (Doi et al., 2021).

Humans have two central biological stress response systems, which are called the hypothalamic–pituitary–adrenal (HPA) axis and the autonomic nervous system (ANS) (Oosterman, Schuengel, Forrer, & De Moor, 2019). Both systems are regulated through the same neural circuitry, but the ANS is faster activated (Oosterman et al., 2019). Studies generally focusing on the relationship between

ACEs and stress regulation make their evaluations through the HPA axis system in the literature (Oosterman et al., 2019).

O'Donnell et al. (2003) performed a longitudinal research to investigate whether maternal prenatal anxiety or depression has a persisting and unique effect on the diurnal cortisol rhythm of adolescents. In the first phase, pregnant women as participants completed anxiety-related scales five times from the 18th gestational week to the 81st month after birth. In the second phase, after 15 years, the children of some participants were included in the study to evaluate the variation in cortisol levels. Diminished cortisol amount when awakening and undulated daily cortisol rhythm were detected in adolescents whose mothers had high scores in terms of prenatal anxiety, which may be evaluated as a reduced capacity for responding to environmental stimulation, which may accompany potential risk in terms of metabolic diseases or psychiatric problems (O'Donnell et al., 2003).

In the study of Etringer, Kumsta, Hellhammer, Wadhwa, and Wüst (2009), researchers conducted an experimental study to evaluate HPA axis regulation. Contrary to the control group, the experimental group consisted of participants whose mothers had high scores in terms of psychosocial stress during the prenatal period. The test activating the HPA axis stress response system was used to evaluate psychological and hormonal responses to behavioral difficulties. In addition to this test, a simulation test was also used to activate the stress response system pharmacologically. Like O'Donnell et al. (2003), Etringer et al., 2009) found that much more fluctuation in the stress response system was detected in participants whose mothers had higher psychosocial stress scores than other participants had.

Oosterman et al. (2019) focused on the possible mediating influence of the reactivity of ANS in the relationship between childhood adversities and adaptive

transition to parenthood for pregnant women at risk. Data related to ANS, childhood adversities, maternal self-efficacy, anxiety, depressive symptoms, and harsh parenting were collected at different times. ANS is divided into two subsystems: parasympathetic and sympathetic. However, the sympathetic one did not link childhood adversities with one of the other variables, which were maternal self-efficacy, anxiety, and depressive symptoms. The inability to act in the parasympathetic system, called hyporeactivity, was related to both childhood adversities and increased depressive symptoms in the postnatal period. However, no indirect effect of this situation was found on the relation between childhood adversities and increased depressive symptoms in the postnatal period. In contrast to depressive symptoms, hyporeactivity of the system did not influence anxiety symptoms. In addition to that, childhood adversities have no relationship with parenting self-efficacy (Oosterman et al., 2019). Besides, childhood adversities have a predictive role in harsh parenting; however, researchers believe that this conclusion should be approached cautiously due to the risk factors obtained from the parent's demographic data.

Although these three studies (Etringer et al., 2009; O'Donnell et al., 2003; Oosterman et al., 2019) have different stress factors, they focused on the biological mechanism of the mother in the prenatal period. These studies discussed potential mental problems related to different periods that may occur after birth, specifically for the mother or the child. In this sense, the gestational period is considered a sensitive process in the context of the transmission of psychological dysfunctions to the next generation (Christie et al., 2017). While the difficulties experienced during the transition to parenthood may already cause problems to the mother's functionality

regarding cognition, emotion, and behavior, childhood adversity may put mothers in a much more vulnerable position (Oosterman et al., 2019).

2.2 Benevolent childhood experiences (BCEs)

In order to portray the place of benevolent childhood experiences in the literature and its contribution to this study, it will be helpful to look at the studies examining the influence of early childhood memories on parent-child interaction from the 1970s to the present. As cited in the study of Lieberman et al. (2005), Fraiberg, Adelson, and Shapiro (1975) stated that even if parents' memories of helplessness and fear in early childhood are not remembered, the emotional damage caused by these memories may be reflected in the images parents create about their children. The reflection of adverse experiences from the past into the present has been called the "Ghost in the Nursery" by Fraiberg and colleagues in 1975 (Lieberman et al., 2005).

The punitive and neglectful experiences that parents were exposed to in their relationship with their own parents in the past may be repeated in their relationship with their children; however, this time, their children are exposed to these experiences (Lieberman et al., 2005). With negative images parents create about their offspring, these parents may disregard or misinterpret the signals coming from their offspring based on the offspring's needs, and they may exhibit behaviors that include anger and rejection due to the emotional difficulties of past experiences (Lieberman et al., 2005). These negative attitudes displayed by the parents may cause the offspring to internalize the perception that they are not worthy of love, which is their primary need (Lieberman et al., 2005). Thus, the potential for healthy development of the offspring may be interrupted (Lieberman et al., 2005). This situation, in which sufficient attention and a responsive environment are not provided for healthy self-

development, may pave the way for problems in the relationship between parent and child and the transmission of psychopathology from generation to generation (Lieberman et al., 2005).

As cited in the study of Lieberman et al. (2005), Fraiberg (1980) shed light on parents' adverse experiences and the emotions related to those experiences in another study. Fraiberg mentioned that suppressed, ignored, and isolated emotions create a line of defense by providing an environment for the repetition of the destructive pattern of the past relationship and the damaged ego's effort to protect itself against negative feelings (Lieberman et al., 2005). At this point, the parent who was abused in childhood is at risk of becoming an abuser by identifying with betrayers and aggressors (Lieberman et al., 2005).

Lieberman et al. (2005) claimed that although this theoretical model put forward by Fraiberg (1975, 1980) was effective in clinical interventions, it left an area unanswered and waiting to be researched. While some parents identify with betrayers and aggressors in a way that confirms the model, some break the learned pattern of behavior despite the abuse they are exposed to. Lieberman et al. (2005) focused on the origin of the differences in attitudes that affect parents' relationships with their offspring, and they aimed to support the parent's empathy skills and the protective role required by having a child with combining their findings with techniques that enrich the therapeutic relationship.

Lieberman et al. (2005) conducted a study, and for the sample, they selected children whose ages were between 0 and 6 and were referred due to adverse childhood experiences and their parents who were exposed to conditions related to trauma in their adulthood. The sample came from different ethnic and socioeconomic levels. Content has already been obtained from psychotherapy processes on the child

and parent relationship. The parents' childhood experiences with their parents were examined by examining notes of the therapy sessions and the Adult Attachment Interview transcripts.

As cited in the study of Lieberman et al. (2005), Fraiberg (1975) stated that most empathetic parents are motivated to adapt to the child's destructive emotions, to change and improve the child's life by benefiting from their awareness of the destructive memories they experienced in their childhood and the emotions associated with these memories. However, based on the data they obtained in the study, Lieberman et al. (2005) concluded that the argument of Fraiberg and colleagues (1975) is not always valid. They emphasized the memories of their parents, who felt that they were cared for and protected by an important figure in their childhood. They used the term "Angels in the Nursery" for these memories. Like ghosts, angels may also form a recurring pattern of being experienced with a significant other (Lieberman et al., 2005). Thus, the parent may model identification with the protectors as an alternative to identifying with the betrayer and the aggressor, which may prevent the intergenerational transmission of adverse experiences (Lieberman et al., 2005).

Narayan, Ippen, Harris, and Lieberman (2017) made benevolent experiences the subject of an experimental study for the first time. Mothers who were registered at the foster care center and were raised there were defined as a high-risk group. The sample consisted of fifty-four mothers in the high-risk group. A striking feature of this foster care center was that some of the people who grew up here had children who were also registered and cared for in this center, which means intergenerational foster care. In this study, twenty-nine of these mothers had at least one child raised in this center. Researchers focused on whether angel memories protect high-risk

mothers against high-level psychopathology. Childhood maltreatment was linked with adulthood PTSD symptoms, and the strength of the relationship was changed by benign memories as the moderator. However, while the increase in ghost memories was related to the diversity of maltreatment in the period of childhood, the relationship between childhood maltreatment and adulthood PTSD symptoms was not mediated by ghost memories (Narayan et al., 2017).

In another study, Narayan, Rivera, Bernstein, Harris, and Lieberman (2018) aimed to investigate the reliability of the Benevolent Childhood Experiences (BCEs) scale, a newly developed measurement tool. Higher BCE scores were linked to lower scores of prenatal depression, PTSD symptoms, perceived stress, and stressful life events (SLEs). When ACEs were added to the model, PTSD symptoms in the gestational period and SLEs were found to be related.

Narayan et al. (2020) focused on the stableness of childhood memories from the gestational to the postpartum period by using data related to ACEs and BCEs. Researchers found that while the higher scores related to BCEs had a direct relationship with higher levels of benign memories in the gestational period, these scores had an indirect relationship with higher levels of adverse memories in the postpartum period, with the mediating influence of memories in the gestational period. In contrast to the BCE scores, the ACE scores had a direct relationship with both gestational and postpartum periods. Researchers focused on the possibility of the prenatal period being a critical threshold for intergenerational transmission of angel memories and emphasized the importance of diversifying research and intervention studies for expectant mothers in this period.

2.3 Maternal reflective functioning

Mentalization is a concept introduced to literature by psychoanalytically oriented attachment researchers in the mid-nineties (Slade et al., 2005). It means considering mental states, which are intentions, feelings, ideas, wishes, and beliefs, to understand one's behavior and the behavior of others and to make predictions about action to be taken (Rolli, 2021). Making sense of one's internal states represents embarking on a mental journey of discovery, expanding the knowledge one learns about oneself, and paying attention to the associations of the experiences one encounters (Sharp & Fonagy, 2008). Although one's journey constitutes a potential for knowing and regulating oneself and one's emotions, it is also crucial for productive social relationships by contributing to establishing the foundations of communication, interpersonal interaction, and cooperation. (Slade et al., 2005). In this sense, the more one uses one's mentalizing capacity, the more one has autonomy and a strong image of oneself, and one also becomes a social being that establishes close and sustainable relationships (Slade et al., 2005).

The baby is born with a capacity that will be the source of mentalization skills, but when mental states are discovered and learned with the caregiver, the baby makes sense of these mental states as self-states (Luyten et al., 2017b). The parent, especially the mother as the primary caregiver, should be sensitive to the offspring's reactions to meet the offspring's needs from birth (Chasson & Taubman-Ben-Ari, 2023a). Establishing this sensitive bond signals the existence of the necessary environment for the development of the offspring (Luyten et al., 2017b). A baby's awareness of mental states begins to emerge for the first time at three months of age (Slade, 2005). The parent's capacity to keep in mind the representations of the feelings, intentions, and desires the parent observes in the offspring, process them,

and reflect them to the offspring is called parental reflective functioning (Luyten et al., 2017b). These reflections begin with gesture and action, and with the development of the offspring, words, and play are also added (Rolli, 2021). When the baby encounters these reflections through observation, it begins to recognize the mental states within itself (Rolli, 2021). Discrimination, grouping, and association skills that come with recognition are the building blocks in developing the offspring's mentalization capacity throughout the first year (Slade, 2005).

There is a milestone that the child must go through before acquiring a mentalizing capacity, which is the consciousness that what is in the mind is only a reflection of feelings and thoughts, and many inferences may be made about one's reality (Slade, 2005). Reaching and passing through this milestone for the child is related to the parenting skill in the process that Winnicott called "transitional playspace" (Slade, 2005; Winnicott, 1965, 1971). In this process, the parent is a sensitive observer who builds a bridge between play and reality by using language and symbols (Luyten et al., 2017b).

Parental reflective functioning has three dimensions (Chasson & Taubman-Ben-Ari, 2023a). The first one is pre-mentalizing modes (PM), which means the parent fails to engage with the child's subjective world and makes unfavorable inferences about the child's behavior (Georg, Meyerhöfer, Taubner, & Volkert, 2023). The second one is certainty about mental states (CMS), which is the parent's belief based on making sense of the child's ideas, feelings, wishes, and intentions (Georg et al., 2023). The last one is interest and curiosity (IC), which represents the parent's voluntary access to the child's subjectivity (Georg et al., 2023). Disruptions of functioning in the dimension of CMS are hyper-mentalization and hypo-mentalization (Chasson & Taubman-Ben-Ari, 2023a). Hyper-mentalization is

related to very high levels of CMS, which means that the parent believes in having full awareness of the child's internal states (Luyten et al., 2017b). Hypo-mentalization, associated with very low levels of CMS, represents parents' blank slates about the child's internal states (Luyten et al., 2017b). Besides, while very high levels of IC may be related to hyper-mentalization, low levels of IC could be a basis for hyper-mentalization and hypo-mentalization occurring together (Luyten et al., 2017b).

While there is a clear perspective that the parent's metacognitive capacity is a dominant factor in the child's development, looking at the possible problems that the child may encounter if the child cannot benefit from parental skills based on this capacity may provide a more holistic approach. In cases where the sensitive bond established between the caregiver, which is usually the mother, and the child is described as insecure or disorganized, it is possible to say that the mentalization capacity that is expected to develop in the child remains primitive and is guided by defenses and distortions (Slade, 2005). Problems in intrapsychic and relational functioning may accompany various psychological disorders, including autism spectrum disorder, personality disorder, eating disorder, depression, and psychosis (Luyten et al., 2017b).

Mistakes related to affect mirroring made by parents in early infancy may also leave harmful traces on the development of this capacity of the baby (Slade, 2005). One of these mistakes is that the reflection is too realistic and not symbolic, which increases the baby's stimulation (Slade, 2005). The second is that the reflection is removed from its context and does not occur on the emotion it should be (Slade, 2005). On the other hand, the parent's negative attitudes during the caregiving process may also leave traces on the child's self-development (Slade, 2005). Mistakes

in the parent's reflective processes or attitudes may lead to the risk of miscommunication, which accompanies problems related to emotion regulation skills, responses to stress, and behavior (Smaling et al., 2016). Georg et al. (2023) argued that impaired parental mentalization is related to the risk of insecure attachment through parental sensitivity. They added that parents who had a history of childhood trauma, came from a low socioeconomic level, or had low levels of parental reflective functioning are a risk factor for children to have internalizing and externalizing behavior concurrently, which have the potential to transform behavioral problems into disorders later (Georg et al., 2023).

When looking at the literature, a more specific concept, maternal reflective functioning, may be encountered besides parental reflective functioning. Maternal reflective functioning is defined as the mother's metacognitive capacity to comprehend the mental state of herself and her child and the relationship between herself and her child (Smaling et al., 2016). The weakness in maternal reflective functioning is linked to the child's behavioral problems regarding attention, social interaction, anxiety, and mother-child bonding (Smaling et al., 2016). In addition to studies conducted with data obtained from the mother in the postnatal period, there are also findings related to low levels of parental reflective functioning in the prenatal period predicting the child's externalizing problems (Smaling et al., 2016).

2.4 Maternal self-efficacy

Looking at how maternal self-efficacy is positioned on accumulation in the literature may create a guideline to understand the function of this concept in the current study. In this sense, touching on the fundamental theories in the psychology of learning may be the first step to understand the emergence of this concept.

The fundamental subject of the psychology of learning is how to acquire and regulate a new behavior. The behavioral approach aims to study observable and measurable behaviors by focusing on the influence of the environment on the individual. Joseph Wolpe, Arnold Lazarus, and Hans Eysenck, representatives of the behaviorist approach in the therapy field, were influenced by Pavlov's experimental studies on dogs and Hullia's learning theory, and they integrated the knowledge they acquired into phobia treatment (Corey, 2015). While classical (respondent) conditioning, theorized by Ivan Pavlov, explains the process of behavioral acquisition through the response that emerges as a result of the connection between the two antecedent stimuli, operant conditioning, theorized by Burrhus Frederic Skinner, introduces a system that includes the antecedent stimulus, the response, and the reinforcer (Corey, 2015). Bandura revealed that these two fundamental behavioral theories, based on two-term and three-term contingency mechanisms, may not explain all kinds of learning because behavior is affected by not only stimulation and external reinforcement but also intervening cognitive processes (Bandura, 1977, 1982). While developing social learning theory, Bandura constituted observational learning by benefiting from classical and operant conditioning principles, which leads cognition to become the focus of the behavioral approach (Bandura, 1977, 1982).

One creates a mental representation of how behavior is exhibited by observing one's environment, and this representation guides one when one takes action to perform this behavior in another environment (Bandura, 1997). Direct, vicarious, and symbolic information learned through observation is prominent in the emergence and continuity of behavior (Bandura, 1997). However, as one demonstrates the behavior, one has the opportunity to self-evaluate one's

performance and subsequently make self-corrective adjustments (Bandura, 1997). Thus, one creates a cognitive framework for what, how, and where to do based on the results of one's behavior, which creates a more particular form of observational learning (Bandura, 1997).

While the behavioral approach focuses on the connection between behavior and outcome and engages in the reactive or operant dimensions of learning, it expresses the mechanism that regulates behavior through a controlling stimulus (Bandura, 1997). However, Bandura's social learning theory found it worth examining the path that leads the individual to behavior and based the mechanism that regulates behavior on the individual (Bandura, 1997). Besides the knowledge that one will encounter of which behavior produces which outcome, the importance of having belief and motivation to demonstrate a successful performance to achieve the result one expects is emphasized in the concept of self-efficacy (Aksüt, 2022).

In contrast to the automatic nature of outcome expectancy, efficacy expectancy involves a cognitive process of determining how hard one will try and how long one will maintain that effort despite the challenges and adverse conditions one encounters (Bandura, 1997). Although it is stated that the effort towards the goal will increase as self-efficacy increases, it would be misleading to think that the only thing required for success is efficacy expectation because one may demonstrate one's performance by cultivating self-efficacy if necessary skills and sufficient incentives exist (Bandura, 1997). Based on this, it is possible to say that the self-efficacy perceived by the person is related to personal, behavioral, and environmental factors (Aksüt, 2022). Three dimensions come into prominence in the self-efficacy mechanism, which has a versatile interaction area: magnitude, strength, and generality of self-efficacy (Aksüt, 2022). Magnitude represents the estimate of the

difficulty of the task; strength represents one's self-confidence, and the generality of self-efficacy represents the acceptance that the success achieved can be experienced in different areas (Aksüt, 2022).

Social Learning Theory was later named Social Cognitive Theory, which is more comprehensive (Bandura, 1986). Social Cognitive Theory includes the concepts of self-regulation, self-evaluation, and self-efficacy by considering individuals' emotions, thoughts, and behaviors (Bandura, 1986). Self-efficacy has become the subject of many studies examining individuals in different contexts (Bandura, 1997). One of these contexts has been parenting. When looking at studies on parenting in literature, two approaches may be encountered (Vance & Brandon, 2017). While the first approach focuses on the evaluation of parenting and the outcomes that will contribute to the progress of the child by examining the interaction between the parent and the child in different contexts, the second approach investigates relationality among the parent's characteristics, such as feelings, thoughts, attitudes, and values and behaviors related to parenting such as giving care, soothing, recognizing the child's needs, responding to these needs and so forth (Vance & Brandon, 2017). In the second approach, researchers used the concepts namely parenting confidence, parenting self-efficacy, and perceived competence (Vance & Brandon, 2017). The lack of differentiation between these concepts regarding definition, scale utilized, and theoretical framework made it difficult to synthesize the results (Vance & Brandon, 2017). Vance and Brandon (2017) conducted a study to distinguish these concepts. They noticed that parenting confidence and parenting self-efficacy overlap conceptually, but the concept of competence is divided into two. The concepts of perceived competence or parenting sense of competence may be referred to as the first version of parenting confidence

and parenting sense of competence (Vance & Brandon, 2017). However, the concept of competence represents someone else's objective evaluation of the parent (Vance & Brandon, 2017).

On the other hand, Coleman and Karraker (2000) identified parenting competency as an umbrella term that includes behavior, affect, and cognition. They also argued that parenting self-efficacy represents the main component of the cognitive dimension (Coleman & Karraker, 2000). Parenting self-efficacy means that it expresses the expectation of the mother or father regarding their competence in the parental role (Fang, Boelens, Windhorst, Raat, & van Grieken, 2021). In other words, it represents the parents' perception that they have the skills to provide an environment for their child's progress (Coleman & Karraker, 2003).

Based on Bandura's theory (1977), it can be said that a mother or father with strong expectations of efficacy is successful in the parenting role. This theory-derived knowledge was reflected in the review paper of Fang et al. (2021). They found that high scores in parenting self-efficacy were related to the physical and emotional availability of the parent, a mechanism for coping with problems, an active accompaniment towards the child's world, and not exaggerating the child's problems by labeling them in former research studies (Fang et al., 2021). On the contrary, low scores in parenting self-efficacy are linked to depressive symptoms, controlling and defensive parenting attitudes, the child's behavioral problems, perception related to having a difficult child, stress about parenting, and inadequate coping strategies in terms of parenting (Fang et al., 2021). In addition to the direct pathway between parenting self-efficacy and concepts mentioned above, parenting self-efficacy had mediational influence among parental factors (e.g., parent's mental

health), characteristics of children (child's temperament), and contextual factors (e.g., socio-economic status and social support) (Fang et al., 2021).

Belsky (1984) examined differences originating from personal attributes in parental functioning with the scope of studies related to childhood maltreatment and neglect. Three factors play a role in parental functioning: personal psychological resources, the child's individual characteristics, and contextual sources of stress and support (Belsky, 1984). This theory, which Belsky (1984) calls the process model, evaluates the influence of these three factors on parenting by combining different research findings. Infancy, preschool, and school-age children have different needs for their cognitive, emotional, and social development (Belsky, 1984). Belsky (1984) mentioned the importance of the parent being sensitive to meet these needs and that this sensitivity depends on being a psychologically healthy adult.

Belsky's (1984) process model explains that developmental history may influence personality and psychological well-being, which are the determinants of parental functioning. Contextual sources of stress and support may directly influence parenting, which may be mediated by psychological well-being. In addition, personality may influence contextual sources of stress and support, which may form parenting behavior (Belsky, 1984). In terms of the potential to create a protective factor in parent-child interaction, the efficiency of these three factors is ranked in descending order: personal psychological resources of parents, contextual sources of stress and support, and characteristics of the child (Belsky, 1984).

In the study of Belsky, Conger, and Capaldi (2009), researchers conducted a review including studies that correlate the first two of the three factors mentioned in the Process Model (Belsky, 1984), and they focused on longitudinal studies due to the inherent problems of retrospective studies. Personality problems and conflicted

marriages mediate the negative parenting of individuals exposed to hostile parenting towards their own children, while positive parenting of individuals experiencing supportive parenting is mediated by positive relationships with friends and relatives (Belsky et al., 2009). In addition to mediation, the presence of a person who will provide a corrective emotional experience reduces the tendency related to negative parenting passing the next generation (Belsky et al., 2009).

Taraban and Shaw (2018) examined studies that looked at parenting in early childhood within the framework of the Process Model (Belsky, 1984) from past to present to provide a more up-to-date perspective. The researchers added subheadings to the 3 factors in the old model. Gender and cognition and affect were included in the personal psychological resources of parents. The researchers argued that the parent's perception of the child may be decisive in the child's behavior.

When looking at the literature on parenting self-confidence, it can be said that parenting self-efficacy has a central role in the relationships with parenting behavior (Coleman & Karraker, 2003). A study conducted with expectant mothers during the prenatal period found that participants who had a visualization of motherhood showed positive parenting behaviors and adapted to parenthood more quickly than those who did not (Coleman & Karraker, 2003). Maternal self-efficacy, as a more specific title to provide an overview of parenting, presented as a multifaceted concept in Belsky's model (1984), constitutes the outcome variable of the current study as a variable that can be associated with other personal psychological sources of the mother.

2.5 Maternal self-efficacy and adverse childhood experiences

When looking at the studies focusing on the mother's childhood adversities and parenting self-efficacy, it is noticed that they are generally constructed through a mediated relationship (Chau et al., 2023; Manshadi, Fallah, & Chavoshi, 2023; Treat, Sheffield-Morris, Williamson, & Hays-Grudo, 2019). On the other hand, Cordeiro, Wyers, Oliver, Foroughe, and Muller (2021) conducted an intervention study in which the maternal self-efficacy of participants was measured before and after the treatment and were compared in two groups, mothers who had ACEs and mothers who did not have ACEs.

In these four studies (Chau et al., 2023; Cordeiro et al., 2021; Manshadi et al., 2023; Treat et al., 2019), maternal adverse childhood experiences were the predictor. Treat et al. (2019) and Chau et al. (2023) used parenting self-efficacy of mothers as a mediator with some other variables, such as maternal depression, postnatal depression, and social support. Whereas Treat et al. (2019) focused on the influences of the mother's childhood adversities and parenting self-efficacy on the child's socio-emotional development, Chau et al. (2023) investigated the influences of these two concepts on mother-infant bonding disturbances. Although the outcomes preferred by these two studies seem different, they are two related concepts in literature. Damage to the bond between mother and child may lead to insecure attachment types, socio-emotional problems, and developmental delays for the child (Chau et al., 2023). On the other hand, in the studies of Cordeiro et al. (2021) and Manshadi et al. (2023), parenting self-efficacy or competence was utilized as the dependent variable.

While the samples in three of the studies were mothers, Cordeiro et al. (2021) examined the effects longitudinally in the intervention group; most of the participants are mothers, but there are also individuals who care for the child, such as fathers and

grandparents. Regarding instruments, either the Adverse Childhood Experiences (ACEs) Questionnaire or the Childhood Trauma Questionnaire (CTQ) was utilized as a single tool measuring maternal ACEs (Cordeiro et al., 2021; Manshadi et al., 2023; Treat et al., 2019). Nevertheless, Chau and colleagues (2023) utilized various tools to measure maternal ACEs by separating all the items in different scales in accordance with types of abuse (physical, emotional, and sexual) and forming three new subscales. Moreover, the researchers emphasized that the distinguishing aspect of this study was that these types of abuse were analyzed together and separately while others were controlled (Chau et al., 2023). When measuring the concept of parenting self-efficacy or competence, each of these four studies used a different scale.

Treat and colleagues (2019) found a relationship between maternal ACEs and the social-emotional development of young children, and maternal depression and parenting self-efficacy played a mediator role in this relationship. On the other hand, Chau et al. (2023) stated that the mother's physical and psychological childhood abuse was weakly and positively related to mother-infant bonding disturbances. Postpartum depression symptoms and maternal self-efficacy fully mediated this relationship. However, while postnatal depression symptomatology alone mediated the relationship as an independent mediator, maternal self-efficacy did not do that without postnatal depression symptomatology. This result means that while the number of mothers' child abuse experiences increases, maternal self-efficacy decreases in case the mother has postnatal depression symptomatology, which leads to mother-infant bonding disturbances (Chau et al., 2023).

In the study of Cordeiro et al. (2021), researchers found that caregiver self-efficacy significantly increased after the intervention program (i.e., Emotion Focused Family Therapy (EFFT) workshop) for participants with and without child

maltreatment. Participants with maltreatment had more caregiver blocks, which are used in EFFT to describe the emotions that prevent the parent from responding to the child's needs and their involvement difficulties compared to participants without child maltreatment. After the workshop, researchers encountered that caregiver blocks were reduced more in terms of emotion and behavior in participants with maltreatment. Caregivers who had a maltreatment history stated more gains in preventive emotions and child emotion regulation. Unlike the study of Chau et al. (2023), there was no condition related to depressive symptomatology in the study of Cordeiro et al. (2021). Besides, like the study of Treat et al. (2019), caregiver self-efficacy and the child's social-emotional development, namely emotion regulation, were related.

Like the studies of Treat et al. (2019) and Chau et al. (2023), Manshadi et al. (2023) determined that childhood maltreatment of parents was related to parenting competence. This relationship exhibited that the former had both direct and indirect influences on the latter through maternal reflective functioning and perceived social support.

When the results regarding the dimensions of parental reflective functioning are examined, it is stated that the results are consistent with previous findings in the literature (Manshadi et al., 2023). While there was a positive link between childhood maltreatment and the pre-mentalizing modes (PM) dimension ($r = .22$, $p < .001$), there is a negative and modest link between PM and parental competence ($r = -.48$, $p < .001$). In contrast to the PM, there was a negative relationship between the certainty about mental states (CMS) and interest and curiosity (IC) dimensions and childhood maltreatment (for CMS $r = -.13$, $p < .001$, for IC $r = -.02$, $p < .001$). At the same

time, there was a positive relation between the dimensions of CMS and IC and parental competence (for CMS $r = .39$, $p < .001$, for IC $r = .21$, $p < .001$).

2.6 Adverse childhood experiences and benevolent childhood experiences

Zhu et al. (2023) investigated the influence of maternal ACEs and positive childhood experiences (PCEs) on offspring's psychosocial well-being both without one another and in the context of one another. The sample consisted of 2,587 mothers of preschool children aged between 3 and 6. Adverse Childhood Experiences International Questionnaire (ACE-IQ), The Benevolent Childhood Experiences (BCEs) Scale, and the Strengths and Difficulties Questionnaire (SDQ) were used as measurement tools. In parallel with past studies (Greene et al., 2020; McDonald et al., 2019), maternal ACEs were positively associated with psychosocial problems in children. Besides, the relationship between maternal PCEs and offspring's psychosocial problems was found to be significant and negative in this study. After maternal ACEs and PCEs were added to the same model, researchers found that maternal PCEs strongly predict the psychosocial problems of offspring whose mothers had low levels of ACEs, and maternal ACEs strongly predict the psychosocial problems of offspring whose mothers had high levels of PCEs. This study's model means that as the severity and intensity of maternal ACEs increase, the influence area of maternal PCEs may narrow, and high levels of PCEs may increase sensitivity to ACEs.

2.7 Maternal reflective functioning and adverse childhood experiences

Berthelot, Lemieux, Garon-Bissonnette, Lacharité, and Muzik (2019) used parental reflective functioning (PRF) as a possible mediator in the relationship between ACEs

and psychological symptoms related to depression and post-traumatic stress. However, while Chasson and Taubman-Ben-Ari (2023a) included PRF in the model as the outcome variable, ACEs were the predictor variable, and disintegrative responses, which include intrusive thoughts about harmful scenarios for infant and dissociative experiences during infant care, were the possible mediators. On the other hand, Håkansson, Watten, Söderström, Skårderud, and Øie (2018) focused on the relationship between PRF and adverse and adaptive experiences by investigating the types of adverse (emotional, physical, sexual abuse, and neglect) and benevolent (safety and competence) experiences in different developmental phases.

When it comes to samples of these studies, differences become prominent. Like Håkansson et al. (2018), Kristiansen et al. (2020) preferred mothers with substance use disorders (SUD) in the gestational or the postpartum period. Chasson and Taubman-Ben-Ari (2023a) included mothers up to the 16th week after birth. On the other hand, Berthelot et al. (2019) chose expecting parents as the sample, but the mediation model that was established in their study was found to be valid for female participants.

In the study of Håkansson et al. (2018), the outcomes indicated that parental reflective functioning was positively related to adaptive experiences (r = .61, p < .01) whereas it negatively related to adverse childhood experiences (r = -.33, p < .05). Besides, adaptive experiences in early childhood were reported as protective functioning even if the mother had adverse experiences after the early childhood period (Håkansson et al., 2018).

Unlike Parent Development Interview-Revised (PDI-R2), which was utilized in the study of Håkansson et al. (2018), there were two subscales, which were uncertainty and certainty, in the Reflective Functioning Questionnaire (RFQ), which

were used by Berthelot et al. (2019) and Kristiansen et al. (2020). Therefore, the relationship between ACEs and reflective functioning was examined in two dimensions. Berthelot et al. (2019) found that participants having childhood trauma had higher scores on the Uncertainty Scale of RFQ (hypo-mentalization) but lower scores on the Certainty Scale of RFQ (hyper-mentalization) when compared with participants who had no trauma. Besides, they determined that reflective functioning had a mediating influence on the relationship between child trauma and psychological symptoms. On the other hand, in the study of Kristiansen et al. (2020), the results indicated that there was no substantial relationship between trauma and reflective functioning. According to the results, certain reflective functioning was not significantly related to trauma. However, uncertain reflective functioning was linked with trauma in childhood ($\chi^2(1) = 5.11$, $p = .039$) and adolescence ($\chi^2(1) = 8.41$, $p = .006$).

Berthelot et al. (2019) also aimed to evaluate the contribution of reflective functioning skills to parenting attitudes: parenting sense of competence and prenatal attachment. Prenatal attachment means the bond between the expecting mother and the fetus in gestational process. They found that reflective functioning predicted parental confidence and prenatal attachment. Consistent with this result, Manshadi et al. (2023) added to the literature the finding that the dimensions of PRF mediated the relationship between maternal childhood trauma and parenting competence.

Unlike the study of Manshadi et al. (2023), (Chasson and Taubman-Ben-Ari (2023a) found that there was no relationship between maternal ACEs and interest and curiosity (IC), which is a dimension of PRF. Like Manshadi et al. (2023), they determined that there was a relationship between maternal ACEs and two other dimensions of PRF, pre-mentalizing modes (PM) and certainty about mental states

(CMS), and this relationship was provided through a mediated relationship. In this mediated relationship, two dimensions of disintegrative responses, intrusive thoughts, and dissociative experiences, came into prominence (Chasson & Taubman-Ben-Ari, 2023a). While intrusive thoughts had a mediator role only in the link between maternal ACEs and certainty about mental states (CMS), dissociative experiences had a mediator role only in the relationship between maternal ACEs and pre-mentalizing modes (PM) (Chasson & Taubman-Ben-Ari, 2023a).

When personal growth, referring to the psychological development of a person after an adverse experience, was included in the model as a moderator, intrusive thoughts became a mediator in the relationship between maternal ACEs and PM only in mothers with low levels of personal growth (Chasson & Taubman-Ben-Ari, 2023a). In addition, intrusive thoughts mediate the relationship between maternal ACEs and CMS only in mothers with moderate levels of personal growth. Besides, dissociative experiences had a mediating role in the relationships between maternal ACEs and PM and also ACEs and CMS in mothers with moderate or high levels of personal growth (Chasson & Taubman-Ben-Ari, 2023a).

2.8 Maternal self-efficacy and maternal reflective functioning

Cunningham and Renk (2018) aimed to examine the relationship between mothers' attributions and perceived parenting competency via the mediating variable of mothers' parenting self-efficacy. The operational definition of attribution in the study largely overlaps with parental reflective functioning. Therefore, the findings of the study were included in the current study. In addition to the first aim of the study, researchers investigated the three variables regarding the predictability of problems of the child in terms of emotion and conduct. On the other hand, Gordo, Martínez-

Pampliega, Iriarte Elejalde, and Luyten (2020) focused on whether parental competence mediated the link between parental reflective functioning and children's socioemotional adjustment.

In the study of Cunnigham and Renk (2018), researchers focused on mothers having at least one child aged between 1½- to 5-years. The mothers were separated into two groups regarding the number of ACEs: low and high levels. Researchers determined that the mediated relationship in the model was supported by only mothers with high levels of ACEs. They found that the mother's attribution was positively related to parental competence. However, parenting self-efficacy was negatively linked with the mother's attribution and parental competence, which was inconsistent with the study's initial hypotheses. Therefore, Cunningham and Renk (2018) argued an auxiliary hypothesis, which was that these concepts are associated in a curvilinear fashion.

On the other hand, Gordo et al. (2020) included both mothers and fathers in the study because one of their aims was to evaluate whether the relationship among parental reflective functioning, children's social-emotional adjustment, and parental competence was similar between mothers and fathers. Like the study of Cunningham and Renk (2018), there was a relationship between PRF and parental competence in this study. Gordo et al. (2020) found that PRF has a direct relationship with socioemotional adjustment, and it also has an indirect relationship with that through parental competence. When it comes to the dimensions of parental reflective functioning, consistent with the literature, a high level of certainty about mental states (CMS) and interest and curiosity (IC) was weakly related to an increase in parental competence and a low level of pre-mentalizing modes (PM) was weakly

associated with an increase in parental competence. These associations in women were not different from that in fathers.

When the research studies mentioned above regarding the relationships between the concepts in the current study are examined, it may be seen that the relationships between ACEs and parenting self-efficacy and parental reflective functioning are discussed more than the relationships between other concepts. Considering parental resources, which are the most influential factor for parenting in Belsky's process model (1984), developmental history, efficacy expectation, and mentalization may be examples. In addition to the fact that these concepts are paired with each other more than others, it is also possible that hypotheses based on relationality may not be confirmed for different reasons in studies focusing on these relations. Besides, BCEs reveal a gap in the literature, especially regarding their relationship with the concepts in this current study. Considering these issues, the coming together of these concepts in the mother sample in Turkey may pave the way for other studies on the relationality of these concepts.

Bronfenbrenner's bioecological systems approach (1994) states that the organism is affected by the systems that surround it and interact with each other and has the potential to affect those systems. The problem at the core of this study, the intergenerational transmission of childhood adversity, seems to be in the microsystem; but its relationship with cultural and economic factors requires consideration from a broader perspective. Interventions and actions taken by the state, non-governmental organizations, and academia on this issue may support the development of the individual by touching on the systems and the interaction of the systems with each other (Çorapçı & Doğan, 2023).

In Turkey, the Ministry of Family and Social Services supports parents with group training in family life skills and basic skills in raising children (Çorapçı & Doğan, 2023). On the other hand, mother-baby-focused associations, such as TEMAS Emzirme ve Anne Sütü Gönüllüleri Derneği, The Turkish Association for Infant Mental Health, and The Türkiye Maternal Mental Health Awareness Alliance, generally conduct different programs to raise awareness, provide theoretical and practical information about baby development and parenting, and create a social support environment, which supports the self-sufficiency of parents. In addition, some of the programs related to mother-child interaction were carried out within the framework of academic studies, such as Bebek95 (2023), and the effectiveness of these programs was researched (Aydoğdu, Aysu, Aral, & Gürsoy, 2021; Çorapçı, Müderrisoğlu, Sart, & Yeniad, 2022, 2023; Sari & Altay, 2020).

To conclude, the outcomes obtained in this current study may contribute to the increase in studies that associate BCEs with ACEs, maternal reflective functioning, and maternal self-efficacy, the creation of content for both existing and newly designed preventive or intervention-oriented programs focusing on maternal mental health and mother-child interaction and counseling services that will support the individual development of the mother and shed light on the positive memories in the mother's developmental story.

CHAPTER 3

METHODOLOGY

3.1 Participants

The study's participants were mothers in Turkey with at least having one child aged 12 to 36 months. There were 203 participants. During the online data collection process, participants could not move on from one question to another without answering the questions they encountered; therefore, there was no missing data. However, the marital status and occupational status questions in the demographic information section were directed to different questions depending on the answer given, so it can be said that each participant did not encounter the same questions.

One hundred fifty-five of the 203 mothers in the study were included in the analysis. The inclusion criterion for participants in the study was that they had at least one child aged 12-36 months. Twenty-two participants were excluded from the sample because they did not have children between 12 and 36 months. Besides, some situations expected to influence the results constituted the current study's exclusion criteria. These criteria are as follows: the child having a genetic or chronic disease, the mother having a psychiatric, psychological, or neurological diagnosis, and the mother declaring that she has twin children within the specified age range. Due to these exclusion criteria, 13, 7, and 4 participants were removed from the sample, respectively. The genetic or chronic diseases stated by 13 participants regarding their children included parechovirus (PeV) syndrome, down syndrome, hypothyroidism, allergy, epilepsy, hemophilia, gas pain due to carbohydrate and fat leakage, croup, hydronephrosis, and reflux. The psychiatric, psychological, or neurological diagnoses stated by 7 participants consisted of migraine, epilepsy, obsessive-

compulsive disorder (OCD), social phobia, anxiety, and post-traumatic stress disorder (PTSD). After the participants were excluded from the sample, it was seen that the marital status of only one participant was divorced. In order to ensure homogeneity of the sample, this participant was also excluded from the sample. When the descriptive analysis started with the remaining 156 participants, it was noticed that one participant gave random answers; therefore, this participant was removed from the sample. Thus, a total of 48 participants were not included in the analysis. It was calculated that at least 98 participants needed to be reached, considering critical values as .80 for power, .15 for medium effect size, and .05 for alpha level (G-Power 3; Faul, Erdfelder, Lang, & Buchner, 2007). Therefore, the required number of participants for statistical analysis was reached with 155 participants. The native language of all participants was Turkish. The average age of the children in this study is 22.28 months (*SD* = 7.11).

Table 1 shows the distribution of demographic information of education level, current occupational status, spouse's occupational status, income, gender of the child, spending time with the child on weekdays/weekends, and the opinion about the sufficiency of the time.

Approximately 92% of the participants had at least an undergraduate academic degree, and approximately 46% of them were currently employed. Participants who were not currently employed were asked whether they had ever worked. It was determined that 66 of the 84 participants had previously worked, comprising approximately 43% of participants who were not currently employed. Besides, approximately 98% of participants had a spouse who was currently employed. Approximately 57% of participants stated that they could easily meet their basic needs regarding the question of income, and approximately 30% of them had

an income level to live comfortably. Approximately 54% of participants have a son. While approximately 72% of the participants spent more than 8 hours with their children on weekdays, 92% of them spent more than 8 hours with their children on weekends. Additionally, approximately 84% of participants thought that the time they spent with their children was sufficient. Besides, it was found that mothers who found this time sufficient had significantly more adverse experiences in childhood than mothers who found this time insufficient.

Table 1. Distribution of Demographic Information

Variable		*N = 155*
Education Level	Primary school (5 years)	2
	High school dropout	1
	High school	8
	University dropout	2
	University	93
	Postgraduate dropout	5
	Postgraduate	44
Current Occupational Status (Working)	Yes	71
	No	84
Spouse's Occupational Status (Working)	Yes	152
	No	3
Income	Having enough money monthly for basic needs	20
	Meeting basic needs easily	88
	Having enough income to live comfortably	47
Gender of the Child	Girl	72
	Boy	83
Spending Time with the Child on Weekdays	0-3 hours	11
	4-7 hours	33
	8-11 hours	30
	12-15 hours	81
Spending Time with the Child on Weekends	0-3 hours	2
	4-7 hours	10
	8-11 hours	25
	12-15 hours	118
Sufficiency of Spending Time with the Child	Yes	130
	No	25

Table 2 depicts descriptive statistics for demographic information, which are the mother's current age and age of being a mother and the number of children in total and between the ages of 12-36 months. While the mean age of the mothers was 32.05 (*SD* = 4.27) with a range of 25-48, the mean age of being a mother was 28.92 (*SD* = 4.02) with a range of 18-45. The mean of the total number of children was 1.43 (*SD* = 0.64) with a range of 1-4, and the mean of the number of children aged between 12 and 36 months was 1.04 (*SD* = 0.19) with a range of 1-2.

Table 2. Descriptive Analysis of the Demographic Information *(N=155)*

Variables	Min.	Max.	*M*	*SD*
Current age of mothers	25	48	32.05	4.27
Age of being a mother	18	45	28.92	4.02
Total number of children	1	4	1.43	0.64
Total number of children between the ages of 12-36 months	1	2	1.04	0.19

3.2 Instruments

The demographic form (see Appendices D and E for English and Turkish, respectively) and five self-report measurement instruments were used. The self-report measurement tools are the Patient Health Questionnaire-9 (see Appendices F and G for English and Turkish, respectively), the Adverse Childhood Experiences (ACEs) Questionnaire (see Appendices H and I for English and Turkish, respectively), the Benevolent Childhood Experiences (BCEs) Scale (see Appendices J and K for English and Turkish, respectively), the Parental Reflective Functioning Questionnaire-Short Form (PRFQ-SF; see Appendices L and M for English and Turkish, respectively), and The Self-Efficacy for Parenting Tasks Index-Toddler Scale (SEPTI; see Appendices N and O for English and Turkish, respectively).

Appendices F through O include all the measurements in English and Turkish. Table 3 demonstrates all the measurement tools utilized in the current study.

3.2.1 Demographic form

The demographic form was developed by the researcher. This form consisted of questions about the mother's age, mother tongue, educational status, occupational status, profession if working and marital status, occupational status and profession of the spouse or child's father, income level, age of being a mother, number of children, gender and health status of the child aged between 12-36 months and the mother's amount of time spent with the child during week and weekend, time-related satisfaction and the psychological/psychiatric or neurological diagnosis. Socioeconomic variables (Christie et al., 2017; Berthelot et al., 2019) and psychiatric disorders (Berthelot et al., 2019) might be confounding variables in the relationship between childhood trauma and maternal reflective functioning. Therefore, questions related to education, income, and psychological/psychiatric or neurological diagnosis were added to the demographic form (see Appendices D and E for English and Turkish, respectively).

Table 3. Instruments and Related Variables

Variable	Instruments	Number of items
Depressive symptoms	Patient Health Questionnaire-Depressive Symptoms (PHQ-9; Sarı et al., 2016; Kroenke, Spitzer, & Williams, 2001)	9 items
Adverse childhood experiences	Adverse Childhood Experiences Scale (ACES; Felitti et al., 1998; Gündüz, Yaşar, Gündoğmuş, Savran, & Konuk, 2018)	10 items
Benevolent childhood experiences	Benevolent Childhood Experiences Scale (BCES; Gunay-Oge, Pehlivan, & Isikli, 2020; Narayan et al., 2018)	10 items
Maternal reflective functioning	Parental Reflective Functioning Questionnaire-Short Form (PRFQ-SF; Arıkan et al., 2020; Luyten, Mayes, Nijssens, & Fonagy, 2017a)	16 items
Maternal self-efficacy	The Self-Efficacy for Parenting Tasks Index-Toddler Scale (SEPTI; Elibol, Mağden, & Alpar, 2007; Coleman & Karraker, 2003)	51 items

3.2.2 Patient Health Questionnaire-Depressive Symptoms (PHQ-9)

The Patient Health Questionnaire-Depression Symptoms is developed by Kroenke et al. (2001) to measure depressive symptoms. PHQ-9 is a self-administered measurement with nine items ranging from 0 (“none of the time”) to 3 (“all the time”). Kroenke et al. (2001) stated high levels of internal reliability of the questionnaire, which was .89. In addition, the test-retest reliability of the questionnaire was reported as excellent (r = .84).

Some of the items are: “Feeling tired or having little energy” “Poor appetite or overeating” and “Feeling bad about yourself — or that you are a failure or have let yourself or your family down.”

Sari et al. (2016) adapted the Turkish version of PHQ-9. The questionnaire’s internal consistency coefficient was found to be .84. The Cronbach Alpha coefficient of the current study was .84. The Turkish version of the scale was accessed due to its

frequent use in the mental health field. This version overlaps with the items in the study by Sari et al. (2016).

In the review paper of Fang et al. (2021), researchers argued that maternal depression may influence parenting self-efficacy. Therefore, this measurement tool was included in the current study to detect depressive symptoms in the sample in addition to the question of the psychological/psychiatric or neurological diagnosis in the demographic form (see Appendices F and G for English and Turkish, respectively).

3.2.3 Adverse Childhood Experiences (ACEs) Questionnaire

The questionnaire, developed by Felitti and colleagues (1998), is a 17-item self-report. It is designed to identify negative states and events experienced between 0-18. Later, this questionnaire was revised and made into its current 10-item version. An increase in the score obtained from the questionnaire represents an increase in the adverse experiences in childhood. The highest score that can be obtained from the questionnaire is 10, while the lowest score is 0. Additionally, there are no reverse items in the questionnaire.

Some of the items are: “Did you often or very often feel that ... No one in your family loved you or thought you were important or special? or Your family didn’t look out for each other, feel close to each other, or support each other?” and “Was a biological parent ever lost to you through divorce, abandonment, or other reason?”

This questionnaire's validity and reliability study, adapted to our country by Ulukol Kahiloğulları, & Sethi (2013), was conducted by Gündüz et al. (2018). The researchers found reliability coefficients as .74 and expressed interrater reliability as

high. Regarding the questionnaire's construct validity, researchers used the Symptom Assessment-45 Questionnaire to examine the correlation coefficient in the relationship with the ACEs Questionnaire.

The questionnaire was used in the current study with permission from the first author in the study of Gündüz et al. (2018). The Cronbach Alpha coefficient of the current study was .65 (see Appendices H and I for English and Turkish, respectively).

3.2.4 Benevolent Childhood Experiences (BCEs) Scale

The scale, developed by Narayan et al. (2018), is a 10-item self-report. It is designed to identify positive states and events experienced between 0-18. An increase in the score obtained from the scale represents an increase in the positive experience in childhood. The highest score that can be obtained from the scale is 10, while the lowest score is 0.

Some of the items are: "Did you have at least one caregiver with whom you felt safe?" and "Did you have opportunities to have a good time?"

It is adapted to Turkish by Gunay-Oge et al. (2020). The researchers found the internal consistency coefficient and test-retest reliability as, in turn, .61 and .91.

The scale was used in the current study with permission from the first author in the study of Gunay-Oge et al. (2020). The Cronbach Alpha coefficient of the current study was .69 (see Appendices J and K for English and Turkish, respectively).

3.2.5 Parental Reflective Functioning Questionnaire-Short Form (PRFQ-SF)

Parental Reflective Functioning Questionnaire was developed by Luyten et al. (2017a) to assess the ability of parents of children aged 0-5 to recognize their internal processes and make sense of their offspring's internal processes. However, in the Turkish validity study (Arıkan et al., 2020), the name of the scale was changed to Parental Reflective Functioning-Short Form by adding two words to the name of the original scale in order to distinguish it from the first version of the scale with 27 items in the Turkish validity study of Karabulut, Ilhan, Kumru, and Arikan (2016). The short form of this questionnaire is an 18-item self-report scale and consists of 3 factors, which are "Interest and Curiosity (IC)," "Certainty about Mental States (CMS)," and "Pre-Mentalizing Modes (PM)." Scores are calculated separately for these three dimensions of parental reflective functioning, but no total score includes all dimensions.

Some of the items are: "I wonder a lot about what my child is thinking and feeling." for interest and curiosity in mental states, "I always know what my child wants." for certainty about mental states, and "The only time I'm certain my child loves me is when he or she is smiling at me." for pre-mentalizing modes.

The answers consist of a 1-7 Likert-type scale, and while one represents "strongly disagree," seven represents "strongly agree." Additionally, four represents neutral/undecided. The increase in the score obtained in the PM subscale represents a decrease in mentalization capacity. Unlike the PM subscale, very high and low scores on the IC and CMS subscales mean hyper-mentalization and hypo-mentalization, respectively. However, it is possible to say that the scores seen at the extremes are not adaptive.

Arıkan et al. (2020) studied the validity of the scale for questionnaire Turkish mothers who had a child aged between 1 and 3. They removed items 11 ("I can sometimes misunderstand the reactions of my child.") and 18 ("I believe there is no point in trying to guess what my child feels.") from the questionnaire because of the insignificant or low loading of these items. Additionally, in the study of Sümer et al. (2024), researchers focused on the sample of mothers who had children aged between 8 and 12 in different countries, including Turkey, and removed these two items due to the similar reasons to the study of Arıkan et al. (2020). Therefore, it can be stated that the Turkish version of this questionnaire has 16 items.

While Luyten et al. (2017a) found internal consistency coefficients of IC, CMS, and PM as respectively .75, .82, and .70, Arıkan et al. (2020) found these values as .72, .75, and .77. In the current study, these values were .71, .85 and .58 respectively for the reliability of the scale with 16 items.

This scale has been translated into many languages and all translations are shared on the website (see https://www.ucl.ac.uk/psychoanalysis/research/parental-reflective-functioning-questionnaire-prfq). Access to the English and Turkish versions of the scale is provided in this way (see Appendices L and M for English and Turkish, respectively).

3.2.6 The Self-Efficacy for Parenting Tasks Index-Toddler Scale (SEPTI)

The scale was developed and used by Coleman and Karraker (2003) to measure the self-efficacy skills of mothers and fathers of children aged 1-3. The sub-dimensions used in the parenting scale represent a structure conceptualized by Emde (1989) and later outlined by Zeanah et al. (1997), as cited in the study of Coleman and Karraker, 2003. Three approaches to defining parenting self-efficacy are stated in the literature

as follows: task-specific, domain-specific, and domain-general (Coleman & Karraker, 2003). It is possible to say that the domain-general method is more common among these three approaches (Coleman & Karraker, 2003). However, according to Bandura (1989), the domain-specific method offers a more sensitive approach to the relationship between the parent's self-evaluation and the behavior displayed (Coleman & Karraker, 2003). Thereby, the researchers addressed the problem of a limited number of domain-specific measurement tools by aiming to develop this scale. (Coleman & Karraker, 2003).

The scale consists of 53 items and has 7 sub-dimensions. These sub-dimensions and some of the items are as follows: “Even when I have had an unusually distressing day, I think my child knows I am available to meet his or her emotional needs.” for the emotional availability, “ I think I am tolerant and understanding when my child displays negative emotions.” for the nurturance, valuing the child, and empathetic responsiveness, “I have my home arranged to prevent as many accidents as possible with my toddler.” for the protection, “I allow my child enough freedom to actively explore the environment.” for the discipline and limit setting “Playing is a part of my relationship with my child that I have very little difficulty with.” for play, “I easily find opportunities to point out things about the world during my daily interactions with my child.” for the teaching and “I have been successful in getting my child to eat on a fairly regular schedule.” for the instrumental care, structure, and routines.

The answers consist of a 1-6 Likert-type scale, and while one represents “strongly disagree,” seven represents “strongly agree.” The lowest score on the scale can be 53, while the highest score can be 318. The increase in the total score indicates that the parent's self-efficacy has increased. Cronbach's Alpha coefficients

for each sub-dimension are as follows: Emotional Availability = .67, Nurturance = .71, Protection = .53, Discipline = .81, Play = .92, Teaching = .73, and Instrumental Care = .46. The coefficient for all scales was calculated as .91. Intercorrelations between the subscale took values between .26 and .71 and the mean value of them is .43.

Elibol et al. (2007) adapted the scale for Turkish parents who have a child whose age is 12-36 months. Due to the similarity in the 6-point Likert-type scale, a 5-point Likert-type scale was used. Factor analysis, item analysis, and test-retest reliability calculations were performed during the adaptation process. As a result of the analyses, no factorization was found; therefore, results regarding the subscales were not included. Higher Cronbach Alpha coefficients were obtained when items 13 and 23 were deleted; therefore, these two items were removed from the scale. The Cronbach Alpha coefficient and the test-retest reliability coefficient of the 51-item scale were found to be .90 and .86, respectively. The Cronbach Alpha coefficient of the current study was .88. The questionnaire was used in the current study with permission from the first author in the study of Elibol et al. (2007) (see Appendices N and O for English and Turkish, respectively).

3.3 Procedure

Firstly, permission from the Institutional Review Board in Social Sciences and Humanities (SBINAREK) at Boğaziçi University was obtained (see Appendix A). After the thesis committee approved the current study on April 25, 2024, the online data collection process started. Data were collected between April 26 and May 4, 2024, in an 8-day period. The online survey was designed with Google Forms, and the link to the survey was placed on the online poster describing the current study.

With social media platforms and message groups, the online poster was forwarded to reach mothers having at least one child whose age was between 12 and 36 months. Participants who voluntarily clicked the link to the survey of the current study were expected to read the informed consent form (see Appendices B and C for English and Turkish, respectively) to confirm their voluntary participation. Then, they encountered the online survey consisting of the demographic form and four scales. The online survey provided by Google Form consisted of the informed consent form, demographic form, the Patient Health Questionnaire-Depressive Symptoms (PHQ-9), Adverse Childhood Experiences (ACEs) Questionnaire, Benevolent Childhood Experiences (BCEs) Scale, Parental Reflective Functioning Questionnaire-Short Form (PRFQ-SH), and The Self-Efficacy for Parenting Tasks Index-Toddler Scale (SEPTI) respectively. When determining this order, it was aimed to ensure that participants would be previously exposed to scales that they were expected to have difficulty answering. Therefore, scales related to depressive symptoms and adverse childhood experiences, respectively, were used. It was anticipated that the survey would be completed in approximately 15 minutes.

3.4 Design and data analysis

With the correlational research design, the study focused on the role of childhood experiences and reflective functioning on parenting self-efficacy in mothers. Following the data collection process, analyses were performed with Statistical Packages for Social Sciences (SPSS version 29.0).

First, the sample's demographic characteristics and variables were analyzed descriptively. Secondly, Pearson Product-Moment correlations, Independent Sample t-test, and One-Way Analysis of Variances (ANOVA) were used to examine the

influence of some demographic information on the scores obtained from instruments. Thirdly, correlation coefficients based on the relationships between variables were evaluated. Finally, mediation analyses were conducted after controlling the assumptions, which are sample size, outliers, singularity, normality, multicollinearity, homoscedasticity, linearity, and independence of residuals.

In the field of psychology, causal processes are one of the main research topics (Igartua & Hayes, 2021). In addition to examining whether the predictor variable influences the criterion variable, the mechanism by which this effect becomes functional has also become a matter of curiosity (Igartua & Hayes, 2021). Mediation analysis was developed to test hypotheses regarding the influence of the predictor variable on the criterion variable via one or more mediator variables and to determine the full or partial role of the mediator variable (Hayes, 2013).

The model in Figure 1 depicts the total effect between X (independent/predictor variable) and Y (dependent/outcome variable) with path *c*, which means that X affects Y. The model in Figure 2 demonstrates the simple mediational model, and *a, b, and c'* are unstandardized regression coefficients that symbolize the path between variables, like *c*. After the mediator (M) is added to the model, path *c'* replaces path c and represents the indirect effect.

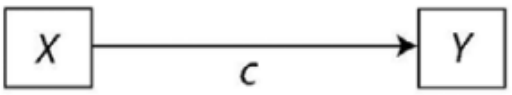


Figure 1. The simple relationship between a predictor variable and an outcome variable

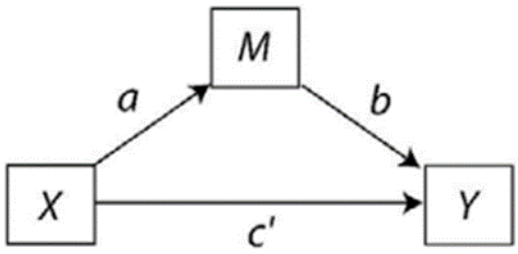


Figure 2. Mediated relationship representing the indirect effect

For the main research question of the current study, two mediational analyses were conducted to specify the possible mediator role of maternal reflective functioning on the link between childhood experiences and maternal self-efficacy. In the first mediation analysis, the number of ACEs is the predictor, maternal self-efficacy is the outcome, and the three dimensions of maternal reflective functioning, which are PM, CMS, and IC, are mediators. In the second mediation analysis, while the outcome and the mediators are the same in the first analysis, the number of BCEs takes its place as a predictor in the model.

Four conditions need to be met to set and test a mediational model (Baron & Kenny, 1986; Judd & Kenny, 1981):

1) The predictor/independent variable (X) must be significantly correlated with the outcome variable (Y), which is represented as *c*.
2) The predictor/independent variable (X) must be significantly correlated with the mediator (M), which is represented as *a*.
3) The mediator (M) must be significantly correlated with the outcome variable (Y), which is represented as *b* when both the predictor/independent variable (X) and the mediator (M) are used as predictors.
4) After the mediator is controlled, there is no need for a significant relationship between the predictor variable and the outcome variable.

Consequently, these four conditions were planned to be tested in the current study using the models in Figure 3 and Figure 4.

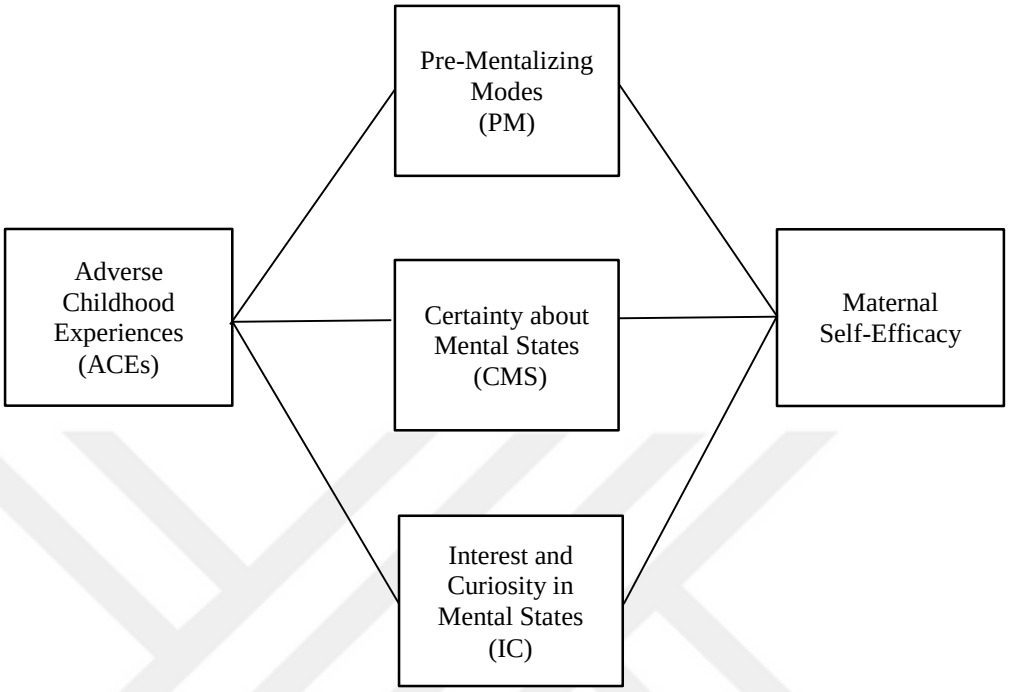


Figure 3. The first model of the current study

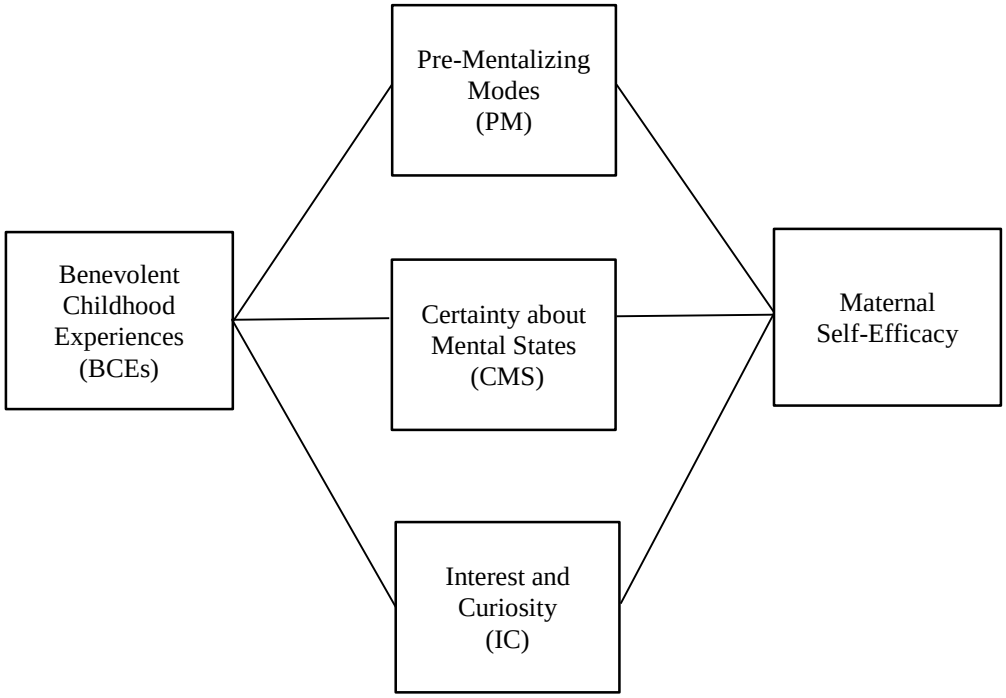


Figure 4. The second model of the current study

To conclude, this sample of 155 mothers was analyzed based on demographic characteristics, scores obtained from the instruments which mentioned in this chapter, and planned models, and the findings were presented in the next section.

CHAPTER 4

RESULTS

This section includes four parts: (1) descriptive analysis of instruments utilized in the current study, (2) the roles of the demographic characteristics of the sample on the study variables, (3) the correlations among the study variables, and (4) results addressing the mediational models. The Pearson Product-Moment correlations, Independent-sample t-test, and One-Way Analysis of Variances (ANOVA) for understanding the roles of the demographic characteristics of the sample on the study variables, the Pearson Product-Moment correlations for the relationality of the study variables, and PROCESS macro for understanding the possible mediated relationships according to third and fourth research questions are used.

4.1 Descriptive analysis of instruments

Table 4 demonstrates descriptive features of the scores obtained from each instrument. These features comprise values associated with minimum and maximum scores, means, standard deviations, skewness, kurtosis, and the standard error of skewness and kurtosis.

As the skewness and kurtosis values approach 0, the scores obtained from the instruments approach normal distribution, and it is stated that these values are acceptable between -3 and +3 (Tabachnick & Fidell, 2014). In this sense, it can be stated that the scores obtained from the instruments used in this study may be accepted as within the normal distribution.

Table 4. Descriptive Analysis of the Instruments *(N = 155)*

Instruments	*Min.*	*Max.*	*M*	*SD*	*Skewness*	*SE*	*Kurtosis*	*SE*
Patient Health Questionnaire-Depressive Symptoms	0	25	9.19	5.25	.89	.19	.32	.39
Adverse Childhood Experiences Questionnaire	0	8	1.70	1.76	1.21	.19	1.29	.39
Benevolent Childhood Experiences Scale	2	10	8.56	1.74	-1.48	.19	2.13	.39
Parental Reflective Functioning Questionnaire-Short Form-PM	6	33	12.35	5.14	1.22	.19	1.82	.39
Parental Reflective Functioning Questionnaire-Short Form-CMS	7	35	23.52	6.01	-.25	.19	-.17	.39
Parental Reflective Functioning Questionnaire-Short Form-IC	17	35	31.30	3.58	-1.03	.19	1.16	.39
The Self-Efficacy for Parenting Tasks Index-Toddler Scale	145	233	195.29	19.01	-.22	.19	-.68	.39

Note. PM = Pre-Mentalizing Modes, CMS = Certainty about Mental States, IC = Interest and Curiosity.

Although the range between the scores from benevolent and adverse childhood experiences was similar, regarding the frequencies of ACEs and BCEs, it was determined that approximately 93% of the participants had a negative experience of 4 or less, and approximately 94% had a positive experience of 6 or more. In this case, it can be stated that the frequency of ACEs in the sample was lower than that of BCEs, which means that protective factors outweigh risk factors for the mental health of this sample. The average depressive symptoms, which were detected by using the Patient Health Questionnaire-Depressive Symptoms (PHQ-9) in the sample, of the mothers were at a mild level. When looking at the frequencies of depressive symptoms, it was determined that more than 60% of the participants had depressive symptoms of mild or lower, and approximately 16% of the participants had depressive symptoms of moderately severe or higher. Only 8% of participants reported that their depressive symptoms were very or extremely difficult. Data regarding depressive symptoms obtained from the instrument indicated that the

sample was not depressed, which confirmed that this study focused on a non-clinical sample.

4.2 The roles of the demographic characteristics of the sample on the study variables

The relationships between the current age of the participants, the age of being a mother, the age of the child, and the study variables, namely adverse and benevolent childhood experiences, maternal reflective functioning, maternal self-efficacy, and depressive symptoms, were found by using The Pearson Product-Moment correlations. Besides, differences in the study variables regarding having another child, the gender of the child, the mother's opinion regarding the time spent with the child, and socioeconomic status were detected by using the Independent-sample t-test and One-Way ANOVA.

4.2.1 Relationships between demographic characteristics and the study variables

Table 5 depicts correlations between demographic characteristics and the variables in the current study. Mothers' current age was positively and weakly correlated with three variables, namely Certainty about Mental States (CMS) ($r = .18$, $p < .05$) and maternal self-efficacy ($r = .20$, $p < .05$). While mothers' age of being a mother was negatively and weakly linked to one dimension of maternal reflective functioning, pre-mentalizing modes (PM) ($r = -.17$, $p < .05$), it was positively and weakly linked to maternal self-efficacy ($r = .21$, $p < .01$). On the other hand, the age of the child was not related to any of study variables.

Table 5. Relationship between Demographic Characteristics and the Study Variables

Variables	Current age	The age of being a mother	The age of the child
Depressive Symptoms	-.04	-.01	-.09
Adverse Childhood Experiences	-.03	-.14	.07
Benevolent Childhood Experiences	.00	.03	-.07
Maternal Reflective Functioning-PM	-.06	-.17*	.13
Maternal Reflective Functioning-CMS	.18*	.00	.10
Maternal Reflective Functioning-IC	.15	.14	-.04
Maternal Self-Efficacy	.20*	.21**	-.15

Note. *$p < .05$, **$p < .01$, (2-tailed). PM = Pre-Mentalizing Modes, CMS = Certainty about Mental States, and IC = Interest and Curiosity.

4.2.2 Differences in the variables regarding demographic characteristics

When the number of the child was considered as a criterion, there were two groups: having a child *(N = 101)* and having more than one child *(N= 54)*. Any significant differences in depressive symptoms, childhood experiences, maternal reflective functioning, and maternal self-efficacy between these two groups could not be found. Besides, the gender of the child was considered as a criterion, and any differences between mothers having a daughter *(N = 72)* and mothers having a son *(N = 83)* could not be found in all the study variables.

When the participants split into two groups with regard to the mother's opinion regarding the time spent with the child was sufficient, a significant difference in the scores of ACEs was found between mothers considering the time spent with the child was sufficient ($M = 1.82$, $SD = 1.81$) and mothers considering the time spent with the child was not sufficient ($M = 1.08$, $SD = 1.32$; t (43.54) = 2.41, $p = .02$, two-tailed) as shown in Table 6. The effect size of ACEs related to the difference in the means (mean difference = .74, 95% CI [.12, 1.37]) was small (Cohen's $d = .43$). It can be stated that mothers who think that the time they spend with their children was sufficient had more adverse childhood experiences than

mothers who think that the time they spend with their children was insufficient. Besides, any difference could not be found in depressive symptoms, benevolent childhood experiences, maternal reflective functioning, and maternal self-efficacy.

Table 6. Differences in the Study Variables Regarding Mothers' Opinions about Time Spent with the Child

	Sufficient (N = 130)		Insufficient (N=25)					
Variables	*M*	*SD*	*M*	*SD*	*df*	*t*	*p*	*Cohen's d*
Depressive Symptoms	9.25	5.17	8.92	5.74	153	.28	.78	.06
Adverse Childhood Experiences	1.82	1.81	1.08	1.32	43.54	2.41	.02	.43
Benevolent Childhood Experiences	8.53	1.78	8.72	1.57	153	-.50	.62	-.11
Maternal Reflective Functioning-PM	12.35	5.08	12.40	5.54	153	-.05	.96	-.01
Maternal Reflective Functioning-CMS	23.30	6.07	24.68	5.71	153	-1.05	.29	-.23
Maternal Reflective Functioning-IC	31.26	3.36	31.52	4.65	153	-.33	.74	-.07
Maternal Self-Efficacy	194.85	19.03	197.60	19.13	153	-.66	.51	-.15

Note. PM = Pre-Mentalizing Modes, CMS = Certainty about Mental States, and IC = Interest and Curiosity.

Finally, the influence of income level on depressive symptoms, childhood experiences, maternal reflective functioning, and maternal self-efficacy was evaluated. Three groups were formed because three of the four answers categorizing income level were selected by the participants: Having enough money monthly for basic needs (Group 1, *N = 20*), meeting basic needs easily (Group 2, *N = 88*), and having enough income to live comfortably (Group 3, *N = 47*). Participants did not select the answer, which was related to not having enough money for even basic needs like food and rent. There were statistically significant differences at the $p < .05$ level in depressive symptoms (F (2, 152) = 5.06, p = .01) and BCEs (F (2, 44.98) = 8.59, p = .00) as shown in Table 7. The eta squared value was used to determine the

effect size, which was categorized as .01 as small, .06 as medium, and .14 as large by Cohen (1988). The effect sizes of depressive symptoms and BCEs were respectively .20 and .06. Post-hoc comparisons using Tukey HSD determined that the mean score of Group 1 was significantly different from Group 2 and Group 3 in BCEs and depressive symptoms. It can be argued that BCEs and depressive symptoms were sensitive to differences in income levels. Since approximately 87% of the participants had at least enough income to easily meet their needs and 92% had at least an undergraduate degree, it can be assumed that working with a group with a medium to high socioeconomic status increased the frequency of benevolent experiences.

Table 7. Differences in the Study Variables regarding Income Level

Variables	*Df*	*MS*	*F*	*p*	η^2
Depressive Symptoms	2	132.42	5.06	.01	.06
Error	152	26.18			
Total	154				
Adverse Childhood Experiences	2	10.23	2.21	.12	.04
Error	46.86	3.01			
Total					
Benevolent Childhood Experiences	2	46.79	8.59	.00	.20
Error	44.98	2.46			
Total					
Maternal Reflective Functioning-PM	2	88.95	2.88	.07	.04
Error	46.79	25.56			
Total					
Maternal Reflective Functioning-CMS	2	13.77	.38	.69	.00
Error	152	36.44			
Total	154				
Maternal Reflective Functioning-IC	2	2.27	.18	.84	.00
Error	152	12.98			
Total	154				
Maternal Self-Efficacy	2	836.11	2.35	.10	.03
Error	152	355.20			
Total	154				

Note. Statistically significant results were determined at $p < .05$. PM = Pre-Mentalizing Modes, CMS = Certainty about Mental States, and IC = Interest and Curiosity.

4.3 Correlations among the study variables

In exploring the correlations among adverse childhood experiences, benevolent childhood experiences, maternal reflective functioning, maternal self-efficacy, and depressive symptoms, the Pearson product-moment correlation coefficient was used. While evaluating correlation coefficients, Cohen's standards (1988) were considered: correlation coefficients ranged from .10 to .29, meaning weak association; those ranged from .30 to .49, meaning moderate association; and those ranged from .50 to .99, meaning strong association. Table 8 demonstrates correlations among variables in the current study. There were 14 statistically significant associations among the study variables. One of them was moderate to strong, seven of them were moderate to strong, and six of them were weak to moderate.

ACEs were negatively and moderately related to BCEs (r = - .44, p < .01), and they were positively and weakly related to PM (r = .16 p < .05) and depressive symptoms (r = .25, p < .01). There were no relationships between ACEs and other variables. BCEs were negatively and weakly associated with PM (r = -.24, p < .01. and they were negatively and moderately related to depressive symptoms (r = -.35, p < .01). Unlike ACEs, they were positively and moderately related to maternal self-efficacy (r = .31, p < .01). PM was negatively and weakly related to CMS (r = -.16, p < .05 and IC (r = -.23, p < .01). Besides, PM was negatively and moderately associated with maternal self-efficacy (r = -.46, p < .01) and was positively and moderately associated with depressive symptoms (r = .43, p < .01). CMS was positively and moderately related to IC (r = .41, p < .01) and was positively and strongly associated with maternal self-efficacy (r = .51, p < .01). IC was positively and moderately linked to maternal self-efficacy (r = .46, p < .01). Maternal self-

efficacy was negatively and weakly correlated with depressive symptoms (r = -.28, p < .01).

Table 8. Relationships among the Study Variables *(N = 155)*

	1	2	3	4	5	6	7
1. Depressive Symptoms							
2. Adverse Childhood Experiences	.25**						
3. Benevolent Childhood Experiences	-.35**	-.44**					
4. Maternal Reflective Functioning-PM	.43**	.16*	-.24**				
5. Maternal Reflective Functioning-CMS	-.09	.02	.06	-.16*			
6. Maternal Reflective Functioning-IC	.01	-.04	.12	-.23**	.41**		
7. Maternal Self-Efficacy	-.28**	-.14	.31**	-.46**	.51**	.46**	

Note. *p < .05, **p < .01 (2-tailed). PM = Pre-Mentalizing Modes, CMS = Certainty about Mental States, and IC = Interest and Curiosity.

4.4 Mediational model analysis

Two mediational model analyses were conducted using PROCESS Procedure for SPSS Version 4.2 to examine whether maternal reflective functioning mediates the relationship between childhood experiences and maternal self-efficacy. Instead of conducting several multiple regressions, this computational tool allows the user to explore the paths between variables while considering the three regression equations of Baron and Kenny (1986) (Hayes, 2013). When it comes to these equations for the mediation models of the current study, four steps were followed:

Step 1: Demonstrate that the independent variable (ACEs and BCEs) predicts the mediator (maternal reflective functioning).

Step 2: Demonstrate that the independent variable (ACEs and BCEs) predicts the outcome variable (maternal self-efficacy).

Step 3: Demonstrate that the mediator (maternal reflective functioning) predicts the outcome variable (maternal self-efficacy).

Step 4: Evaluate the mediational model.

According to the model templates of PROCESS macro (Hayes, 2013), model 4, representing simple mediation in Figure 2, which was mentioned in the part of Design and Data Analysis in Chapter 3, was appropriate for the current study. It enables the user to include a maximum of 10 mediators functioning simultaneously. In the current study, maternal reflective functioning was the mediator, and it has three dimensions: PM, CMS, and IC. Therefore, these three dimensions entered the model as parallel mediators to operate simultaneously.

There were two independent variables in the current study: ACEs and BCEs. Therefore, two mediational models were investigated. While the first model explored whether maternal reflective functioning mediated the ACEs and maternal self-efficacy, the second model explored whether maternal reflective functioning mediated the BCEs and maternal self-efficacy. The indirect effects of dimensions of maternal reflective functioning were evaluated utilizing the bootstrap method with 1,000 samples, a generally reasonable number (Field, 2013).

First of all, depressive symptoms were included in the models as the covariate because they negatively and weakly correlated with maternal self-efficacy (r = -.28, p < .01), as shown in Table 8. However, while investigating predictors of the outcome variable in step 2, the result showed that there was no influence of depressive symptoms on maternal self-efficacy. Therefore, it was omitted from the mediational models, and the steps were repeated.

First Mediational Model: Mediating role of the three dimensions of maternal reflective functioning in the relation between ACEs and maternal self-efficacy, as shown in Figure 5.

Step 1: Demonstrate that ACEs are the predictor of the dimensions of maternal reflective functioning, PM, CMS, and IC.

The consequences demonstrated that ACEs predicted one dimension of maternal reflective functioning, PM (b = .461, SE = .233, p = .05), and they did not predict CMS (b = .065, SE = .276, p > .05) and IC (b = -.073, SE = .164, p > .05). This condition was not met for the dimension of CMS and IC; therefore, mediational analyses continued with the dimension of PM.

Step 2: Demonstrate that ACEs are the predictor of maternal self-efficacy.

The total effect model determined that ACEs did not significantly predict maternal self-efficacy (b = -1.542, SE = .863, p > .05). This condition was not met for the study sample; therefore, the first model was not tested.

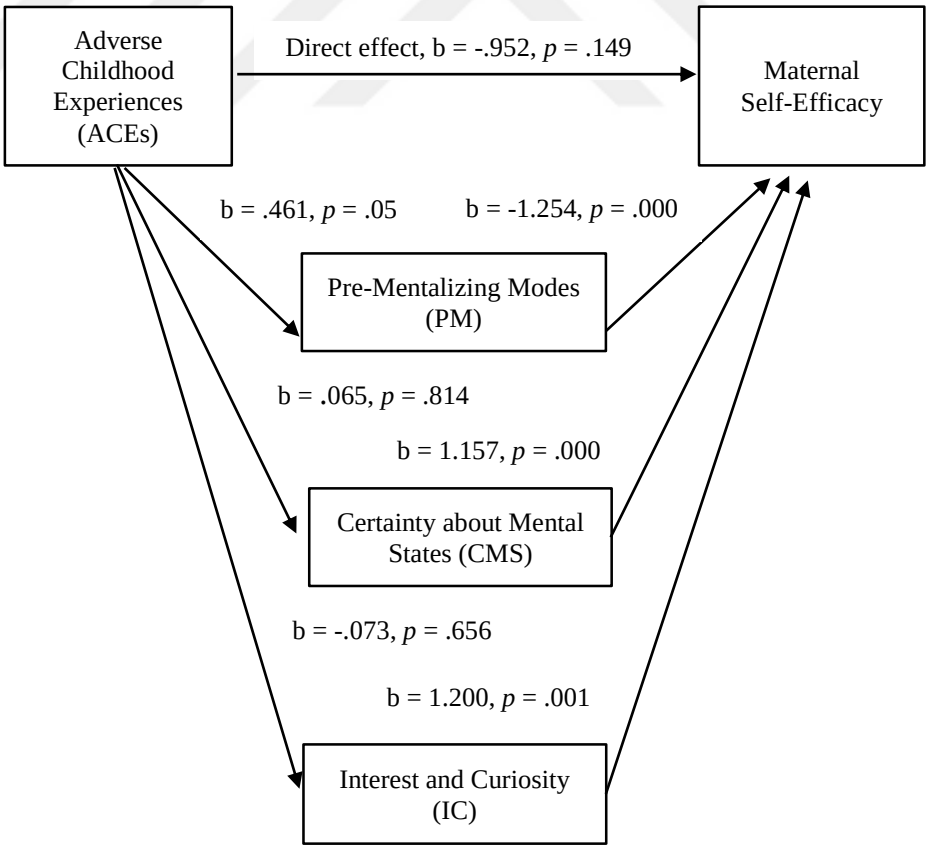


Figure 5. Results based on the first model

Second Mediational Model: Mediating role of the three dimensions of maternal reflective functioning in the relation between BCEs and maternal self-efficacy, as shown in Figure 6.

Step 1: Demonstrate that BCEs are the predictor of the dimensions of maternal reflective functioning, PM, CMS, and IC.

The results determined that while BCEs predicted one dimension of maternal reflective functioning, PM (b = -.703, SE = .231, $p < .05$), and they did not predict CMS (b = .193, SE = .278, $p > .05$) and IC (b = .238, SE = .165, $p > .05$). This condition was not met for the dimension of CMS and IC; therefore, mediational analyses continued with the dimension of PM.

Step 2: Demonstrate that BCEs are the predictor of maternal self-efficacy.

The total effect model determined that BCEs significantly predicted maternal self-efficacy (b = 3.383, SE = .838, $p < .001$).

Step 3: Demonstrate that BCEs and one dimension of maternal reflective functioning, PM, are the predictors of maternal self-efficacy.

The consequences determined that BCEs significantly and indirectly predicted maternal self-efficacy through PM (b = .807, SE = .342, 95% CI [.165, 1.507]). Moreover, the direct effect of BCEs on maternal self-efficacy while considering the mediating influence of PM was also significant (b = 2.083, SE = .658, $p < .05$).

Step 4: Evaluate the mediational model.

BCEs have both direct and indirect influences on maternal self-efficacy. The indirect influence of BCEs was realized through one of the dimensions of maternal reflective functioning, PM. Thereby, it can be stated that PM partially mediated the relationship between BCEs and maternal self-efficacy.

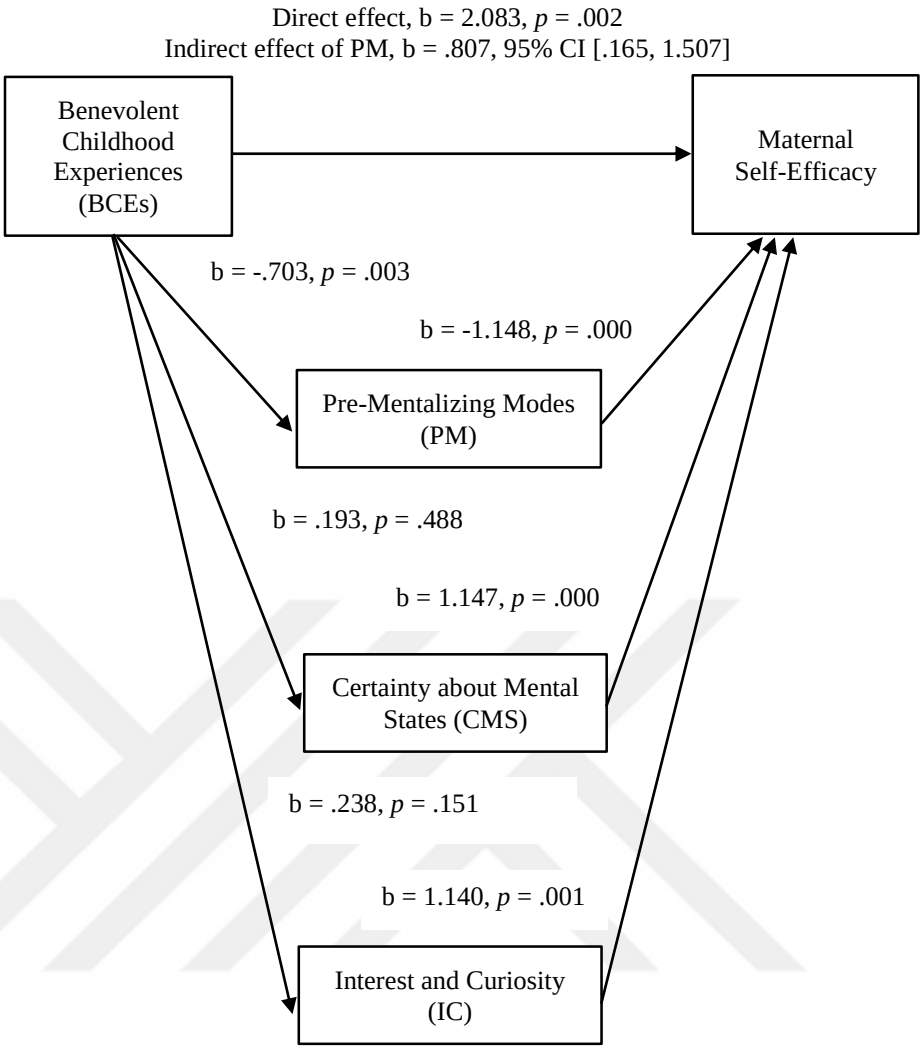


Figure 6. Results based on the second model

To conclude, the results of the analyses based on demographic characteristics, scores obtained from the instruments, and planned models were presented, and they were evaluated and discussed in the next chapter.

CHAPTER 5

DISCUSSION

This chapter consists of the following parts namely: (1) the purpose of the current study, (2) the discussion related to the research questions, (3) the strength of the current study, (4) the limitations and recommendations for future studies and (5) implications of the current study.

5.1 The purpose of the current study

Examining the underlying mechanism of the relationship between adverse and benevolent childhood experiences and maternal self-efficacy by using the role of the maternal reflective functioning was the aim of the study. Additionally, the relationship among these concepts was planned to be investigated. Besides, whether the level of the study variables changes regarding the mother's current age, the age of being a mother, socioeconomic status, having another child, the child's age and gender, and the mother's opinion on whether the time spent with the child was considered.

5.2 The discussion related to the research questions

5.2.1 The Role of the demographic characteristics of the sample on the study variables

While the mother's current age and age of being a mother were related to some study variables, the child's age was not associated with any of the study variables. The increase in the mother's current age and age of being a mother was associated with the increase in maternal self-efficacy. Whereas the mother's current age was

positively related to the CMS dimension of maternal reflective functioning, the age of being a mother was negatively related to the PM dimension of maternal reflective functioning. The findings about the relationship between the mother's current age and maternal reflective functioning capacity are consistent with the study of Carlone et al. (2023), Luyten and Fonagy (2015), and Smaling et al. (2016). On the other hand, Luyten et al. (2017a) found a conflicting result regarding this relationship in another study. When it comes to maternal self-efficacy, Coleman and Karraker (2003) determined a negative relationship with maternal age, and Chasson and Taubman-Ben-Ari (2023a) and Chau et al. (2023) detected that there was no correlation with maternal age. Therefore, it can be stated that there needs to be more studies based on the relationship between maternal age and maternal self-efficacy.

In the review paper of Fang et al. (2021), researchers argued that child-related factors like age and gender were not related to parenting self-efficacy. Two of the articles mentioned in the review paper focused solely on mothers. In these studies, which focused on mothers of children in the last year of preschool, Holloway, Suzuki, Yamamoto, and Behrens (2005) conducted analyses of 116 participants, and Suzuki, Holloway, Yamamoto, and Mindnich (2009) executed analyses of 235 participants. On the other hand, Chau et al. (2023) found that the infant's age had a positive relationship with maternal self-efficacy. It is possible to state that there are conflicting results when looking at both the age group and who the focused parent was in the literature, which may be another area that needs to be researched.

It was determined that the gender of the child and having a single child or more than one child did not make a difference in the current study variables. In the study of Chasson and Taubman-Ben-Ari (2023a), researchers found no relationship

between the number of children categorized as having a single child or more than one child and maternal self-efficacy, which is compatible with the current study.

When the study variables are compared in terms of the answers given to the income level, it has been concluded that mothers with an income level that having enough money monthly for basic needs (Group 1) have fewer benevolent childhood memories and more depressive symptoms compared to mothers with income levels that meeting basic needs easily (Group 2) and that having enough income to live comfortably (Group 3). Although differences between groups were not examined, some studies focused on the relationship between these variables. Chasson and Taubman-Ben-Ari (2023a) found that adverse childhood experiences were negatively correlated with income. Besides, Christie et al. (2017) highlighted the negative relationship between depressive symptoms and income in parenting studies.

5.2.2 Correlations among the study variables

The outcomes of the current study indicated that ACEs were significantly related to only three of the study variables: BCEs, PM dimension of maternal reflective functioning, and depressive symptoms. While it was negatively and moderately related to BCEs, it was positively and weakly related to PM and depressive symptoms. Zhu et al. (2023) found that ACEs and BCEs were moderately and negatively related. In the study of Håkansson et al. (2018), ACEs and BCEs were measured by the Trauma Antecedent Questionnaire (TAQ) for three developmental periods: early childhood, latency, and adolescence. Adverse experiences in all periods were strongly associated with benevolent experiences in all periods, except for just one moderate relationship between ACEs in adolescence and BCEs in early childhood. Besides, adverse experiences in all periods had moderate to strong

relationships with anxiety and depressive symptoms, and it has been found that the relationship becomes increasingly stronger as the developmental period approaches adulthood (Håkansson et al., 2018).

Treat et al. (2019) found that maternal ACEs were associated with the social-emotional development of young children, and depression of the mother and maternal self-efficacy had a mediator role in this relationship. Additionally, Chau et al. (2023) stated that the mother's child abuse experience (especially physical and psychological abuse) was related to mother-infant bonding disturbances. This relationship was completely mediated by postpartum depression symptoms and maternal self-efficacy, $\beta = 0.06$, SE = 0.03, 95 % CI [0.01-012]. In the mediational relationship, the predictor variable should be substantially associated with the mediator (Baron & Kenny, 1986; Judd & Kenny, 1981). Therefore, it can be stated that maternal ACEs were linked with depressive symptoms in the study of Treat et al. (2019) and Chau et al. (2023), which may be a finding also observed in the current study.

On the other hand, ACEs were negatively and moderately linked with maternal self-efficacy in the study of Treat et al. (2019). Besides, if there was a condition related to postpartum depression, maternal self-efficacy mediated the link between maternal psychological abuse experiences and problems in the bond between the mother and the infant (Chau et al., 2023). Thus, it can be said that maternal psychological abuse experiences were associated with maternal self-efficacy in a special context. Researchers argued that there may be different pathways that need to be investigated between childhood abuse experiences and maternal self-efficacy other than postpartum depression.

In the current study, maternal ACEs had no relationship with maternal self-efficacy, which contradicts some previous studies (Treat et al., 2019; Chau et al., 2023; Manshadi et al., 2023). This result may be interpreted through two reasons based on the study of Chau et al. (2023). Firstly, the ACEs Scale was the measurement tool used in the current study and gave cumulative scores regarding adverse experiences in childhood. A cumulative score obtained may have caused details of different types of adverse experiences and relationships among these types to be overlooked. Considering that different types of abuse experienced in childhood are rarely seen alone, the relationships between different types may have an influence on the result, so it may be useful to control the other types of abuse at the point where one type of abuse is analyzed (Chau et al., 2023). Contrary to maternal psychological abuse experiences, when it comes to maternal physical abuse experiences and problems in the bond between the mother and the infant, researchers determined that there was no mediated relationship between postpartum depression and maternal self-efficacy. Furthermore, maternal sexual abuse was not associated with mediators and the outcome variable, which led to not being tested in a mediation model. Secondly, considering the presence of adverse childhood experiences that the participants do not prefer to reflect, the skewness in the distribution of the obtained scores may also pose an obstacle to the expected relationships (Chau et al., 2023). Although ACEs were between -3 and +3, which are the skewness and kurtosis values accepted for normal distribution (Tabachnick & Fidell, 2014) in the current study, it can be said that there was a tendency toward positively skewed data in the histogram graph. This tendency may be a reason why the expected relationships between ACEs and other study variables did not occur.

The current study found that just one dimension of maternal reflective functioning, PM, was related to ACEs. When looking at the previous studies, different results could be encountered regarding the relationship between maternal reflective functioning and maternal ACEs and possible explanations for the relationship. Håkansson et al. (2018) found that adverse experiences in early childhood and latency were negatively linked to maternal reflective functioning, measured by cumulative score. In the study of Berthelot et al. (2019), traumatic experiences in childhood were weakly and negatively associated with hyper-mentalization and weakly and positively related to hypo-mentalization as impairments in reflective functioning, measured by two subscales, Certainty and Uncertainty, of the Reflective Functioning Questionnaire (RFQ). Berthelot et al. (2019) have made assumptions about this weak association. One of the assumptions was that after the childhood traumas, the mentalization skills of the participants could improve with protective factors in the community sample. Another assumption was that the measurement tool could not examine the effects of trauma on mentalization in as much detail as other tools, including interviews. The last assumption was that the effect of trauma on mentalization was trauma-specific rather than widespread.

With a similar measurement tool, which was the Reflective Functioning Questionnaire (RFQ), Kristiansen et al. (2020) found that childhood trauma was related to hypomentalization and was not related to hypermentalization. Researchers explained that their insignificant relationship may have originated from the low sample due to a lack of variability and high levels of hypermentalization. Additionally, based on the study of Fonagy et al. (2016), Kristiansen et al. (2020) determined that in nonclinical samples, low to moderate levels of hypermentalization had a protective role instead of impairments in reflective functioning.

In the study of Chasson and Taubman-Ben-Ari (2023a), ACEs and dimensions of maternal reflective functioning were not related. However, researchers noticed that the relationships between ACEs and PM and CMS dimensions of parental reflective functioning were significant for mothers with high ACEs in mediated models. Contrary to Chasson and Taubman-Ben-Ari (2023a), Manshadi et al. (2023) found, as expected, that while PM was positively related to ACEs, CMS and IC were negatively related to ACEs. These inconsistent findings regarding the relationships between ACEs and dimensions of maternal reflective functioning, including the results of the current study, may need to be investigated with further studies, including different measures and clinical and community samples.

In the review paper of Slade and Sleed (2023), researchers evaluated the relationship between childhood trauma and parental reflective functioning, and they observed both significant and insignificant links between them in studies. In fact, in a study focusing on fathers, the mentalizing skills of participants who were exposed to physical abuse were low; however, when the abuse was investigated cumulatively without being categorized, there was no significant relationship between childhood trauma and mentalizing skills (Slade & Sleed, 2023). Researchers have interpreted different findings in the literature regarding the relationship between these two variables under two basic headings. First, there were differences regarding the instrument that measured trauma and the standards that defined categories for this concept. The second was which samples were studied, and two issues related to the samples could emerge. One was that the participants' sharing about trauma, which is a sensitive issue, could be affected by the context of the study. Another was that adverse conditions that could be associated with trauma specific to the samples may have created a pattern in mentalizing scores. When this pattern limited variability, it

could have become difficult to recognize the pure effect of trauma, which is a multifactorial concept (Slade & Sleed, 2023).

The current study found that BCEs and one dimension of maternal reflective functioning, PM, were weakly and negatively associated. When considering BCEs and maternal reflective functioning, based on the study of Håkansson et al. (2018), it can be stated that the number of studies on the relationship between benevolent childhood experiences and reflective functioning was limited in the literature. Håkansson et al. (2018) executed the study with a scale that evaluates maternal reflective functioning through a cumulative score, and they found that there were positive and moderate to strong relationships between maternal reflective functioning and BCEs in early childhood, latency and adolescence period of mothers with substance use disorder (SUD). On the other hand, BCEs were moderately related to depressive symptoms in the current study. Håkansson et al. (2018) determined that anxiety and depressive symptoms were negatively and strongly linked to benevolent experiences in the period of early childhood, latency, and adolescence. They also found that higher mentalization capacity was strongly related to low levels of depressive symptoms. In the current study, only the PM dimension of maternal reflective functioning was positively related to depressive symptoms, which may mean that the capacity to engage with the child decreases in mothers with more depressive symptoms than other mothers.

When it comes to the relationships among the dimensions of maternal reflective functioning, the current study detected that PM was weakly and negatively correlated with CMS and IC, which is compatible with the study of Chasson and Taubman-Ben-Ari (2023a) and Gordo et al. (2020). Unlike the current study, Manshadi et al. (2023) found a moderately negative relationship between PM and IC.

Besides, consistent with the current study, CMS was weakly and negatively related to PM and moderately and positively related to IC in the study of Manshadi et al. (2023).

Another result of the current study demonstrated that maternal self-efficacy was associated with the dimensions of maternal reflective functioning. Consistently with the study of Gordo et al. (2020), it was positively linked with CMS and IC and negatively linked with PM. Berthelot et al. (2019) found that reflective functioning predicted parental confidence. On the other hand, in the study of Cunningham and Renk (2018), parenting self-efficacy had the mediator role in the relationship between mothers' attributions, which represent mentalization, and parental confidence, which was supported for mothers with high scores in terms of trauma. Contrary to their expectations, the relationship between the mediator and the variables was negative, which the researchers explained in a curvilinear fashion. However, the direct relationship between mothers' attribution and parental confidence was positive, consistent with the current study's result.

5.2.3 Mediational analysis

In the current study, mediation analysis was applied to examine the role of maternal reflective functioning in the link between childhood experiences and maternal self-efficacy, which were the third and fourth research questions. Although ACEs were related to one dimension of maternal reflective functioning, PM, in step 1, contrary to previous studies in the literature (Chau et al., 2023; Manshadi et al., 2023; Treat et al., 2019), there were no significant relationships between ACEs and maternal self-efficacy in step 2 for mediation analysis. Therefore, data did not allow testing of the first mediation model. However, in the study of Manshadi et al. (2023), childhood

maltreatment of parents was related to parenting competence directly and indirectly. They stated that one of the indirect paths was realized through parental reflective functioning. Moreover, certainty about mental states (CMS), interest and curiosity (IC), and pre-mentalizing modes (PM) were mediators in the relationship between maternal childhood trauma and parenting competence in their study.

Considering both the skewness and kurtosis values, which were close to zero, and the histogram graph of maternal self-efficacy, it can be said that maternal self-efficacy was normally distributed. Besides, maternal self-efficacy, as an outcome variable, was moderately related to all variables except ACEs. At this point, reviewing the conditions related to the ACEs variable may facilitate evaluating the results. A positively skewed data trend in the histogram of ACEs may indicate low variability and pose an obstacle to possible relationships (Chau et al., 2023).

There may be some sample-related reasons for encountering data with this tendency in the findings of the study. In addition to the community sample, the fact that approximately 92% of the participants were university graduates or had a postgraduate degree indicates that a highly educated sample was studied. Considering that the participants are more homogeneous regarding socioeconomic status in the community sample, it may be possible for them to draw similar patterns, especially in terms of reflecting on adverse childhood experiences. At this point, the possibility that socioeconomic status may have an influence on the pattern of benevolent childhood experiences of the participants can also be taken into consideration.

On the other hand, there may be instrument-related reasons for the tendency of data. In addition to the fact that traumatic experiences are already difficult to disclose, the wording used in some items on the ACEs Scale may have influenced

some participants' preference for the answer. Framing the answers regarding the existence of adverse childhood experiences as “Yes” or “No” instead of the Likert scale may have made it easier for the participants to select “No” and not to directly accept the existence of their adverse experiences. Besides, asking more than one question within the same item in the scale may have affected the sensitivity of the measurement tool regarding the area it is intended to measure. The existence of alternatives within the item, both for the action and for the person performing the action, may affect the participant's decision regarding the item to be answered using “Yes/No”. Therefore, the relationships between adverse childhood experiences and two dimensions of maternal reflective functioning, CMS and IC, and maternal self-efficacy expected based on previous studies may not have been statistically significant or may have been weak.

Although there is a relationship only between ACEs and the PM dimension of maternal reflective functioning, it may be necessary to look at the findings in the literature regarding this relationship, considering its statistical weakness and sensitivity to individuals excluded from the sample. Berthelot et al. (2019) highlighted inconsistent results in studies conducted with adults reached from the community sample and focused on the relationship between ACEs and reflective functioning. While this relationship was stronger in children, adolescents, and clinical groups, this relationship was weak in adults reached from the community sample, which was associated with the role of benevolent childhood experiences in post-traumatic recovery Berthelot et al. (2019). The presence of benevolent experiences may help explain the statistically non-significant relationship between the CMS and IC dimensions of maternal reflective functioning and ACEs and the unexpected direction in the relationship between the CMS dimension and ACEs.

Regarding the second model, the current study found that BCEs had a direct relationship with maternal self-efficacy, and they were also indirectly linked through the PM dimension of maternal reflective functioning. In this model, the PM partially mediated the relationship. Although the relationships among PM, BCEs, and maternal self-efficacy formed consistently with the literature, it was not possible to compare the findings of the current study with another study focusing on the mediator role of PM in the relationship between BCEs and maternal self-efficacy because of the limited studies. As a study that included two of these three variables, Chasson and Taubman-Ben-Ari (2023b) focused on childhood experiences and maternal self-efficacy in another study. While ACEs were not related to maternal self-efficacy, BCEs had a significant relationship with maternal self-efficacy, and self-compassion and dissociative experiences played a mediating role in this relationship (Chasson & Taubman-Ben-Ari (2023b).

5.3 Strengths of the current study

The current study is the first to investigate the variables of adverse and benevolent childhood experiences, maternal self-efficacy, and maternal reflective functioning together in Turkey. Many of the studies focused on maternal ACEs in topics related to parenting; however, in addition to ACEs, the role of BCEs was considered in terms of protective factors in the current study. Parental reflective functioning is a concept that has recently been introduced to the literature in Turkey (Karabulut et al., 2016). It is possible to say that this concept is studied in association with attachment (Sümer et al., 2024), the mother's parenting stress (Özbilgin İşildak, 2023), and the child's socioemotional problems (Taşdelen & Arıkan, 2022). Findings obtained in the current study regarding the relationships among childhood experiences and maternal

reflective functioning and parenting self-efficacy, which is a more established concept, may pave the way for new studies.

One of the cornerstones of Rogerian's person-centered approach is self-concept, which relates to how one perceives oneself (Poyrazlı, 2003). Another is empathy, which means that one has the capacity to look at another's perspective to understand the other's world (Poyrazlı, 2003). These concepts constitute the two poles of reflective functioning: self-oriented and other-oriented. Balancing these two is important for healthy self and interpersonal interaction (Luyten et al., 2017b). When we look at culture in Turkey from the lenses of the Rogerian approach, it has been observed that there is a difficulty in verbally conveying emotions, which are the tools by which one understands oneself and others, and non-verbal methods are generally preferred (Poyrazlı, 2003). In interpersonal communication, there is a tendency to express the issue in an event-oriented manner rather than conveying how the person feels about a topic (Poyrazlı, 2003). Considering the possibility of a mother growing up in Turkey being an event-oriented person in communication, maternal reflective functioning may be a tool for the transmission of this tendency. For this reason, evaluating the factors that affecting maternal reflective functioning capacity may provide clues for a healthy transmission of mentalization skills. The bond between the caregiver and the child in the first three years of life creates an environment for experiencing the concepts of self and the other and also an environment for discovering and regulating emotions (Fonagy et al., 2023). Considering the influence of peripartum depression, which is predicted to extend to one year, providing a perspective on understanding the mother's reflective functioning capacity in the 1-3-year-old period, when maternal self-efficacy may be vulnerable to difficulty, in the light of adverse and benevolent childhood experiences

may contribute to the increase of preventive and intervention-oriented studies specific to mothers in this period.

Regarding the results of the study, it can be said that it is possible that mothers' lack of positive childhood memories makes it difficult to integrate into the child's mental world and that the mother may consider herself inadequate in parenting skills. In this sense, the current study may support practitioners in including mentalization-focused preventive group counseling in studies targeting new mothers, including the pregnancy period, and adding content to existing studies.

5.4 Limitations and recommendations for future studies

Firstly, the study was designed using the correlational research, which means that although theory and previous studies supported the findings, the directions between variables cannot be conclusive. Secondly, each scale of the study was self-report, which constitutes response bias. Thirdly, childhood experiences were assessed retrospectively, which accompanies recall bias. Due to response and recall bias, the results obtained may need to be approached with caution.

Fourthly, the convenience sampling method was performed to select the sample, and the survey was delivered to mothers online via social media and message groups. Mothers reached through this preferred method may not represent mothers with children aged 12-36 months in the country, considering socioeconomic characteristics. Based on the review paper prepared by Slade and Sleed (2023), the effect of sample selection on the correlations obtained, especially regarding sharing of adverse childhood experiences, should be considered. Mothers with lower income and education levels could be contacted by non-governmental organizations. Additionally, Slade and Sleed (2023) included studies comparing the mentalizing

skills of mothers and fathers. In this respect, parents differed according to the times of birth, which are preterm and full-term, and showed similar skills from time to time. In this regard, it may be useful to include fathers in future studies and compare them with mothers.

On the other hand, Slade and Sleed (2023) also mentioned the influence of the measurement tool on the contradictory results in the literature. This study was intended to measure ACEs and BCEs with instruments developed in a similar format, which is answering the questions through “Yes” and “No”. However, in future studies, a tool that will provide greater variability for ACEs may be used, or the diversity in answers may be increased by using a Likert-type scale. Besides, item analysis may be conducted with samples of different age groups to increase the measurement accuracy in studies using the Parental Reflective Functioning Questionnaire-Short Form.

Literature based on the binary relationships of the concepts focused on in the current study was presented only through quantitative research due to scarce resources. Although the current study is a quantitative study, using studies that consider the needs of mothers whose children were between the ages of 1-3 through self-reflection in qualitative studies could be supportive when evaluating the results.

It has been frequently observed in the literature that the mother's self-efficacy and perception of the marital relationship with the husband and the support the mother receives from her social environment are studied together. Another recommendation may be adding questions regarding these issues to the demographic form to discuss the possible effects of the mother's support mechanisms on the outcome. In addition, the fact that the mother has received training about childcare

may be supportive when evaluating findings related to reflective functioning capacity and self-efficacy.

The concepts of childhood experiences and reflective functioning have been used in many studies in relation to the prenatal period (Berthelot et al., 2019; Hakansson et al., 2018; Kristiansen et al., 2020). Future studies may investigate the relationship between these concepts by starting the study from the prenatal period and using a longitudinal design. In addition to that, this current study was designed around concepts related to the mother, but as in some studies (Gordo et al., 2020; Treat et al., 2019; Zhu et al., 2023) in the chapter of the literature review, these concepts may also be associated with the child's socioemotional development. Future studies may focus on the relationship among these concepts by focusing on the child's development.

5.5 Implications of the study

The outcomes of this study regarding the role of maternal reflective functioning in the link between benevolent childhood memories and maternal self-efficacy may offer a new starting point for new interventions to be designed or implemented for maternal well-being and positive interaction between mother and child.

The steps the mother will take to recognize and understand the child's subjective world, in which the mentalization skills of the child will develop, are very related to the mother’s own mentalization skills (Fonagy et al., 2023). The current study has determined that as the number of benevolent childhood experiences that the mother recalled decreases, the mentalization skills that will support the mother's ability to interact with the child's world decrease, and, depending on this relationship, the mother's self-efficacy regarding parenting skills decreases. The mother's lack of

BCEs or recollection of BCEs and focus on ACEs may negatively affect both self-concept and perception and inferences about the child, which may create difficulties regarding establishing interaction between the mother and the child.

Bronfenbrenner (1994) states that the change in an individual's circumstances is related to the change of systems and the interaction of systems with each other. Implications of academic studies may serve to the change process. Based on the interpretations of the obtained statistical results associated with Attachment Theory (Bowlby, 1958), Social Cognitive Theory (1986), and Process Model (Belsky, 1984), the implications of the study are that:

1. Professionals working with pregnant women and new mothers can be informed to refer them to government agencies or municipal units that offer free psychological counseling services when they encounter individuals who are mentally preoccupied with adverse childhood experiences or unaware of their benevolent childhood experiences.
2. Professionals working in the field of mental health can enrich the sessions by producing studies that focus on moments of feeling safe and valuable when working with mothers who are mentally preoccupied with adverse childhood experiences or unaware of benevolent childhood experiences, both in individual counseling services and group psychological counseling processes.
3. Mental health professionals who provide psychoeducation to parents and prefer to reach parents through social media platforms should contribute to mother-child interaction by producing and sharing exercises related to daily life that will make it easier to enter the child's world by considering mothers who have low awareness of benevolent childhood experiences but do not

have the opportunity to experience individual work or group counseling for their psychological well-being.

Consequently, regarding psychological counseling, this study offers a perspective that the mother's self-efficacy based on parenting skills may be supported with practices of counseling that will increase the awareness of the mothers regarding benevolent childhood experiences and skill building that will expand the mother’s mentalization capacity for interaction with the child.

CHAPTER 6

CONCLUSION

This study focused on a possible mechanism underlying the relationship between adverse and benevolent childhood experiences and maternal self-efficacy. The findings obtained from the study, which selected mothers with children aged 12-36 months as a sample, showed that adverse childhood memories had a relationship with one of the dimensions of maternal reflective functioning, the pre-mentalizing (PM), in the planned model. However, the PM dimension of maternal reflective functioning mediates the link between benevolent childhood experiences and maternal self-efficacy. In this sense, it can be said that the study partially achieved its goal.

Another aim of the study was to present an overview of benevolent childhood experiences, which are protective factors (Sameroff, 2010), as well as adverse childhood experiences, which have the potential to be transmitted between generations as risk factors (Sameroff, 2010). In order to diversify and enrich the content of psychological counseling services that aim to improve the mentalization capacity of mothers, the data obtained from this study may be useful for researchers and experts working on mother-child relationships to return to the sources in the literature and identify areas that can be improved.

APPENDIX A

ETHICAL APPROVAL FORM

T.C.
BOĞAZİÇİ ÜNİVERSİTESİ REKTÖRLÜĞÜ
Sosyal ve Beşeri Bilimler İnsan Araştırmaları Etik Kurulu (Sbinarek)

Sayı : E-84391427-050.01.04-176860 25.04.2024
Konu : 2023-42T Kayıt Numaralı Başvurunuz Hakkında

Sayın Doç. Dr. Zeynep Hande SART

Tez danışmanlığını yürüttüğünüz öğrenciniz Bihter Topyay Şahin'in "THE ROLE OF CHILDHOOD EXPERIENCES AND MATERNAL REFLECTIVE FUNCTIONING ON MATERNAL SELF-EFFICACY SKILLS" başlıklı projesi ile Boğaziçi Üniversitesi Sosyal ve Beşeri Bilimler İnsan Araştırmaları Etik Kurulu (SBİNAREK)'e yaptığınız 2023-42T kayıt numaralı başvuru 18.04.2024 tarih ve 2024/03 sayılı kurul toplantısında incelenmiş ve projeye etik onay verilmesi uygun bulunmuştur.

Bu karar tüm üyelerin toplantıya on-line olarak katılımıyla ve oybirliği ile alınmıştır. Onay mektubu tüm üyeler adına Komisyon Başkanı tarafından e-imzalanmıştır. Bilgilerinizi rica ederiz.

Saygılarımızla,

Dr. Öğr. Üyesi Işıl ERDUYAN
Kurul Başkanı

Bu belge, güvenli elektronik imza ile imzalanmıştır.
Belge Doğrulama Kodu : 0E8U-Z1VT-0G3K Belge Doğrulama Adresi : https://www.turkiye.gov.tr/bogazici-universitesi-ebys

Adres: 34342 Bebek-İSTANBUL
Telefon No:
e-Posta:
Kep Adresi: bogaziciuniversitesi@hs01.kep.tr
Fax No:
İnternet Adresi: www.bogazici.edu.tr
Bilgi için:Nurşen MUNAR
Mühendis
Telefon No:

APPENDIX B

INFORMED CONSENT (ENGLISH)

Supporting Institute: Boğaziçi University Faculty of Education Educational Sciences Department Guidance and Psychological Counseling Master of Arts Program
Name of the study: The Role of Childhood Experiences and Maternal Reflective Functioning on Maternal Self-Efficacy Skills
Project Conductor: Associate Dr. Zeynep Hande Sart
E-mail: ********@**********
Phone: **********
Researcher: Bihter Topyay Şahin
E-mail: **********

Dear Mother,

The study aims to investigate the relationship between the childhood experiences of mothers having one child aged 12-36 months, their parental reflective functioning, and their self-efficacy skills regarding parenting. The study is performed as a master's thesis under supervision.

Volunteering is required to participate in the study. Therefore, you have the right to terminate and leave the study at any time without any liability. If you prefer not to continue to the study, your information up to the point you answered will be deleted. If you complete the study, your data will be saved anonymously, and information collected from you will be considered fully confidential. Your data will be protected and stored within the scope of the Personal Data Protection Law.

When participating in the study, you will meet the demographic form and five instruments based on self-report. These instruments, in the order they will be used, are the Patient Health Questionnaire-Depression Symptoms (PHQ-9), the Adverse Childhood Experiences (ACEs) Questionnaire, Benevolent Childhood Experiences (BCEs) Scale, Parental Reflective Functioning Questionnaire-Short Form (PRFQ-SH), and The Self-Efficacy for Parenting Tasks Index-Toddler Scale (SEPTI). Completing this survey will take approximately 15 minutes. After completing your survey, your answers will be converted into numerical data. These data will be used in statistical analysis to produce scientific inferences related to questions posed by the master's thesis conducted within the framework of the research mentioned above. The answers obtained can be presented in scientific publications or conferences in the future.

Your involvement in the study will be at your own discretion. You are not charged or promised a fee. There are no physical, sociological, legal, or economic risks related to the study. You may encounter some questions that may trigger you during the study. You can access the psychological support mechanisms listed below if you need psychological support during or after leaving the study.

- Taksim Eğitim ve Araştırma Hastanesi

Beyoğlu, 0212 909 50 00

- Metin Sabancı Baltalimanı Kemik Hastalıkları Eğitim ve Araştırma Hastanesi Levent Semt Polikliniği

Levent, 0212 268 3545

- Metin Sabancı Baltalimanı Kemik Hastalıkları Eğitim ve Araştırma Hastanesi
Baltalimanı, 0212 323 7075
- Sait Çiftçi Devlet Hastanesi
Beşiktaş, Yıldız, 0212 381 6700
- İstinye Devlet Hastanesi
İstinye, 0212 323 44 44
- Marmara Üniversitesi Eğitim ve Araştırma Hastanesi
Pendik, 0216 625 45 45
- Şişli Etfal Eğitim ve Araştırma Hastanesi
Şişli, 0212 231 22 09
- Üsküdar Devlet Hastanesi
Üsküdar, 0 216 474 79 00
- Ankara Büyükşehir Belediyesi Gençlik Çocuk ve Aile Danışmanlık Merkezi
Demetevler Şubesi, 0312 507 34 50/0312 507 34 51
Ulus Şubesi, 0312 507 36 92/0312 507 36 49
- Keçiören Belediyesi, Aile Terapi Merkezi
Keçiören, 0312 338 87 06/0312 339 67 18
- İzmir Büyükşehir Belediyesi Psikososyal Destek Hizmeti, Genç İzmir
Örnekköy, 0232 293 12 00
- İzmir Karabağlar Belediyesi,
Karabağlar, 0232 414 76 00, 0232 414 76 01

If you want to get any information related to the study during and after the study, you may reach Bihter Topyay Şahin or Assoc. Prof. Z. Hande Sart. Regarding your rights in the study, you may also communicate Boğaziçi University Social and Human Sciences Human Research Ethics Committee (*******@*********).

☐ I understood the scope and requirements of this study and I agree to participate.

Date (day/month/year): ...../...../.....
Initials of your name and surname: .....

APPENDIX C

INFORMED CONSENT FORM (TURKISH)

AYDINLATILMIŞ ONAM FORMU

Araştırmayı destekleyen kurum: Boğaziçi Üniversitesi Eğitim Fakültesi Eğitim Bilimleri Bölümü Rehberlik ve Psikolojik Danışmanlık Anabilim Dalı
Araştırmanın adı: Annelerin Öz yeterlik Becerilerinde Çocukluk Deneyimleri ve Anne İçsel Düşünme İşlevinin Rolü
Proje Yürütücüsü: Doç. Dr. Zeynep Hande Sart
E-mail: **********@**********
Telefonu: **********
Araştırmacı: Bihter Topyay Şahin
E-mail: **********

Sayın Anne,

Araştırmanın amacı, 12-36 aylık bir çocuğu olan annelerin çocukluk deneyimleri, ebeveynliğe dair içsel düşünme işlevleri ve ebeveynliğe dair öz yeterlik becerileri arasındaki ilişkiyi incelemektir. Çalışma, gözetim altında yüksek lisans tezi olarak gerçekleştirilmiştir.

Araştırmaya katılmak için gönüllülük gerekmektedir. Bu nedenle istediğiniz zaman herhangi bir sorumluluk üstlenmeksizin çalışmayı sonlandırma ve araştırmadan ayrılma hakkına sahipsiniz. Araştırmaya devam etmemeyi tercih ettiğiniz takdirde cevapladığınız ana kadar olan bilgileriniz silinecektir. Araştırmayı tamamlamanız halinde verileriniz isimsiz olarak kaydedilecek ve sizden toplanan bilgiler tamamen gizli kabul edilecektir. Verileriniz Kişisel Verilerin Korunması Kanunu kapsamında korunup saklanacaktır.

Araştırmaya katılırken demografik form ve öz bildirime dayalı beş ölçme aracıyla karşılaşacaksınız. Bu ölçekler sırasıyla Hasta Sağlık Anketi, Çocukluk Çağı Olumsuz Yaşantılar Ölçeği, Çocukluk Çağı Olumlu Yaşantılar Ölçeği, Ebeveyn İçsel Düşünme İşlevselliği Ölçeği-Kısa Form ve Anne Babalık Becerilerinde Özyeterlik Ölçeği'dir. Bu ölçeklerin doldurulması ortalama 15 dakika sürmektedir. Anketi tamamladıktan sonra vermiş olduğunuz cevaplar sayısal verilere dönüştürülecektir. Bu veriler, yukarıda bahsedilen araştırma çerçevesinde yürütülen yüksek lisans tezinin ortaya koyduğu sorulara ilişkin bilimsel çıkarımlar üretmek amacıyla istatistiksel analizde kullanılacaktır. Elde edilen yanıtlar, ilerleyen süreçte bilimsel yayınlarda ya da konferanslarda sunulabilir.

Araştırmaya katılımınız tamamen sizin takdirinizde olacaktır. Sizden herhangi bir ücret talep edilmez veya taahhüt edilmez. Çalışmanın herhangi bir fiziksel, sosyolojik, hukuki veya ekonomik riski bulunmamaktadır. Çalışma sırasında sizi tetikleyebilecek bazı sorularla karşılaşabilirsiniz. Çalışma sırasında veya sonrasında psikolojik desteğe ihtiyaç duymanız halinde aşağıda sıralanan psikolojik destek mekanizmalarına ulaşabilirsiniz.

- Taksim Eğitim ve Araştırma Hastanesi

Beyoğlu, 0212 909 50 00

- Metin Sabancı Baltalimanı Kemik Hastalıkları Eğitim ve Araştırma Hastanesi Levent Semt Polikliniği

Levent, 0212 268 3545

- Metin Sabancı Baltalimanı Kemik Hastalıkları Eğitim ve Araştırma Hastanesi

Baltalimanı, 0212 323 7075

- Sait Çiftçi Devlet Hastanesi

Beşiktaş, Yıldız, 0212 381 6700

- İstinye Devlet Hastanesi

İstinye, 0212 323 44 44

- Marmara Üniversitesi Eğitim ve Araştırma Hastanesi

Pendik, 0216 625 45 45

- Şişli Etfal Eğitim ve Araştırma Hastanesi

Şişli, 0212 231 22 09

- Üsküdar Devlet Hastanesi

Üsküdar, 0 216 474 79 00

- Ankara Büyükşehir Belediyesi Gençlik Çocuk ve Aile Danışmanlık Merkezi

Demetevler Şubesi, 0312 507 34 50/0312 507 34 51
Ulus Şubesi, 0312 507 36 92/0312 507 36 49

- Keçiören Belediyesi, Aile Terapi Merkezi

Keçiören, 0312 338 87 06/0312 339 67 18

- İzmir Büyükşehir Belediyesi Psikososyal Destek Hizmeti, Genç İzmir

Örnekköy, 0232 293 12 00

- İzmir Karabağlar Belediyesi,

Karabağlar, 0232 414 76 00, 0232 414 76 01

Çalışma sırasında ve sonrasında çalışma ile ilgili herhangi bir bilgi edinmek isterseniz bize araştırmacı Bihter Topyay Şahin'e veya proje yürütücüsü Doç. Dr. Z. Hande Sart'a ulaşabilirsiniz. Araştırmayla ilgili haklarınız konusunda Boğaziçi Üniversitesi Sosyal ve Beşeri Bilimler İnsan Araştırmaları Etik Kurulu'na (*******@********) danışabilirsiniz.

☐ Yukarıda yazılanları anladım ve çalışmaya katılmayı kabul ediyorum.

Tarih (gün/ay/yıl): ...../...../.....
İsminiz ve soyisminizin baş harfi: .....

APPENDIX D

DEMOGRAPHIC FORM (ENGLISH)

Dear Mother,

Thank you for choosing to participate in this study voluntarily. Your participation and answers will contribute to the scientific examination of mothers' experiences in their childhood and self-assessments of their parenting skills and experiences. Please answer each question to the best of your ability.

1. Your age:

2. Your mother tongue:

3. The last school you graduated from:
   ( ) I have no education
   ( ) I have no education, but I am literate
   ( ) Primary school/Primary education dropout
   ( ) Primary school (5 years)
   ( ) Primary education (8 years)
   ( ) Secondary school dropout
   ( ) Middle school
   ( ) High school dropout
   ( ) High school
   ( ) University dropout
   ( ) University
   ( ) Postgraduate
   ( ) Graduate dropout
   ( ) Other

4. Are you working?
   ( ) Yes Please specify your profession: .....
   ( ) No Have you worked before?: ( ) Yes Please state your profession: ……
   ( ) No

5. Marital status:
   ( ) Married Is your spouse working?
   ( ) Yes Please indicate your profession:……
   ( ) No
   ( ) Divorce
   ( ) Lives separately Is your child's father working?
   ( ) Single ( ) Yes Please indicate your profession:……
   ( ) Other ( ) No

6. When you consider your family's basic needs along with your income and expenses, which of the following best describes your household's current financial situation?
   ( ) We often don't have enough money for even basic needs like food and rent.
   ( ) We only have enough money to cover our basic needs from month to month.
   ( ) We can easily meet our basic needs.
   ( ) We have enough income to live comfortably.

7. Age when you became a mother for the first time: …….

8. How many children do you have?: ……

9. How many children do you have between the ages of 12-36 months?: …

10. While answering these questions what is the exact age (months) of the child (consider only 12-36 months)?: …….

    When answering the questions, think about your 12-36 month old child.

11. What is the gender of your child?: Girl ( ) Boy ( )

12. Does your child have a chronic (long-term) health problem?
    ( ) Yes Please specify the health problem: ……..
    ( ) No

13. On average, how much time do you spend with your child on weekdays?
    ( ) 0-3 hours
    ( ) 4-7 hours
    ( ) 8-11 hours
    ( ) 12-15 hours

14. On average, how much time do you spend with your child on weekends?
    ( ) 0-3 hours
    ( ) 4-7 hours
    ( ) 8-11 hours
    ( ) 12-15 hours

15. Do you find the time you spend with your child sufficient?
    ( ) Yes
    ( ) No

16. Do you have any psychological, psychiatric or neurological diagnoses?
    ( ) Yes
    ( ) No

APPENDIX E

DEMOGRAPHIC FORM (TURKISH)

DEMOGRAFİK FORM

Sayın Anne,
Bu çalışmaya gönüllü bir biçimde katılmayı seçtiğiniz için teşekkür ederiz. Katılımınız ve yanıtlarınız annelerin çocuklukta yaşadıkları deneyimlerini ve ebeveynlik becerilerine ve deneyimlerine dair kendilerine ilişkin değerlendirmelerini bilimsel açıdan incelemeye katkı sunacaktır. Lütfen her soruyu elinizden geldiğince cevaplayınız.

1. Yaşınız:

2. Ana diliniz:

3. En son mezun olduğunuz okul:
   ( ) Eğitimim yok
   ( ) Eğitimim yok ama okur yazarım
   ( ) İlkokul/İlköğretim terk
   ( ) İlkokul (5 yıllık)
   ( ) İlköğretim (8 yıllık)
   ( ) Ortaokul terk
   ( ) Ortaokul
   ( ) Lise terk
   ( ) Lise
   ( ) Üniversite terk
   ( ) Üniversite
   ( ) Lisansüstü
   ( ) Lisansüstü terk
   ( ) Diğer

4. Çalışıyor musunuz?
   ( ) Evet Mesleğinizi belirtiniz: .....
   ( ) Hayır Daha önce çalışıyor muydunuz?: ( ) Evet Mesleğini belirtiniz: ……
   ( ) Hayır

5. Medeni durumunuz:
   ( ) Evli Eşiniz çalışıyor mu? ( ) Evet Mesleğini belirtiniz: ……
   ( ) Hayır
   ( ) Boşanmış
   ( ) Ayrı yaşıyor Çocuğunuzun babası çalışıyor mu?
   ( ) Bekar ( ) Evet Mesleğini belirtiniz: ……
   ( ) Diğer ( ) Hayır

6. Ailenizin temel ihtiyaçları ile gelirinizi ve harcamalarınızı birlikte düşündüğünüzde, aşağıdakilerden hangisi hanenizin şu anki mali durumunu daha iyi tanımlar?
   ( ) Sık sık yemek ve kira gibi temel ihtiyaçlarımız için bile yeterli paramız olmaz.
   ( ) Aydan aya ancak temel ihtiyaçlarımız idare edebilecek kadar paramız var.
   ( ) Temel ihtiyaçlarımızı rahatça karşılayabiliyoruz.
   ( ) Rahatça yaşamak için yeterli gelirimiz var.

7. İlk kez anne olduğunuz yaş: …….

8. Kaç çocuğunuz var?: …….

9. 12-36 ay yaş aralığında kaç çocuğunuz var?: ……..

10. Çocuğunuz ile ilgili karşılaşacağınız soruları kaç aylık olan çocuğunuz düşünerek yanıtlayacaksınız?: ……..

    Soruları yanıtlarken 12-36 aylık olan çocuğunuzu düşünerek yanıtlayınız.

11. Çocuğunuzun cinsiyeti nedir?: Kız ( ) Oğlan ( )

12. Çocuğunuzun kronik (uzun süreli) bir sağlık sorunu var mı?
    ( ) Evet Sağlık problemini belirtiniz: ……..
    ( ) Hayır

13. Çocuğunuz ile hafta içi günlerde ortalama ne kadar süre birlikte vakit geçiriyorsunuz?
    ( ) 0-3 saat
    ( ) 4-7 saat
    ( ) 8-11 saat
    ( ) 12-15 saat

14. Çocuğunuz ile hafta sonu günlerde ortalama ne kadar süre birlikte vakit geçiriyorsunuz?
    ( ) 0-3 saat
    ( ) 4-7 saat
    ( ) 8-11 saat
    ( ) 12-15 saat

15. Çocuğunuz ile beraber geçirdiğiniz süreyi yeterli buluyor musunuz?
    ( ) Evet
    ( ) Hayır

16. Herhangi bir psikolojik, psikiyatrik veya nörolojik tanınız var mı?
    ( ) Evet
    ( ) Hayır

APPENDIX F

PATIENT HEALTH QUESTIONNAIRE-DEPRESSIVE SYMPTOMS (ENGLISH)

Over the last 2 weeks, how often have you been bothered by any of the following problems?

0 = Not at all 1 = Several day

2 = More than half the days 3 = Nearly every day

	0	1	2	3
1. Little interest or pleasure in doing things				
2. Feeling down, depressed, or hopeless				
3. Trouble falling or staying asleep, or sleeping too much				
4. Feeling tired or having little energy				
5. Poor appetite or overeating				
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down				
7. Trouble concentrating on things, such as reading the newspaper or watching television				
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual				
9. Thoughts that you would be better off dead or of hurting yourself in some way				

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all □
Somewhat difficult □
Very difficult □
Extremely difficult □

APPENDIX G

PATIENT HEALTH QUESTIONNAIRE-DEPRESSIVE SYMPTOMS (TURKISH)

HASTA SAĞLIK ANKETİ

Son 2 hafta içerisinde, aşağıdaki sorunlardan herhangi biri sizi ne sıklıkla rahatsız etti?

0 = Hiçbir zaman 1 = Bazı günler
2 = Günlerin yarısından fazlasında 3 = Hemen hemen her gün

	0	1	2	3
1. Bir şeyleri yapmaya az ilgi veya zevk duymak				
2. Üzgün, depresif veya umutsuz hissetmek				
3. Uykuya dalmada veya uyumaya devam etmekte zorluk, veya çok fazla uyumak				
4. Yorgun hissetmek veya enerjinizin az olması				
5. İştahsızlık veya çok fazla yemek				
6. Kendinizi kötü hissetmeniz — veya kendinizi başarısız ya da kendinizi veya ailenizi hayal kırıklığına uğrattığınızı düşünmeniz				
7. Gazete okumak veya televizyon seyretmek gibi faaliyetlerde dikkatinizi toplamakta güçlük çekmeniz				
8. Başkalarının fark edebileceği kadar yavaş hareket etmeniz veya konuşmanız Veya tam aksine— normalden çok daha fazla hareket edecek kadar kıpır kıpır veya huzursuz olmanız				
9. Ölmüş olsanız daha iyi olacağınız veya bir şekilde kendinize zarar verme düşünceleri				

Bu sorunlardan herhangi birini işaretlediyseniz, bu sorunlar işinizi yapmanızda, evinizle ilgili işleri halletmenizde veya diğer insanlarla olan ilişkilerinizde ne kadar zorluk yarattı?

Hiç zorluk yaratmadı □
Oldukça zorluk yarattı □
Çok zorluk yarattı □
Aşırı derecede zorluk yarattı □

APPENDIX H

ADVERSE CHILDHOOD EXPERIENCES SCALE (ENGLISH)

Below are some questions about your adverse childhood experiences until the age of 18. Please read each question carefully and give the answer as "Yes" or "No" for the relevant experience.

1.	Did a parent or other adult in the household often or very often... Swear at you, insult you, put you down, or humiliate you? or Act in a way that made you afraid that you might be physically hurt?	YES/NO
2.	Did a parent or other adult in the household often or very often... Push, grab, slap, or throw something at you? or Ever hit you so hard that you had marks or were injured?	YES/NO
3.	Did an adult or person at least 5 years older than you ever... Touch or fondle you or have you touch their body in a sexual way? or Attempt or actually have oral, anal, or vaginal intercourse with you?	YES/NO
4.	Did you often or very often feel that ... No one in your family loved you or thought you were important or special? or Your family didn't look out for each other, feel close to each other, or support each other?	YES/NO
5.	Did you often or very often feel that ... You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? or Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?	YES/NO
6.	Was a biological parent ever lost to you through divorce, abandonment, or other reason?	YES/NO
7.	Was your mother or stepmother: Often or very often pushed, grabbed, slapped, or had something thrown at her? or Sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard? or Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?	YES/NO
8.	Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?	YES/NO
9.	Was a household member depressed or mentally ill or did a household member attempt suicide?	YES/NO
10.	Did a household member go to prison?	YES/NO

APPENDIX I

ADVERSE CHILDHOOD EXPERIENCES SCALE(TURKISH)

ÇOCUKLUK ÇAĞI OLUMSUZ YAŞANTILAR ÖLÇEĞİ

Aşağıda 18 yaşınıza kadar olan süreçteki olumsuz çocukluk deneyimlerinize dair birtakım sorular yer almaktadır. Her soruyu lütfen dikkatlice okuyunuz ve ilgili deneyime dair cevabınızı "Evet" veya "Hayır" yanıtları üzerinden veriniz.

1.	Bir ebeveyniniz ya da ev halkından yetişkin biri sıklıkla ya da çok sıklıkla... Size küfür etti mi, sizi hor gördü mü, sizi aşağıladı mı ya da sizi küçümsedi mi? Ya da Sizi fiziksel anlamda incitecek bir şekilde davranıp sizi korkuttu mu?	EVET/HAYIR
2.	Bir ebeveyniniz ya da ev halkından yetişkin biri sıklıkla ya da çok sıklıkla... Sizi itip tartakladı mı, tokatladı mı ya da size bir şey fırlattı mı? Ya da Size hiç iz kalacak ya da yaralanacağınız kadar güçlü vurdu mu?	EVET/HAYIR
3.	Bir yetişkin ya da sizden en az 5 yaş büyük biri hiç... Size dokundu mu ya da sizi hiç okşadı mı ya da sizden hiç onların bedenine cinsel anlamda dokunmanızı istedi mi? Ya da Sizinle oral, anal ya da vajinal olarak cinsel ilişki yaşadı mı ya da teşebbüs etti mi?	EVET/HAYIR
4.	Siz sıklıkla ya da çok sıklıkla aşağıdaki gibi hissettiniz mi? Ailenizde kimse sizi sevmiyor ya da sizin önemli ya da özel olduğunuzu düşünmüyor? Ya da Aileniz size göz kulak olmadı, ailenizle yakın hissetmediniz ya da birbirinizi desteklemediniz?	EVET/HAYIR
5.	Sıklıkla ya da çok sıklıkla aşağıdaki gibi hissettiniz mi? Yeterince yemek yoktu, kirli giysiler giymek zorundaydınız ve sizi koruyacak kimse yoktu? Ya da Aileniz size bakmak için ya da ihtiyacınız olduğunda doktora götürmek için çok sarhoştu ya da kendinde değildi?	EVET/HAYIR
6.	Ebeveynleriniz hiç ayrıldı mı ya da boşandı mı?	EVET/HAYIR
7.	Anneniz ya da üvey anneniz: Sıklıkla ya da çok sıklıkla itilip tartaklandı mı, tokatlandı mı ya da ona bir şey fırlatıldı mı? Ya da Bazen, sıklıkla ya da çok sıklıkla tekmelendi mi, dövüldü mü, yumrukla ya da daha sert bir şeyle ona vuruldu mu? Ya da Hiç en az birkaç dakika sürekli bir şekilde ona vuruldu mu ya da silahla ya da bıçakla tehdit edildi mi?	EVET/HAYIR
8.	Içki problemi olan, alkolik ya da uyuşturucu kullanan biriyle yaşadınız mı?	EVET/HAYIR
9.	Ev halkından biri depresyonda ya da zihinsel hasta mıydı ya da intihara teşebbüs etti mi?	EVET/HAYIR
10.	Ev halkından biri hapse girdi mi?	EVET/HAYIR

APPENDIX J

BENEVOLENT CHILDHOOD EXPERIENCES SCALE (ENGLISH)

Below are some questions about your benevolent childhood experiences until the age of 18. Please read each question carefully and give the answer as "Yes" or "No" for the relevant experience.

1.	Did you have at least one caregiver with whom you felt safe?	YES/NO
2.	Did you have at least one good friend?	YES/NO
3.	Did you have beliefs that gave you comfort?	YES/NO
4.	Did you like school?	YES/NO
5.	Did you have at least one teacher who cared about you?	YES/NO
6.	Did you have good neighbors?	YES/NO
7.	Was there an adult (not a parent/caregiver or the person from #1) who could provide you with support or advice?	YES/NO
8.	Did you have opportunities to have a good time?	YES/NO
9.	Did you like yourself or feel comfortable with yourself?	YES/NO
10.	Did you have a predictable home routine, like regular meals and a regular bedtime?	YES/NO

APPENDIX K

BENEVOLENT CHILDHOOD EXPERIENCES SCALE (TURKISH)

ÇOCUKLUK ÇAĞI OLUMLU YAŞANTILAR ÖLÇEĞİ

Aşağıda 18 yaşınıza kadar olan süreçteki olumsuz çocukluk deneyimlerinize dair birtakım sorular yer almaktadır. Her soruyu lütfen dikkatlice okuyunuz ve ilgili deneyime dair cevabını "Evet" veya "Hayır" yanıtları üzerinden veriniz.

1.	Kendinizi güvende hissettiren ve temel bakımınızdan sorumlu en az bir kişi var mıydı?	EVET/HAYIR
2.	En az bir tane yakın arkadaşınız var mıydı?	EVET/HAYIR
3.	Sizi rahatlatan inançlarınız var mıydı?	EVET/HAYIR
4.	Okulu sever miydiniz?	EVET/HAYIR
5.	Sizinle yakından ilgilendiğini düşündüğünüz en az bir öğretmeniniz var mıydı?	EVET/HAYIR
6.	İyi komşularınız var mıydı?	EVET/HAYIR
7.	Size destek veren veya gerektiğinde tavsiye alabileceğiniz bir yetişkin (ebeveyn/bakımveren veya 1. soruda *(Bkz: Kendinizi güvende hissettiren ve temel bakımınızdan sorumlu en az bir kişi var mıydı?)* belirttiğiniz kişi hariç) var mıydı?	EVET/HAYIR
8.	Eğlenceli vakit geçirmek için yeterli imkanlarınız var mıydı?	EVET/HAYIR
9.	Kendinizi sever miydiniz veya kendinizle barışık mıydınız?	EVET/HAYIR
10.	Düzenli öğün ve düzenli uyku saatleri gibi tahmin edilebilir ya da tutarlı ev kuralları var mıydı?	EVET/HAYIR

APPENDIX L

PARENTAL REFLECTIVE FUNCTIONING QUESTIONNAIRE

(ENGLISH)

Listed below are several statements concerning you and your child. Read each item and decide whether you agree or disagree and to what extent. Use the following rating scale, with seven if you strongly agree; and one if you strongly disagree. The midpoint, if you are neutral or undecided, is 4.

Strongly Agree 1 2 3 4 5 6 7 Strongly Disagree

*Evaluate the following statements for your child between the ages of 12-36 months, about whom you stated in the personal information form that you will think and answer the questions.

	1	2	3	4	5	6	7
1. The only time I'm certain my child loves me is when he or she is smiling at me.							
2. I always know what my child wants.							
3. I like to think about the reasons behind the way my child behaves and feels.							
4. My child cries around strangers to embarrass me.							
5. I can completely read my child's mind.							
6. I wonder a lot about what my child is thinking and feeling.							
7. I find it hard to actively participate in make believe play with my child.							
8. I can always predict what my child will do.							
9. I am often curious to find out how my child feels.							
10. My child sometimes gets sick to keep me from doing what I want to do.							
11. I can sometimes misunderstand the reactions of my child.							
12. I try to see situations through the eyes of my child.							
13. When my child is fussy, he or she does that just to annoy me.							
14. I always know why I do what I do to my child.							
15. I try to understand the reasons why my child misbehaves.							
16. Often, my child's behavior is too confusing to bother figuring out.							
17. I always know why my child acts the way he or she does.							
18. I believe there is no point in trying to guess what my child feels.							

APPENDIX M

PARENTAL REFLECTIVE FUNCTIONING QUESTIONNAIRE-SHORT FORM

(TURKISH)

EBEVEYN İÇSEL DÜŞÜNME İŞLEVSELLİĞİ ÖLÇEĞİ-KISA FORM

Aşağıda siz ve çocuğunuz hakkında birtakım ifadeler yer almaktadır. Her maddeyi lütfen dikkatlice okuyunuz ve her maddeye ne derecede katılıp katılmadığınızı belirtiniz. Cevaplarınızı maddelerin yanındaki sayıları seçerek gösteriniz. Belirtilen ifadeye tamamen katılıyorsanız 7; hiç katılmıyorsanız 1; ne katılıyor ne katılmıyorsanız ya da kararsızsanız 4 rakamını işaretleyiniz.

*Aşağıdaki ifadeleri kişisel bilgi formunda hakkında düşünerek soruları yanıtlayacağınızı belirttiğiniz 12-36 aylık yaş aralığında olan çocuğunuz için değerlendiriniz.

	1	2	3	4	5	6	7
1. Çocuğumun beni sevdiğinden yalnızca o bana gülümsediği zaman emin olurum.							
2. Çocuğumun ne istediğini her zaman bilirim.							
3. Çocuğumun duygu ve davranışlarının altındaki sebepleri anlamak isterim.							
4. Çocuğum yabancıların yanında beni mahcup etmek için ağlar.							
5. Çocuğumun aklından geçenleri tamamıyla okuyabilirim.							
6. Çocuğumun ne düşündüğünü ve hissettiğini çok merak ederim.							
7. Çocuğumun evcilik, doktorculuk ve benzeri oyunlarına aktif bir şekilde katılmakta zorlanırım.							
8. Çocuğumun ne yapacağını her zaman tahmin edebilirim.							
9. Çocuğumun nasıl hissettiğini genellikle merak ederim.							
10. Çocuğum bazen yapmak istediğim şeyden beni alıkoymak için hasta olur.							
11. Çocuğumun yaptıklarını bazen yanlış anlayabiliyorum.							
12. Olaylara çocuğumun gözünden bakmaya çalışırım.							
13. Çocuğum mızmızlandığı zaman bunu beni kızdırmak için yapar.							
14. Çocuğuma neyi neden yaptığımı her zaman bilirim.							
15. Çocuğumun neden yaramazlık yaptığını anlamaya çalışırım.							
16. Çoğu zaman, çocuğumun davranışları çaba göstersem de anlaşılamayacak kadar karmaşıktır.							
17. Çocuğumun davranışlarının sebebini her zaman bilirim.							
18. Çocuğumun ne hissettiğini tahmin etmeye çalışmanın bir işe yaramadığına inanıyorum.							

APPENDIX N

THE SELF-EFFICACY FOR PARENTING TASKS INDEX-TODDLER SCALE

(ENGLISH)

There is no right or wrong answer to any of the following sentences. Opinions about each sentence may vary from person to person. Your answer should reflect only your views. When expressing your opinion about each sentence, first read the sentence carefully; Then mark (X) the option that best expresses your feelings and thoughts. Even if the statements are like each other, please answer all of them without leaving any blank.

1 = Strongly Disagree 2 = Moderately Disagree 3 = Slightly Disagree
4 = Slightly Agree 5 = Moderately Agree 6 = Strongly Agree

*Evaluate the following statements for your child between the ages of 12-36 months, about whom you stated in the personal information form that you will think and answer the questions.

	1	2	3	4	5	6
Emotional Availability						
1. Even when I have had an unusually distressing day, I think my child knows I am available to meet his or her emotional needs.						
2. I believe that I adequately meet my child's needs to feel secure and accepted.						
3. When my child needs me, I am able to easily put aside whatever else I may be doing.						
4. I find it difficult to always be available to provide my child with the comfort he/she needs in dealing with the many frustrations and fears that toddlers face each day.*						
5. Providing physical comfort for my child is easy for me.						
6. I am usually willing to stop what I'm doing and cuddle my child when he/she seems to need affection.						
7. I am often too preoccupied with my own problems to keep up with my child's changing emotions.*						
Nurturance/Valuing/Empathetic Responsiveness						
8. I am able to sense when my child is starting to become distressed.						
9. My toddler knows that I understand when his/her feelings are hurt.						
10. I think my child knows by my behavior how much I really adore him/her.						

	1	2	3	4	5	6
11. My child feels very loved by me.						
12. I think I am tolerant and understanding when my child displays negative emotions.						
13. I find it very distressing when my child isn't in a good mood.*						
14. I definitely fulfill my parental duties when it comes to providing emotional support for my child.						
15. When my child has a problem, he/she knows I will want to help.						
Protection						
16. Providing a safe, hazard-free environment for my child is very difficult for me.*						
17. I feel comfortable with my ability to react well should an emergency arise in which my child's physical well-being is in danger.						
18. When I leave my child in someone else's care, I make sure that the substitute care provider will be capable of protecting my child from harm.						
19. I have my home arranged to prevent as many accidents as possible with my toddler.						
20. I am very good about never leaving my child unattended.						
21. I always make sure I can see my child in order to make sure he/she does not get hurt.						
22. I have difficulty determining what is and what is not safe for my child to do.*						
Discipline/Limit Setting						
23. Disciplining my child does not seem to be coming as naturally to me as other parts of parenting.*						
24. I have trouble getting my child to listen to me.*						
25. Other parents seem to have more success with setting limits for their children than I do with my child.*						
26. Setting limits for my toddler is relatively easy for me.						
27. When my toddler tests the limits that I have set up, I find myself becoming extremely discouraged. *						

	1	2	3	4	5	6
28. Telling my child “no” when safety isn’t the issue is hard for me. *						
29. I allow my child enough freedom to actively explore the environment.						
30. I can always think of something to play with my child.						
31. I am a fun playmate for my toddler.						
32. I find it hard to loosen up and just play with my child.*						
33. I am able to get actively involved in playing with my child.						
34. Playing is part of my relationship with my child that I have very little difficulty with.						
35. I really need to learn how to just have fun with my child.*						
36. I think I spend an appropriate amount of time just playing with my child.						
Teaching						
37. I believe my toddler learns a great deal from my efforts to show him/her things.						
38. Assisting my child with learning to talk and understand words is part of parenting that I leave to others.*						
39. Sitting down regularly with my child to read or do some other one-on-one activity is not difficult for me.						
40. I am probably not that great at teaching my child about the world.*						
41. I have some difficulty figuring out the appropriate level of instruction when I'm trying to explain something to my child.*						
42. Helping my child learn colors, names of objects, etc. is not one of my strongest points.*						
43. My child learns more from me than anyone else in his/her life.						
44. I easily find opportunities to point out things about the world during my daily interactions with my child.						
45. Although I would like to help my child learn more about her/his surroundings, this is an area of parenting that I do not feel well-equipped for.*						

	1	2	3	4	5	6
Instrumental Care/ Structure/ Routines						
46. I have been able to establish a daily routine with my toddler that feels comfortable to both of us.						
47. I am able to provide my child with a comfortable amount of daily structure.						
48. I have been successful in getting my child to eat on a fairly regular schedule.						
49. I feel I have no control over my child's sleep habits.*						
50. I am not very good at getting my child to stick to a regular daily schedule.*						
51. Although I have tried to train my child to eat well, my efforts have been met with very little success.*						
52. I don't seem to be able to establish a regular bed time routine with my child.*						
53. I have worked out a fairly regular morning routine with my toddler.						

*Items marked are reverse scored.

APPENDIX O

THE SELF-EFFICACY FOR PARENTING TASKS INDEX-TODDLER SCALE

(TURKISH)

ANNE BABALIK BECERİLERİNDE ÖZYETERLİK ÖLÇEĞİ

Aşağıdaki cümlelerden hiçbirinin doğru ya da yanlış cevabı yoktur. Her cümle ile ilgili görüş kişiden kişiye değişebilir. Vereceğiniz cevap sadece sizin kendi görüşlerinizi yansıtmalıdır. Her cümleyle ilgili görüşünüzü belirtirken, önce cümleyi dikkatle okuyunuz; sonra duygu ve düşüncelerinizi en iyi ifade eden seçeneği (X) ile işaretleyiniz. İfadeler birbirine benzer olsalar bile lütfen boş bırakmadan tamamını cevaplayınız.

1 = Hiç Katılmıyorum 2 = Az Katılıyorum 3 = Orta Düzeyde Katılıyorum
4 = Çok Katılıyorum 5 = Tamamen Katılıyorum

*Aşağıdaki ifadeleri kişisel bilgi formunda hakkında düşünerek soruları yanıtlayacağınızı belirttiğiniz 12-36 aylık yaş aralığında olan çocuğunuz için değerlendiriniz.

	1	2	3	4	5
Duygusal Yeterlilik					
1. Çocuğum, benim çok sıkıntılı-stresli bir günümde bile, onun duygusal ihtiyaçlarını (sevilme ihtiyacı, ilgi görme ihtiyacı vb.) karşılayacağımı bilir.					
2. Çocuğuma güven içinde olduğunu ve ailenin bir bireyi olarak benimsenip- sevildiğini hissettirdiğime inanıyorum.					
3. Çocuğumun bana ihtiyacı olduğu an, her ne yapıyorsam yapayım kolaylıkla bırakabilirim.					
4. Çocuğuma her gün karşı karşıya kaldığı korku ve engellerle baş etmesi ve rahatlaması için destek olmak bana zor gelir.*					
5. Çocuğumun fiziksel rahatlığını (altının temiz olması, ortamın sıcak olması vb) sağlamak benim için kolaydır.*					
6. Çocuğumun sevgiye ihtiyacı olduğunu fark ettiğimde, ne yapıyorsam yapayım seve seve bırakıp, ona sarılıp kucaklarım.*					
7. Genellikle çocuğumun duygularındaki değişimi takip edip, anlamaya çalışmak yerine kendi problemlerimle daha çok meşgul olurum.*					
Duyarlı Tepki Verme, Bakım-İlgi, Değer Verme					
8. Çocuğum kendisini sıkıntılı hissetmeye başladığın an bunu hemen anlayabilirim.					
9. Çocuğum üzüldüğünde-kırıldığında, benim onu anlayabileceğimi bilir.					

	1	2	3	4	5
10. Çocuğum onu taparcasına sevdiğimi, benim ona karşı olan davranışlarımdan anlar.					
11. Çocuğum onu sevdiğimi hisseder.					
12. Çocuğum olumsuz duygular sergilediğinde (sinirli, huysuz, inatçı davranışlarda bulunduğunda) ona karşı anlayışlı ve hoşgörülü olduğumu düşünüyorum.					
13. Çocuğumun duygusal ihtiyaçlarını (sevilme ihtiyacı, ilgi görme ihtiyacı vb) karşılama konusunda anne babalık görevimi tam olarak yerine getiririm.					
14. Çocuğum bir problemi olduğunda, benim ona yardım etmek isteyeceğimi bilir.					
Koruma					
15. Çocuğuma, tehlikelerden uzak güvenli bir ortam sağlamak benim için çok zordur.*					
16. Çocuğumun sağlığı ile ilgili acil bir durum ortaya çıktığında, doğru davranabileceğim için bu konuda rahatım.					
17. Çocuğumu, bakması için, ancak tehlikelerden koruyacağından emin olduğum kişiye bırakırım.					
18. Çocuğumu evde olabilecek kazalardan korumak için gerekli düzenlemeleri yaptım.					
19. Çocuğumu, asla gözetimsiz-tek başına bırakmamaya çok özen gösteririm.					
20. Çocuğuma herhangi bir zarar gelmemesi için, onu gözümün önünden ayırmam.					
21. Çocuğumun yaptığı şeylerin güvenli olup olmadığını belirlemede zorlanırım.*					
Disiplin/Kısıtlama Yapma					
22. Çocuğuma söz geçirmede zorlanıyorum.*					
23. Diğer anne babaları çocuklarına sınır koymada (kısıtlama getirmede) kendimden daha başarılı buluyorum.					
24. Çocuğuma sınır koymak (kısıtlama getirmek) benim için oldukça kolaydır.					
25. Çocuğum koyduğum kısıtlamalara uymamayı denediğinde (test ettiğinde) aşırı derecede moralim bozulur.*					
26. Tehlikeli durumlarda çocuğuma “hayır” demek benim için zordur.*					
27. Çocuğuma çevresini aktif (deneyerek-hareketli-etkili) bir biçimde keşfedebilmesi için yeterince özgürlük veririm.					

	1	2	3	4	5
Oyun					
28. Her zaman çocuğumla oynayabilecek oyunlar bulabilirim.					
29. Çocuğum için eğlenceli bir oyun arkadaşıyım.					
30. Rahatlayıp, gevşeyip sadece çocuğumla oynamak benim için zordur.*					
31. Çocuğumun oyununa aktif (hareketli-etkili) olarak katılabilirim.					
32. Oyun, çocuğumla olan ilişkimin çok az zorlandığım bir kısmıdır.					
33. Çocuğumla birlikte nasıl eğlenebileceğimi öğrenmeye gerçekten ihtiyacım var.*					
34. Çocuğumla, oyun oynamak için yeterince zaman ayırdığımı düşünüyorum.					
Öğretme					
35. Çocuğumun, benim ona öğretme çabalarımdan dolayı, çok fazla şey öğrendiğine inanıyorum.					
36. Çocuğumun konuşmasına ve kelimeleri anlamasına yardımcı olmayı başkalarına bırakırım.					
37. Çocuğuma düzenli bir şekilde oturup kitap okumak ya da onunla birebir etkinlik yapmak (oynamak, resim yapmak…) benim için zor değildir.					
38. Çocuğuma çevrede olup bitenleri öğretmede sanırım o kadar da başarılı değilim.					
39. Çocuğuma bir şeyleri açıklamaya çalışırken, anlayacağı düzeyde bilgi vermekte zorlanırım.*					
40. Çocuğumun renkleri, eşya isimlerini vb öğrenmesine yardım etme konusunda, yeterli değilim.*					
41. Çocuğum yaşamındaki diğer kişilere oranla benden daha çok şey öğrenir.					
42. Çocuğumla günlük etkileşimim sırasında; ona çevrede olup bitenlerle ilgili açıklamalar yapmak için kolaylıkla fırsat bulurum.					
43. Çocuğuma çevresi hakkında daha fazla şey öğrenmesine yardım etmekten hoşlanmama rağmen, bunda kendimi yeterli bulmuyorum.*					
Günlük İşler/Bakım/Yapılandırma					
44. Çocuğumun günlük düzenini (uyku, yemek, temizlik düzeni) hem onun hem de benim rahat edebileceğimiz şekilde ayarlayabildim.					

	1	2	3	4	5
45. Çocuğumu oldukça rahat ettirecek günlük bir düzen (uyku, yemek, temizlik düzeni) kurabildim.					
46. Çocuğuma oldukça düzenli zamanlarda, düzenli bir programla yemek yedirmede başarılıyım.					
47. Çocuğumun uyku alışkanlığı üzerinde hiçbir kontrolüm olmadığını düşünüyorum.*					
48. Çocuğumun, düzenli günlük programına (yemek saati, uyku saati gibi) uymasını sağlamada çok iyi değilim.*					
49. Çocuğumun iyi bir yeme alışkanlığı kazanmasını denememe rağmen, bunda çok az başarılıyım.*					
50. Çocuğum için düzenli uyku öncesi hazırlık alışkanlıkları (diş fırçalama, süt içme, pijamaları giyme) planlamada başarılı değilim.*					
51. Çocuğum için oldukça düzenli sabah alışkanlıkları (el-yüz yıkama, giyinme, kahvaltı gibi) planlayabildim.					

* İşaretli maddeler ters skorlanıyor.

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