MENTALIZATION AND SYMBOLIZATION IN PSYCHODYNAMIC PLAY THERAPY PROCESS: AN EMPIRICAL INVESTIGATION OF THE EFFECT OF MENTALIZING INTERVENTIONS ON SYMBOLIC PLAY AND MENTALIZATION

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PSİKODİNAMİK OYUN TERAPİSİ SÜRECİNDE ZİHİNSELLEŞTİRME VE SEMBOLİZASYON: ZİHİNSELLEŞTİRME MÜDAHALELERİNİN SEMBOLİK OYUNA VE ZİHİNSELLEŞTİRME ÜZERİNE ETKİSİNE YÖNELİK GÖRGÜL ARAŞTIRMA

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ABSTRACT

The aim of the present study was to investigate the relationship between mentalization and the development of play representations and play affect organization in long-term psychodynamic child psychotherapy. For this purpose the relations between therapist's use of mental state narrative and the child's capacity to use mental state narrative, as well as child's use of rich social representation and organize affect in play were empirically studied with a primarily quantitative methodology supported by clinical analyses of two cases with similar demographic characteristics and presenting problems. In order to analyze play structures in psychotherapy Children's Play Therapy Instrument (CPTI; Kernberg, Chazan, & Normandin, 1998) and to assess the children's and therapist's mental state narrative in play the Coding System for Mental State Talk in Narratives (CSMST; Bekar, Steele, & Steele, 2014) were used. Granger Causality Test derived from time-lagged associations was used to test causal relationships between mentalization and play over the course of treatment. Results of the study indicated that for both cases therapist's use of mental state talk caused affect modulation in play, however for the case who showed clinically significant symptomatic improvement, child's mental state talk also caused affect modulation whereas this was not found for the case who did not show clinical significant symptom reduction. Implications are discussed.

ÖZET

Bu çalışmanın amacı uzun dönemli psikodinamik oyun psikoterapisinde zihinselleştirme ile oyun temsillerinin gelişimi ve oyunda duygu düzenlemenin ilişkisini incelemektir. Bu amaçla terapistin zihin durumlarına yönelik anlatısı ile çocuğun zihin durumlarına yönelik anlatısı arasındaki ilişki ile birlikte, çocuğun oyun içinde zengin sosyal temsil kullanımı ve duygu düzenlemesi arasındaki ilişki benzer demografik özelliklere ve mevcut sorunlara sahip iki vaka üzerinden, klinik analizlerle desteklenen niceliksel metodoloji kullanılarak çalışılmıştır Psikoterapide oyun yapılarını analiz etmek için Children's Play Therapy Instrument (CPTI; Kernberg, Chazan, & Normandin, 1998)ve çocukların ve terapistlerin oyun içindeki zihin durumlarına yönelik anlatılarını değerlendirmek için Coding System for Mental State Talk in Narratives (CSMST; Bekar, Steele, & Steele, 2014) kullanıldı. Tedavi süresince zihinselleştirme ile oyun arasındaki nedensel ilişkileri test etmek için zaman gecikmeli bağlantılara dayanan Granger Nedensellik Testi kullanıldı. Çalışmanın bulguları iki vaka için de terapistin oyun ile ilişkili zihin durumlarına yönelik anlatılarının oyunda duygu düzenlemesine sebep olduğunu göstermiştir. Ancak, klinik olarak semptomatik gelişme gösteren vakada çocuğun zihin durumlarına yönelik anlatıları duygu düzenlemesine sebep olurken, bu sonuca semptomlarında klinik bir azalma olmayan vakada ulaşılamamıştır. Çıkarımlar tartışılmıştır.

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Chapter 1: Introduction

Mentalization in psychodynamic theory is the capacity to reflect on and represent mental states regarding self and others (Fonagy, Gergely, Jurist, & Target, 2002). In early childhood the quality of attachment is considered to be effective in developing this capacity. For the child, the process of forming mental representations of his own and others' mind develops unconsciously, through the caregiver who reflects on the child's pre-verbal and pre-representational affective states (Fonagy et al., 2002). Then this capacity provides the child to regulate his affect states and organize self-experience (Fonagy & Target, 1997). Therefore the goal of mentalization-based psychotherapy is to help the child to develop the capacity to mentalize by reestablishment of attachment relationship (Fonagy, 2000). The emergence of the child's mentalization capacity in response to therapist's capacity to reflect on the child's mental states, to identify his/her emotions and to make links with his/her motivations is central to the development of regulatory structures (Slade, 1999). Play in the psychotherapeutic relationship appears to be a fertile area (Youngblade & Dunn, 1995) for the child to think about mental states of self and other with the help of therapist's emphatic reflection on the child's mental state (Brent, 2009). So that the child is able to discover his own mental state in the mind of the therapist (Fonagy, 2000) but very few studies assessed this specific relationship to support this postulate.

In this study we aimed at investigating the effect of therapist's mentalizing interventions on the child's mentalizing capacity in a

psychodynamic play therapy process. We also studied the relationship between the child's and therapist's use of mental state narrative on the specific components of play activity. First we looked at the interaction between mentalization and the child's representational world in play that is the multiple representation of oneself in interaction with others in play activity (Sandler & Rosenblatt, 1962). Second we looked at the interaction between capacity to mentalize and regulate affect in play. For two single cases of long-term psychoanalytic psychotherapy, we used primarily a quantitative methodology with clinical analysis. In order to measure child's and therapist's use of mental state narrative we used the Coding System for Mental State Talk in Narratives (CSMST; Bekar, Steele, & Steele, 2014) and to measure play activity we used Children's Play Therapy Instrument (CPTI; Kernberg, Chazan, & Normandin, 1998).

Before presenting the empirical study and methodology, a literature review will be conducted starting with the development of attachment theory and mentalization as a representational phenomenon, followed by the development of mentalization in the early years of life. We focus on the relationship between mentalization and play and the function of play for the development of capacity to mentalize. Assessment of mentalization and play and research regarding mentalization in play is reviewed after a brief introduction to mentalization-based clinical intervention in play therapy. Following these, the current empirical study will be described and discussed in detail.

1.1 From Attachment to Representational World

Attachment theory began with Bowlby's ideas about the nature and function of human attachments (1980) and these ideas gave a new direction to the developmental psychology. Bowlby emphasized the importance of early relationships and their functions through lifespan in terms of socioemotional and cognitive development. He conceptualized (1971) attachment as a social and affective bonding that promotes proximity to a caregiver enabling survival.

More than an organizational construct, attachment as an emotional bonding is a significant aspect of the theory. Feelings of security, being connected and closeness forms the emotional experience of the infant (Bowlby, 1980). Bowlby's formulations of infant experiences of separation and loss emphasize the emotional quality of attachment relationship. Separations from the caregiver become a threat for the ongoing relationship with the caregiver because they disrupt the perception of availability of a protective caregiver. Emotional reactions to such separations signal distress for the reunion and activate the attachment system (Bowlby, 1971).So, characterized by the sensitiveness of the caregiver; caregiver organizes the behavioral sequences around the infant.

Following Bowlby, Ainsworth impressed by his work, reasoned that during the first 12 months, differences in maternal sensitivity would cause differences in the mother-infant attachment quality (Ainsworth, Blehar, Water, & Wall, 1978). So, her work allowed her to depict the core elements of insecure and secure attachment in children which explains the individual

differences coming from the attachment organization as secure and insecure emerging from the sequelae of maternal care in the first year (Slade, 1999). Although Ainsworth's Strange Situation procedure gave rise to the behavioral patterns of attachment reflecting individual differences in the way children think and feel about their caregivers' availability and reflect different coping mechanisms, Main was able to make the shift from a behavioral approach to a representational approach within the attachment theory by using Bowlby's (1982) notion of 'internal working models of attachment' (Slade & Aber, 1992). As these working models represent past relationships, they also provide a template for the future interactions with others (Bretherton, 1999). Also it is not just about representations of others, it carries a representation of self and the relationship between self and others. They are 'working' models because they are dynamic rather than stable. Although they are thought to be changeable in early life, they are resistant to change over the life time (Bretherton & Munholland, 1999).

From this point of view Main made an important contribution with the development of Adult Attachment Interview (AAI: George, Kaplan, & Main, 1985). As Bowlby (1982) stated, internal working models are not just about feelings and behavior, it also relates to cognition, memory and attention kind of cognitive capacities. This makes it possible to see individual patterns of attachment through patterns of language and structures of mind (Main et al., 1985). Main and her colleagues' analysis of the AAI revealed specific patterns of narrative organizations. These patterns manifest not in adults' descriptions of the events, rather it was the way they

remembered and organized their memories. At this point, the degree of overall coherence in the narrative, the degree to which they recall, integrate, and communicate his or her emotional reactions in attachment relevant situations is the key element for understanding adult attachment organizations.

Fonagy, with Miriam and Howard Steele (1991) then worked on the representational processes through the reflective function. They thought that representational processes have a significant value on the intergenerational transmission of attachment. According to them narrative coherence is an indicator of the capacity to reflect on to the one's internal world. While reflective function enables coherence, it actually gives the person the capacity to make sense of and integrate the representations of self and other. Fonagy (1995) proposed that through this capacity, a caregiver can offer the sensitivity and a secure attachment relationship for the child.

Along with this suggestion, mentalization has been conceptualized as the ability to understand and interpret the inner worlds of self and others, knowing that others like you have their own feelings, thoughts and desires (Fonagy, Gergely, et al., 2002). This ability is acquired in the course of development. Through mentalization one can make people's behavior meaningful and predictable. Once one can understand other's behavior, intentions and affects, he can flexibly activate self-object representations (Fonagy, Gergely, et al., 2002). So it requires intentionality and second order representation (Verheugt-Pleiter, Zevalkink, &Schmeets, 2008). Understanding and interpreting others' actions enables to make one's own

experiences meaningful (Fonagy, Gergely, et al., 2002). This in turn provides with the ability for affect regulation, impulse control, and self-control with a flexible self as agent through the help of access to accurate picture of the representational world (Fonagy& Target, 1997).

1.2 Development of Mentalization

To reflect on thoughts and feelings, mentalizing includes a relationship which starts with the primary affective relationship with the caregiver (Fonagy& Target, 1997). It is assumed that (Target and Fonagy, 1996; Winnicott, 1960) in order to develop a psychological self, one needs to see his own perception of self in another person's mind. When the caregiver can think about the child's particular experience of himself, she can provide him with a self-structure (Fonagy& Target, 1997). When the opposite happens the child fails to find the image of his mind. So the mental states of the child need to be contained by the caregiver as stated by Winnicott (1971) by 'giving back to the baby the baby's own self'. The containment should include representing child's internal state as bearable and manageable.

In normal development it is assumed (Fonagy, Gergely, et. al., 2002) that a child goes through some specific stages of agency of self as physical, social, teleological, intentional and representational. It was proposed that in the physical stage, sensory data is the basis of the self. In the relationship with the caregiver child starts to understand his physical actions has a meaning in the caregiver's behaviors and emotions. This awareness then

enables the development of the self as a social agent (Verheugt-Pleiter, et al., 2008). In order to read other's mind, the child gives importance to the physical world. The child seeks interaction with his caregiver and has some expectations from the caregiver. Through these expectations he starts to predict the behaviors. Understanding of this relationship between physical objects and expectations gives rise to the teleological position (Fonagy, Gergely, et. al., 2002).

In teleological position child's reactions are dependent upon the physical stimulus, experiences and actions to make sense of the world around him (Fonagy & Target, 1997). What is physical and visible has the significance in the sense that the child thinks presymbolically which means that the child is not able to mentalize the thoughts and feelings (Gergely & Csibra, 1997).

Towards the second year, child starts to understand the mental states that motivate others to act in specific ways (Fonagy& Target, 1997). Because the focus shifts from physical body to the mind, in the intentional position the child cares about the intentions of others. When the child thinks about others as having intentions it means that he is able to understand that others have their own mental worlds. This is suggested to be the first steps of mentalizing (Fonagy, Gergely, et al., 2002). When this stage starts, the child begins to be aware of the possibility of the mental causality. This brings about the transition from physical to an abstract, representational level (Fonagy, Gergely, et al, 2002). By developing a sense of self as having mental states, child understands others' mental states, as well. This requires

actual internal experiences along with the conceptual experiences of them. Here, as the actual experience is the first order representation, concepts are the second order representations (Fonagy, Gergely, et al., 2002).

1.2.1 Parental Affect Mirroring: The Representational Loop

Starting with the birth, mother approaches her child with the idea that the child has intentions with his behaviors, as if the child has already have the internal mental states, because the child is not seen as reacting to physical world (Fonagy, Gergely, et al.,2002). With this approach mother begins to verbalize the child's behaviors with the intentions which the mother assumed. With the formation of relational representations varying in quality, in time the child builds his own internal world by using the mental state of other, of the caregiver (Fonagy, Gergely, et al., 2002).

Fonagy, Gergely and colleagues (2010) explained this process that when the caregiver mirrors the child's behaviors, she also reflects the mental states of the child. This process enables them to interchange the affective states; mother gives what the child internally experienced back to the child after metabolizing it. This refers to the representational loop in which the child recognizes his own self in his mother's mind. So the primary experience transfers into a higher order representation (Verheugt-Pleiter, et al., 2008).

With the transition from primary to second-order representations, the child organizes his experiences by knowing what he feels (Fonagy, Gergely, et al., 2002). In this process the way mother sees the primary

experience of the child and the way she gives it back to the child is an important factor for the development of the ability to mentalize (Gergely& Watson, 1996). If the secondary perception received from mother and the primary experience of the child are too similar, the child cannot distinguish these two and cannot define his own primary experience (Fonagy, Gergely, et al., 2002). At this point there is no use of the secondary representation coming from the mother to develop the capacity to mentalize and symbolize (Verheugt-Pleiter, et al., 2008). Also there is not a differentiation between me and not-me. If they are too different, on the other hand, the secondary experience cannot be recognized as belonging to the primary experience. So, it is this space Winnicott stated (1971) as the transitional space in which the child learns to symbolize and mentalize. When the representational loop goes on and mother orders and arranges experiences as representations with a stable manner, the child is able to represent his own experiences and differentiate what is in his mind and what is in others' (Fonagy, Gergely, et al., 2002).

At this point there may be limitations in the mentalization process (Verheugt-Pleiter, et al., 2008). Fonagy (1995) suggested that if the child cannot see his own primary experience reflected enough in the mind of others, or if these experiences are not gained in the reality oriented perspective of the parent, he cannot have an access to his own mental experience and is unable to respond flexibly to the symbolic qualities of others' behaviors because it is hard for him to step back and to see the meaning behind them resulting in fixed patterns of attribution.

Besides, attachment quality is highly associated with the ability to mentalize for both the caregiver and the child, as stated before. Security of attachment bond is a critical mediator (Fonagy, Gergely, et al., 2002) because in a secure attachment relationship caregiver can make sense of the child's mental states accurately. This is why the sensitivity of the caregiver is a significant part of the attachment bond. Through marked mirroring of the child's distress, a single representation can be formed for the child to deal with overwhelming feelings and to regulate his emotions (Fonagy, Gergely, et al., 2002). The quality of attachment relationship can be separated as secure and insecure, basically. While the security of attachment is related to the ability to mentalize, insecure attachment relationships make it harder to mentalize; especially the disorganized pattern of attachment representation for both children and adults (Fonagy& Target, 1997).

1.3 Mentalization in Play

As stated from the beginning the child needs the presence of other for the containment, and for the re-presentation of his own internal states to see the perception of the self in the mind of the other (Fonagy& Target, 1997). Beginning from the birth 'self' is organized in an attachment relationship with the primary caregivers through the life span. As the child has needs to be satisfied, he expects them to be fulfilled by the caregiver. On the other hand, it is not possible for these expectations to be met perfectly, which is inevitable for the parent-child dyads. So this leads to frustration for the child and it requires the ability to tolerate. So, this dyadic interaction becomes the template for the mental system of the child

providing with the initial sense of self with the focus on internal perceptions, one's own affects and ideas derived from controlled primary affects and actions. In this sense controlling primary affects, developing primary mental content and maintaining a reciprocal relationship are necessary components of this system.

At this point, play serves as a world in which the child can develop, create and organize his own representational world (Chazan, 2002). What play space can provide to the child can be explained as Bowlby (1971) suggested that play can be seen as the caregiver's lap that had been lost its physicality and in which past and future have become present. So, in this space child can bring anything from his total relationship history rather than from a specific event or behavior through play (Chazan, 2002). As play activity requires perceptions, sensations and physical activity, it includes the use of symbols (Bretherton, 1984) and this, in turn, enables the child to extend his representations to form new coping strategies and to manipulate past experiences. Therefore, play can be suggested to provide with the safe area for the child's curiosity and creativity.

When play is assumed as functioning like a place which helps the child to find his path as in normal development, it makes understanding the development of thought through the development and limitations of mentalization clearer (Verheugt-Pleiter, et al., 2008). For clinical practice, Fonagy and Target (1997) presented a model of development of thought to see the development and limitations of the mentalizing capacity of a child in

symbolic play. Based on the concept of ‘playing with reality’ they suggested 3 phases of thinking.

Actual mode as the first phase of thinking is the one in which internal reality and external reality are equated and cannot be distinguished. So, the child perceives his fantasies as the reality.

The other type of mode is the pretend mode (Fonagy& Target, 1997) which is fully based on fantasy play. In this mode of playing, there is a boundary between reality and fantasy which enables the child to play, because when this boundary is lost, the child experiences ideas as real and threatening as in the first phase. So the boundary provides the child with the security to explore the external and internal worlds of both his own and other’s. Another feature of this phase is that it is a way of maintaining omnipotence and compensating frustrations (Fonagy, 1995). When the child begins to play with reality in a secure environment, representationality and intentionality take place and that enables to develop the ability to mentalize. However, if mental states are not shared with other person, this relationship may limit the development of capacity to mentalize.

The third mode of play is integration (Fonagy& Target, 1997). In this mode the child explores the difference between pretend mode and actual mode. With this phase child starts to understand that what he is playing is actually pretending and so he gradually gives up omnipotence. When the child is able to play, he can gain awareness towards his internal world.

The opposite of this process progresses in the way that the child cannot differentiate the reality and fantasy and then the idea becomes too real and threatening for him (Verheugt-Pleiter, et al., 2008). When the idea is too real it is hard for the child to regulate the anxiety coming from this and to play with it. The pretend mode is blocked and the child may interpret reality in the wrong way because he is in the psychic equivalent mode. Rather than the actual mode, if the pretend mode is dominant, this time the child cannot connect his primary experience and the sense of self cannot be experienced as coherent. This situation can be confused with a good ability to play in pretend. However, here, while the child plays in the pretend mode, he cannot integrate the reality to his play. Instead of promoting the development of thought, pretend mode is made use of as a defense against the intolerable feelings by the child (Verheugt-Pleiter, et al., 2008). It was suggested that one of the most prominent feature of dominance of pretend mode is controllingness (Lyons-Ruth & Jacobvitz, 1999). When the child withdraw into fantasy, he becomes over-controlling to deal with threatening ideas experienced as real.

This model makes it possible to consider play as a prototype of the area that mentalization comes about because the experience of secure play enables the integration of the pretend and psychic equivalence modes (Verheugt-Pleiter, et al., 2008). Interpersonal process that includes the complex mirroring of the child’s ideas and feelings and the playfulness while pretending facilitate the child to link them with reality. So, he can experience playfulness as a pretend but real mental experience. Through the

playful interpersonal relationship, the child can experience perceptions, thoughts and emotions by gaining an awareness of that they have causes and consequences of action. When he can think deeply about all these mental states without fear, he can start to form the basis of self as agent (Fonagy& Target, 2009; Verheugt-Pleiter, et al., 2008).

1.4 Mentalizing Interventions

Following these assumptions, when the nature of play to enhance the capacity to mentalize is taken into account, application of mentalization and play to work with children has taken place. Although mentalization-based therapy was originally developed by Fonagy and Bateman (2012) for adult patients, then it is also explored to work with children, families and parents (Midgley&Vrouva, 2012; Verheugt-Pleiter, Zevalkink, & Schmeets, 2008).Fonagy and Bateman (2003) formulated the goals of mentalization-based psychotherapy as to establish more secure attachment relationships, to organize self as more coherent, to develop more stable internal representations and to identify and express affects appropriately. As indicated in the development of thought, the gap between the primary experience and the symbolic representation causes failures in mentalization. Mentalization based psychotherapy aims at filling this gap (Bateman &Fonagy, 2003) by therapist using a mentalizing stance. Verheugt-Pleiter et al. (2008) describe and conceptualize the interventions and principles in psychotherapy for children to enhance mentalizing capacity by focusing on the primary concerns in the process. Psychotherapy in this model serves as a transitional space between reality and fantasy for the development of mental

processes and representations (Verheugt-Pleiter et al., 2008). For child psychotherapy to enhance mentalizing capacity, some principles are identified by Verheugt-Pleiter and colleagues (2008, pp. 55–57).

Working in the here and now actually represents the concept of 'holding' (Winnicott, 1960) in which the therapist reflects the inner world of the child markedly by monitoring the affective quality of the interaction with the child. Another crucial factor that the therapist should focus on in the process is recognizing child's level of mental functioning and establishing contact in the same level. Therapist should understand in which level the child is, because different levels of mental functioning require different kinds of relating. To facilitate child's affects to be expressed and help him to build up his inner structure, therapist is needed to give reality value to them. When the therapist recognizes the child's experiences and can offer a shared experience in the here-and-now, child can feel that his sense of self is confirmed. In the play, the child may be in pretend mode or in the equivalent mode. Therapist can promote play by initiating pretend mode as a way of exploring the experience by means of fantasy. Along with these, therapist should remember that process is more important than the result of the process and the technique, because process mostly takes place in the non-conscious.

In this process of enhancing mentalizing capacity, it is critical to start with the simplest forms to the complex forms of mental states. It is difficult for a child to understand conflict and ambivalence. Rather, he can make sense of simple states like belief and desire easily. Also, refraining

child’s unconscious states early in the process have no use for the child because it is hard for him to gain awareness for the inaccessible realm while it is still difficult to recognize the accessible ones. Because it is hard for a child to recognize the way mental states change, it is important to indicate current and moment-to-moment changes in the child’s mental states. This is also why it is important for the therapist to stay in the here and now (Fonagy& Target, 2009).

Interventions for enhancing mentalizing capacity of the child are also described and conceptualized with respect to attention regulation, affect, regulation and mentalization (Verheugt-Pleiter et al., 2008).

1.4.1 Attention Regulation

By knowing that a child can become calm when he is understood, the therapist can adapt her responses to the child’s regulation profile and attune to the same level. So, this can be an appropriate starting point. To achieve this, therapist offers attention to the child’s play or activity and introduces structure in play or story. Naming and describing physical states also make the child to think about his body which is a building block for the development of self as agent. When the body becomes something the child can think about, with the therapist he can work on the regulation of physical processes. Then naming/describing behavior makes it possible to name mental content enabling expression of emotions and cognitions. This can be seen in the next step for the exploration of the inner self. Naming anxiety and feeling threatened provides the child to learn how to cope with such

situations. The therapist can use her own sense of feeling anxious or threatened to give the child a coping mechanism. Also when the therapist indicates the behaviors of the child can step back and see the whole picture so that he can understand the way he behaves.

1.4.2 Affect Regulation

Affect regulation requires understanding the affects first, and then they need to be associated to something and finally to be expressed. The presence of therapist as 'other' enables child to share his subjective experience as in the earliest relationship with the caregiver. Feelings expressed by the child can be seen as the first signals to the caregiver. While the parent responds to those signals by accepting and confirming them, in this dyadic relationship, through the resonance primary intersubjectivity is formed. Fonagy, Gergely, and colleagues (2002) suggested that when a child recognizes that the other, caregiver, mirrors markedly his own affect, this is a critical point in the child's development of self. The reciprocal exchange of feelings provides with the organization of developmental progress. The caregiver acts like an ego facilitator, regulating feeling states to the optimal levels, so that allows child to deal with intense affective stimulation.

Therefore, it is important to give reality value to the child's experiences as in the first years of life. Then, an inner world can be built. For this purpose, therapist required to help the child to describe the feelings by naming them or by accompanying the behavioral patterns.

Discussing the consequences of strong feelings can be the other technique for the child to see the cause and effect relationships between actions and feelings (Bateman &Fonagy, 2004). While the shared experience with the therapist enables the child to think about his own behavior, the safety of the shared experience enables him to communicate the feelings behind these behaviors. In this shared experience it is crucial to have boundaries for safety and playfulness and markedness for the encouragement of the exploration of the inner world. While playing within boundaries, introduction of fantasy facilitates the pretend mode and pretend mode enables working on separating fantasy and reality, because pretend play is a way of representing wishes, intentions and feelings with the help of symbols. Setting boundaries and joining in the pretend mode help therapist to achieve this. So the relationship becomes safer for the child, gradually, and the child can start to internalize the function of the therapist as the representative of affects.

Giving reality value to the child's mental states through play figures or directly through the child can be the next step in the process. This provides with the deduction of second order representations by the time. This is a more complex part than giving reality value to inner experiences, because here, therapist shares the feeling in its intensity and enables them to be more compatible and acceptable for the child.

Play offers the child to repair and develop a sense of himself as effective (Chazan, 2002). If the negative emotions are felt uncontained for the child, this causes interruptions in the play activity and disorganization of

affective states. Child’s negative emotions need to be facilitated by the other to an optimum resolution. When the child experiences disorganization and displeasure, reattunement of attachment bond enables him to cope with these kinds of negative emotions. Through reattunement the child reengages with the joyful and reliable part of his world. This part is termed by Winnicott (1971) as ‘good-enough holding’. Because the child internalizes the affective relationship rather than the actual person, this internalization helps him to form representations of this relationship. In the safe arena of play, the child can bring these representations out, and extend them in the play activity to help regulating affects. When the affect regulation is impaired, then the interruptions in the play begin. On the other hand, if play is experienced as satisfying and pleasurable, the child is encouraged to express a wider range of emotions in the play (Chazan, 2002).

In the play, while the child experiences past and future as present by staying in between what is possible and what is impossible, he is able to play with reality. This ability then enables him to play with the effects of past; to transform, change, or even revise such kind of effects and to play with the possibilities of future that overwhelms him. When he is able to play with the reality he then becomes able to know better his internal and external worlds; to be aware of self and others that give rise to a better regulation of the self (Fonagy & Target, 1996).

1.4.3 Mentalization

The interventions in the therapy are directed to give the child a structure for representations of internal experiences to be communicated and interpreted. For this purpose therapist can emphasize the mental contents and processes of the child through remarking on fantasies, thoughts, wishes, intentions and interests. Therapist can do this in the pretend mode and with respect to attachment figures. When the child can think about others and start to interpret mental states of others, mentalization can develop. Developing these cognitive-affective structures by creating a structure for his internal and external representations enables the child to organize these representations.

So, psychotherapy for a child should include these components for the organization of self, affect regulation, mentalization and symbolization. Therefore, in treatment, enhancing mentalizing capacity is a critical process for the child's well-being. This capacity then helps him to observe his own emotions, understand and label them. Not just feelings, he needs to understand the relationship between his behavior and internal states both consciously and unconsciously. While the therapist introduces child's own mentalizing perspective, it is important for the therapist to show the mental states of others especially the ones important for the child. While the representational world of the child transforms, child's perspective of self, others and relationships also changes regarding this transformation. So, the child can adapt to his surroundings in a variety of ways. In doing this, the focus in the treatment is to discover the meaning of the play (Slade, 1994).

Therapist can do this by trying to understand the shared moments of subjective experience which requires the active participation of the child. When therapist accompanies the child in this process, they both work on what the child feels, knows and wants. Once the child represent what is hidden symbolically, then it is possible to interpret it (Slade, 1994).

1.5 Assessment of Mentalization

It is important to develop a measure to see the quality of mentalization-based psychotherapies and to see the role of mentalization on the development of psychopathology (Midgley&Vrouva, 2012). However, there are various constructs that are related to the concept of mentalization and this is why the approaches to measure these concepts are relevant to the mentalization. Some of the related concepts are reflective function (RF), metacognition, theory of mind (ToM), mindfulness, mindreading, social or emotional understanding, and perspective taking (Allen, 2003; Choi-Kain& Gunderson, 2008). Hence, it is important to develop a valid and reliable measure for the assessment of mentalization as it is, at the same time, hard due to the fact that the concept is multidimensional and refers to different kinds of psychological processes like desires, intentions, beliefs, needs, perceptions and attitudes (Midgley&Vrouva, 2012). Although all of these concepts are relevant to the mentalization, reflective functioning is a closer term among all (Midgley&Vrouva, 2012).

From the beginning, regarding London Parent-Child Project, Fonagy, Steele, et al. (1991) collected and analyzed data from adults. While

working on the data of Adult Attachment Interviews (George, Kaplan, and Main, 1985), considering intergenerational transmission of attachment, Main's (1991) ideas about the coherence in the narratives gave rise to the development of ideas regarding mentalization and reflective function as a manifestation of mentalization in the speech. So Fonagy and his colleagues (1998) introduced a coding system to assess mentalization operationalized as reflective functioning capacity of adults based on the AAI. Because RF is thought to be related to adult attachment representations and adult's capacity to reflect on mental states and intentions of their own parents, autobiographical narratives in the AAI were taken as indicators for RF in this coding system. While the results of the studies in this project (Fonagy, Steele, & Steele, 1991; Fonagy, et al., 1995) showed variations in the capacity of RF, RF scores and AAI scores were also correlated. Parents high in RF also rated highly secure on the AAI and have securely attached children. In another study (Fonagy, Steele, Moran, Steele, & Higgit, 1991) it was found that mothers' ability to interpret other's mental states of others was the predictive of their children's attachment security.

The Parent Development Interview (PDI; Aber, Slade, Berger, Bresgi, & Kaplan, 1985) was introduced to examine parents' representations of their children, their relationship with their children and themselves as parents. George and Solomon (1996) used PDI to assess parents of school-aged children. Mothers who represented themselves as secure in relationship with their children have secure children while the insecure mothers have more likely insecure children. The relationship between maternal reflective

functioning and adult and infant attachment was assessed (Slade, Grienenberger, Bernbach, Levy, & Locker, 2004) showing that PDI and AAI scores are positively correlated and PDI is a suitable tool to measure reflective functioning in parents. Mothers who are able to narrate their own childhood attachment relationships with their parents more coherently are most likely to make sense of their children's mental experiences. The second part of the study regarding the intergenerational transmission of attachment also showed that mothers who can make sense of their children's experiences have most likely secure children.

Child Reflective Functioning Scale (CRFS: Target, Oandasan, & Ensink, 2001), on the other hand, was developed to assess reflective functioning (RF) or mentalization in middle childhood. Similar to the PDI developed from the AAI, the Child Attachment Interview (CAI; Shmueli-Goetz, 2014) made it possible to assess RF in children. Children's descriptions of themselves and their attachment relationships provided with the indicators of mentalization regarding self and attachment figures. Although it is possible to assess RF or mentalization with this scale in the middle childhood, it is hard to apply it to younger children. While interview-based assessments are more applicable to older children and adults, especially younger children are required to make play based assessments. This need brings about various kinds of tools to assess mentalization skills in children.

While for younger children play-based assessments are more suitable, measures used in the research and intended to see the capacity to

mentalize mostly focused on measuring the theory of mind, the mental state language (Bekar, Steele, & Steele, 2014; Brown, Donelan Mc-Call, & Dunn, 1996; Dyer, Shatz, & Wellman, 2000; Furrow, Moore, Davidge & Chiasson, 1992; Hughes & Dunn, 1997;Meins, et al., 2002; Shatz, Wellman, & Silber, 1983; Youngblade and Dunn, 1995) and emotional understanding such as affective labeling and affective perspective taking (Brown et al., 1996; Youngblade & Dunn 1995; Hughes & Dunn, 1997).

Cognitive aspect of mentalization is the most widely studied aspect in these assessments. Theory of Mind (ToM; Premack & Woodruff, 1978) research mostly focused on the cognitive perspective taking and false belief understanding among preschool age children (Midgley & Vrouva, 2012). These tasks basically provides with the reality-belief distinction as it differentiates the children's knowledge about pretend and psychic equivalence modes (Fonagy& Target, 2000). False belief tasks to see the development of theory of mind in children require children to explain a puppet character's behavior based on a false belief (Wellman &Bartsch, 1988).

However, because only the cognitive aspect of mentalization is inadequate to explain this construct, affective skills in mentalization have also been studied. Affective mentalizing skills, on the other hand, have been operationalized as affective labeling and affective perspective taking (Cutting & Dunn, 1999; Hughes & Dunn, 1998; Youngblade& Dunn, 1995). In affective labeling tasks children are shown four felt faces portraying sad, angry and frightened expressions and expected to identify them. Affective

perspective taking tasks, on the other hand, include different vignettes about animal puppets feeling happiness, sadness, anger or fear, and children are asked to predict what the puppet feels in a particular situation.

Most of the studies assessed mentalization skills through children's mental state language (Shatz et al., 1983) or considering affective and cognitive aspects related to the mental state talk (Bartsch & Wellman, 1995; Bretherton & Beeghly, 1982; Brown & Dunn 1996; Dunn, Brown, Slomkowski, Tesla, &Youngblade, 1991; Hughes & Dunn, 1997; Hughes & Dunn, 1998; Youngblade & Dunn, 1995). Mental state language in relation to cognitive and affective skills, then, provided with a more comprehensive understanding of mentalization skills. Using a revised form of coding system of Gelman and Shatz (1977), these studies focused on mental state language in detail. With this coding system it is possible to identify the contrasives in the speech along with the linguistic preparedness for producing expressions of mental reference. In this system there are seven categories to code including mental state, modulation of assertion, directing the interaction, clarification, expression of desire, and action-memory. Additionally contrasives and initiation were coded. As these categories help identifying mental states referring to the thoughts, memories and knowledge of 'self' and 'other', they also mark the degree of assertion, the direction of interaction, and clarification in the child's and other's utterances.

In one of these studies, children's ability to communicate about mental states was assessed by describing the frequency and function of verbs of mental reference (Shatz, Wellman, & Silber, 1983). Youngblade

and Dunn (1995) additionally measured mental state talk by looking at the frequency of talking about feeling states whether speaker used a feeling term like ‘sad or happy’ or a phrase that connoted a feeling state.

With these studies, it was suggested that earliest uses of mental verbs are not for mental reference, and once children start to talk about mental states, they use these mental state expressions with reference to others along with self (Shatz, Wellman, & Silber, 1983). Brown and colleagues (1996) worked on mental state talks in children’s conversations with friends, siblings and mothers and they found that those children high on the use of mental state talks were most likely performed better in false belief tasks. Including the affective aspect to the cognitive aspect, mental state language correlated to social emotional understanding and theory of mind (Youngblade& Dunn, 1995; Hughes & Dunn, 1998).

Research about mentalization then have been proceeded regarding the relationship between attachment security and mentalization. Meins and colleagues (2002) used mind-related comments coding scheme including comments on mental states, comments on mental processes, reference to level of emotional engagement and comments on attempts to manipulate people’s beliefs to assess mother’s capacity for mind-related talk with their children. They suggested that mother’s ability to treat their children as mental agents and to make appropriate mind-related comments to their children is the basis for the development of security of attachment for the child. Related studies also showed that securely attached children showed better performance in theory of mind tasks (Fonagy et al., 1997, Meins,

Fernyhough, Russell, & Clark-Carter, 1998) proposing that because these children exposed to the early mental state language, they can be aware of and more easily understand mental states of their own and others'.

It was suggested that early parent- child conversations help children making sense of their own and others' mental states especially emotions (Dunn et al, 1991) and desires (Bartsch& Wellman, 1995). Then it turned out to be more helpful if these conversations are more reflective about others and past events (Brown & Dunn, 1992). These findings gave rise to the idea that story books can be an effective way for reflective mental state conversations. So books were examined for mental state talks (Dyer et al., 2000). Dyer and colleagues examined mental state talks in the storybooks in terms of situational irony in the books, pictures conveying mental state information found in corresponding text and mental state terms including emotional and cognitive states, desire and volition, moral evaluation and obligation. The study showed that storybooks are full of references to mental states because they make use of references to characters' thoughts, feelings, or intentions.

Regarding these studies The Coding System for Mental State Talk in Narratives (CSMST) for mental state talks in the narratives of adults and children was developed (Bekar, Steele, & Steele, 2014). This system is applicable to most story like speech of both adults and children and its comprehensive content enables to measure different dimensions in mental state language such as emotion words, cognition words, perception words, physiological and action-based mental state words, mental state-based

causal connections, as well as diversity of mental state talk. In this coding system it is possible to make a differentiation between self and other-oriented mental state talk. The system has been used and validated with a high inter-rater reliability.

1.6 Importance of the Link between the Capacity to Mentalize and Play

Play is a very crucial place for the social, emotional and cognitive development of children and it offers a rich context in which children can gain mastery on many developmental milestones. Bretherton and Beeghly (1989) suggested that pretend play enables the child to gain emotional mastery by providing a safe environment and by offering an experience to play with different characters and emotional activities. Kaugars and Russ (2009) designed a research assessing the pretend play among preschool children considering affect expression and creativity. By looking at the frequency of affect expression, variety of affect categories and quality of fantasies in the pretend play they found that the more the children expressed emotions the more they engaged in the play and the higher the quality of fantasy play was. Galyer and Evans (2001) also explored the children’s emotion regulation skills within the pretend play context. They used McLoyd’s (1980) scale for transformation in object modes and ideational modes for play assessment. They found that the frequency and duration of pretend play is associated with the development of emotion regulation. Their findings showed that the experience of emotional arousal, appraisal and modulation help children learn these and generalize them into real life situations. So they suggested that frequent pretend play with a more

experienced other may be effective in encouraging the children’s emotional development.

Regarding the mentalization in one hand, Leslie (1987) suggested that understanding that someone has a false belief requires the same structure in the brain as in the understanding pretense. Therefore it is proposed that pretense facilitates the development of theory of mind. In attachment research it was suggested that while insecure children engaged less in joint pretend play, securely attached children engaged more because they can better reflect on the mind of the partner in joint pretend play (Meins et al, 1998). Lillard (1993) explained this situation in the way that children can learn from adults in the play to take different point of views so that they can interpret mental states of others. Based on a meta-analytic review Bergen (2002) reported that growing body of evidence supports the connection between cognitive, social and academic development and high-quality pretend play. She noted that because pretend play facilitates the abstract thought and perspective taking, it may also encourage the higher level cognition.

The paradoxical nature of pretense suggested by Bateson (1955) that pretense may encourage children to reflect on fantasy separate from the reality and the inherently social nature of pretend play that enables children ‘decouple’ reality from fantasy (Leslie, 1987) have been seen as helping cognitive states to share (Brown et al 1996). The idea that as pretend play may encourage mental state talk, mental state talk may also stimulate cooperative interaction needed for pretend play directed attention of

research to the role of play in development of mentalization skills of children. Although there are few studies about this, play can be seen as a fertile context for mentalization research (Brown, Donelan-McCall, & Dunn, 1996; Youngblade& Dunn, 1995).

Youngblade and Dunn (1995) studied the connections between pretend play and understanding of other people's feelings and beliefs regarding the mother- sibling relationships. They used observational methods to see the mental state talk in children during their daily activities by looking at their pretend play. They measured pretend play by assessing the theme of the pretend play, the diversity in the unique themes, number of participatory turns, and role playing considering the mental state talks and theory of mind. They showed that pretend play is a facilitator for the expression of inner states. They suggested that for the development of understanding other people's feeling states, early social pretend play has a crucial role considering the quality of relationships with mother and siblings.

Brown and colleagues (1996) worked on mental state talks in children's conversations with friends, siblings and mothers and they found that there is a strong connection between conversations with friends and siblings and use of mental state talks due to the fact that children were more likely to express shared thoughts and ideas in child-child interactions which mean that these interactions were more 'conversational' than the mother-child interactions. Pretend play assessed by Youngblade and Dunn's (1995)

coding system is seen as an enriched area in which mental state terms were used in conversation.

Another study (Hughes & Dunn, 1997) also focused on the relationship between pretend play and mental state talks. Preschoolers were studied for the early friendship and the development of social understanding. False belief tasks were used and mental-state talk and pretend play were coded in this study, as well. The results showed that the more children engaged in pretend play the more frequently they used mental state talk. They discussed this association in Flavell's terms (1974) as the nature of pretense that may facilitate mental state talk because when the child enters into pretend play, it provides the child with the mental state awareness (Harris, 1991). They also suggested that the act of pretending in terms of role play, role enactment, and discussion of pretense may facilitate children's understanding of other's mental states.

Lastly, (Tessier, Normandin, Ensink, & Fonagy, 2016) studied the relationship between trauma, reflective functioning and play in children. Although there was no clear direction in the relationship between mentalization and play in the extent they cause each other, they could go further to make this distinction. By measuring free play using Children's Play Therapy Instrument (CPTI; Kernberg, Chazan, & Normandin, 1998) and mentalization through Children's Reflective Functioning Scale, they suggested that pretend play helps learn to understand mental reality and develops mentalization capacity. Although they found that play predicts later mentalization regarding others, there were no associations between

mentalization regarding self and play. With the finding that play mediates the relationship between trauma and later mentalization, they concluded that play therapy with the presence of therapist who has an interest in the child’s mental world, can provide with an opportunity to restore the ability to play and mentalization.

1.7 Assessment of Play

As related to the relationship between pretend play and a variety of developmental outcomes, different tools have been used for the assessment of children using play (Gitlin-Weiner, Sandgrund, & Schaefer, 2000). While these measures mostly focus on the assessment of the cognitive, affective and language development, they are not very suitable to apply to psychotherapy process. Although there is not much assessment tools to measure children’s play activity in psychotherapy, Play Therapy Observation Instrument (PTOI; Howe & Silvern, 1981), the NOVA Assessment of Psychotherapy (NAP; Faust & Burns, 1991), and the Children’s Play Therapy Instrument (CPTI; Kernberg, Chazan & Normandin, 1998) can be seen as comprehensive assessment tools for psychotherapy .

Howe and Silvern (1981) developed an instrument for the behavioral observation of children during play therapy and they described four dimensions of children’s functioning during play therapy stated as *emotional discomfort, competence in relation to people and things, use of maladaptive coping strategies* and *use of fantasy play to express personal*

issues. These dimensions also have related to subcategories to handle each in detail.

Faust and Burns developed NOVA Assessment of Psychotherapy (NAP; 1991) for the assessment of the quality of interaction between the therapist and child in terms of their social conversation, the questions asked by each of them, cooperative and aggressive behavior, interpretation of feeling and direct responses. It was suggested that this measure can be used to see the process and outcomes of therapeutic play.

As, these measures lack a comprehensive assessment of various forms of both affect and fantasy, Affect-in-Play Scale (APS; Russ & Peterson, 1990) is a standardized measure offering the assessment of affective components and fantasy in play. It is mainly based on the frequency, variety and intensity of affect expression with positive and negative affect units and the quality of fantasy and imagination in terms of organization of play and quality, complexity, novelty and uniqueness of play.

Similar to these instruments, a more comprehensive assessment of play in psychotherapy; the Children's Play Therapy Instrument (CPTI; Kernberg, Chazan & Normandin, 1998) was developed. Children's Play Therapy Instrument (CPTI; Kernberg, Chazan and Normandin, 1998) is a psychodynamically informed measure that aims to assess the structure and narrative of a child's play activity in psychotherapy. Amongst other measures, it is the most comprehensive measure in the categorizing the

children's play activity in treatment based on psychodynamic constructs. The measure evaluates the child's play on different levels starting with descriptive components such as how much of the session is spent in play, how long play activity is maintained and the reasons for ending, the category of the play activity (e.g., gross motor, fantasy, game play, etc.), the child's capacity to initiate and facilitate play, (i.e. the child's autonomy in play), and the sphere of play (where the play takes place). The instrument also assesses the structure of the play in terms of affective components (types of affect expressed in play and affect regulation strategies), cognitive components (how objects and people are represented in play), narrative components (theme of play, relational scenarios of play and use of language), and developmental components (comparison of child's play with the play of other children of the same chronological age, gender, and social level). In the Functional Analysis, the instrument assesses coping and defensive strategies, as well as a rating of the degree of the child's subjective awareness of himself/herself as a player. The CPTI can further be used to understand normal and pathological aspects of play, as well as to derive various types of play patterns that emerge in treatment to track progress.

Of particular importance to this study are CPTI's representational and affective dimensions. Two different categories in the instrument are relevant for measuring representations. The first one pertains to the *level of representations in play*. While a child is playing, he may choose to take on a role, and to be a certain character. He may choose a single role, with no

other characters in play, showing the child's absorption in himself. He may play dyadically needing the other character to complete an aspect of himself. He may also bring in multiple autonomous characters that he directs which is the highest level of role play showing multiple representations in relation with each other. CPTI also allows the researcher to code the types of relations between these characters, such as whether they are alone, whether they depend on another or whether there is recognition of familial roles and dynamics. The highest level of role play, also named *complex roles,* indicates the child's capacity bring multiple roles to the play space that interact with each other, where there is awareness of familial roles and dynamics, and the child can verbalize these characters or think about the minds of different characters in relation to each other, an important precursor of the capacity for mentalization (Fonagy& Target, 1998). In doing this, the child creates narrative structures that represent different relationships.

The affective dimensions assess the kinds of emotions the child brings to his play and his affect regulation strategies. As the child makes sense of these affective experiences symbolically, he can make smoother transitions between affects. With regulation of affects he is able to integrate his subjective world without being threatened by the intensity of affects. As such, he can think about affectively laden internal states in the play space which allows for mentalization.

1.8 The Current Study

Regarding the role of play in the development of mentalization, fantasy play appears to facilitate the integration of experience and regulation of affects. The structure in which children can express their feelings and their subjective experience to create a coherent narrative contributes to understand their own and other's mental worlds (Tessier et al, 2016). At this point therapeutic action can be taken with interventions directed to develop this capacity to help the child to create a coherent sense of self. With a playful manner and the experience of a secure play involving containment, the presence of therapist who reflects on the child's mind and represent it in a way the child can understand and deal with it contributes to the development of a coherent sense of self and a representational world (Fonagy& Target, 1997). The child who can represent his/her own mind through the interaction with other is able to develop to capacity to mentalize. Then this capacity to mentalize underlies the capacities for affect regulation, impulse control, and experiencing self-agency (Fonagy, Target, 1997).

Considering the importance of doing time series analysis to see the change or patterns in a systematic stance while using single case design (McLeod, 2011), in this study we used two single cases in a long-term psychodynamic therapy process to better evaluate individual change in the process (Aldridge, 1994). We implemented quantitative methods and clinical analysis to see both intra-personal differences and inter-personal differences between two cases in the psychotherapy process, while making

it possible to see the detailed description of patterns in this process (Kazdin & Nock, 2003). Through the flexibility single case design offered, we were able to evaluate individual differences and complexities in more detail and to understand change patterns in the clinical activity (Morley, 1996; Angus, Goldman & Mergenthaler, 2008). Regarding our aims in this study, we were able to discuss the detailed framework of therapist- patient relationship and the dynamic relations between various interventions and their effects over time (Nock, Mıchel, & Photos, 2008).

In line with the function of mentalization and the opportunities single case design offered, the present study aimed (1) to test that therapist's use of play-related mental state narrative causes the child's play-related mental state narrative, (2) to test that child's use of play-related mental state narrative causes complex relations and affect modulation in the play and (3) to test that therapist's use of play-related mental state narrative causes complex relations and affect modulation in the child's play over the course of treatment

Chapter 2: Method

2.1 Data

Data for this study was provided by İstanbul Bilgi University Psychotherapy Research Laboratory, established in order to study the psychotherapy processes conducted at İstanbul Bilgi University Psychological Center. This center provides outpatient psychotherapy and professional training for master's level for students in the Clinical Psychology Program.

2.2 Sample

2.2.1. Clients

Cases for the study were selected considering the similarity between their demographics, behavioral problems at the beginning and the number of sessions they took. Both of the children were females and began therapy as a 6-year-old in the first grade with no diagnosis. Both parents of the children were lower-middle-income and married. Both children had internalizing behavior problems.

2.2.2 Presenting Problems, Brief Dynamic Formulation and Treatment Course

For one of the children (RNİ), referral reason was separation anxiety. It was reported that she had difficulty staying at school without her mother, so she did not want to go to school and had nausea before going to school. Mother was reported that they had rarely separated from each other,

and so they were all together most of the time. The birth of RNİ was a surprise for the parents because mother was at the age of 40 when she was pregnant for RNİ. So she emphasized the fear of losing the baby during the pregnancy. In the family there was a chaotic setting at home with the losses and illnesses of father and a brother. So RNİ took psychological help for same referral reason for about one year. Especially the surgery that the father had was reported as influential in RNİ's problems. She was about 4 years old and anxious about her father at the time. It was known that she often warned her father about smoking. While mother was concerned about the child relatively more than the father, father was observed as more detached in the intake sessions.

Mother's fear about losing the baby during the pregnancy possibly caused her to be overly-attached to the baby. The relationship between RNİ and her mother seemed very symbiotic in the sense that they were like merged into one and shared their needs as well as their anxieties. So, as mother had difficulty being separated with her, RNİ got anxious when being separated. When mother needed to go to hospital she used RNİ as to soothe her anxiety and RNİ also needed her mother to soothe her anxiety to stay at school. Especially the chaotic setting of the family with losses and illnesses was seemed to facilitate this symbiotic relationship. Function of the father could have been effective to build a triangular relationship for the RNİ. However, father's illness in this critical time in which RNİ was supposed to internalize the function of the third in the relationship might have caused more anxiety.

Looking at the overall course of RNİ's therapy, she used the play field to work on her issues of separation. In the initial sessions, she started to test the separateness of her mind from the therapist's by using games such as "Guess what's on my mind?" and "Guess who?". As she found a therapist who was willing to engage in this kind of play but also emphasize the uniqueness of her mind, she started to form a separate identity. As expected, these attempts at separation also came with intense fears and anxiety reflecting the possibility of not being fully protected in case of separation. These fears were contained by the therapist in games such as with manipulation of sand or role plays with play dolls over the theme of danger by interventions such as commenting on the mental content and mental process of the child, or verbalization of intentions. Eventually, she also started to show curiosity about the therapist's internal world and her relationship with other children which were all positive prognostic signs that she formed an internal representation of the therapist who has separate relations. At the end of the therapy she was able to create a more differentiated identity without experiencing a huge threat to her sense of self and to modulate her affects.

For the other child (CG) referral reason was depressive mood. Her problems were similar to RNİ in separating from parents and complaint of enuresis at school. It was reported that she was unhappy, could not learn to read, and did not want to go to school. She also had a past psychological help for 6 months for the same referral reason. About CG it was known that she had a chaotic relationship history. After CG was born, parents had

marital conflict and mother was preoccupied with these conflicts. Mother was blaming the father in these issues. Also, CG was reported as witnessing these conflicts. Due to this situation among the parents, mother and father of CG slept separately and CG slept with her mother for a while. Along with the conflicted parental relationship, CG experienced several changes of caregivers and day care centers. Her parents were observed as insufficient in problem solving and insight.

The preoccupation of the mother reminded the possibility of that CG was not able to see her own mind reflected enough in the mind of mother. Along with this mismatch, CG witnessed and experienced the marital conflict between her parents and also she experienced caregiving relationships as uncontaining due to the temporary changes in the caregivers and caregiving centers. It was proposed that CG identified with her mother and she started to use problem solving strategies she observed in the mother such as projecting bad things to others or blaming others. While problems of enuresis and constipation from the early years indicated anal phase conflicts, need for containment and closeness also thought to be related to be uncontained in a conflicted family setting.

CG's course of therapy characteristically showed a considerable amount of anger and anxiety most related to fears of being inadequate or a loser. In order to defend against this anxiety, she denied that these were feelings belonging to her and instead frequently attributed them to the therapist, confusing the boundary between their separate identities in games such as monopoly or role plays in which she controlled and manipulated

everything. She felt endangered when other had thoughts separate from hers as this brought fears of not being contained. Therapist in such plays functioned to contain all projections and tolerate these feelings by giving them back to the child in a more modulated manner in pretend mode. Through the process, CG started to metabolize these feelings not as concrete realities but as states belonging to her own individual world that she can regulate. However, it was also observed that CG was delayed in her progress compared to RNI who showed significant symptomatic improvement whereas CG did not. Even though her therapy ended at the end of one year, she still needed the therapeutic space to work out the boundary between her internal states and minds of others.

Symptoms and problem behaviors of the children was evaluated with Child Behavior Checklist (CBCL; Achenbach, 1991) at intake and at the end of the psychotherapy. The Child Behavior Checklist (CBCL; Achenbach, 1991) is a widely used measure to identify problematic behaviors in children between the ages of 4 and 18 on a clinical level by the ratings of parents or primary caregivers. CBCL helps identify 8 syndromes that are Anxious/Depressed, Withdrawn/ Depressed, Somatic Complaints, Social Problems, Thought Problems, Attention Problems, Rule Breaking Behavior, Aggressive Behavior which are categorized as internalizing group including Anxious/Depressed, Withdrawn/Depressed, and Somatic Complaints; and externalizing group which consist of Rule Breaking Behavior and Aggressive Behavior. Along with the externalizing and internalizing group scores here is also a total score obtained from all

problem items. T-scores based on a clinical population provide with the cut-off points for borderline and clinical levels. For the translation back translation, bilingual retest method, and pretest studies were used (Erol & Simsek, 2000). The test–retest reliability of the Turkish form was .84 for the Total Problems, and the internal consistency was .88 (Erol, Arslan, & Akcakin, 1995; Erol & Simsek, 2000). Global Assessment of Functioning (GAF) also was applied to assess psychosocial functioning. GAF is rated on a scale from 0 to 100, with a higher score indicating a higher level of functioning. GAF scores were determined by clinicians.

Through Reliable Change Index (RCI; Jacobson & Truax, 1991) change in the clients' symptoms and behaviors reported in the CBCL was evaluated. RCI is a statistic that we use to examine whether a change in an individual's score before and after psychotherapy process is statistically significant or not. RCI is calculated by dividing the change in the scores of the client by the standard error of the difference. If the RCI is 1.96 or greater, then the change is statistically significant, if it is less than 1.96 it is not statistically significant. At this point 1.96 equates to the 95% confidence interval.

For RNİ, Reliable Change Index scores were greater than 1.96 for CBCL (Parent) Total Competence/ Stress Problems (RCI=3,12), CBCL (Parent) Internalizing Behaviors (RCI=3,57), and CBCL (Parent) Total (RCI=3,20). However, for CG Reliable Change Index scores was less than 1.96 for the same categories with scores of RCI=1,56; RCI=-0,35; RCI=1,02, respectively (see Table 1). This showed that while for RNİ there

was a clinically significant change in the reported symptoms over the course of the psychotherapy process, CG did not show a clinically significant change in the symptoms.

Table 1

Reliable Change Indices of RNİ and CG

	Pre-Treatment	**Termination**	**RCI**
RNİ			
CBCL Total Competence/Stress Problems	**39**	51	3,13*
CBCL Internalizing Behaviors	**63**	46	3,57*
CBCL Total problems	56	38	3,21*
CG			
CBCL Total Competence/Stress Problems	**28**	**33**	1,56
CBCL Internalizing Behaviors	**67**	**68**	-0,36
CBCL Total problems	**62**	59	1,03

Note: Bolded scores indicate respectively borderline and clinically significant scores.

**RCI significant*

CBCL = Child Behavior Checklist; CGAS = Children's Global Assessment Scale, RCI=Reliable change index.

2.2.3 Therapists

Therapists who took part in this study were second year clinical psychology master students enrolled in the same program and participating in weekly psychotherapy supervision by different experienced child clinical psychologists. Both of the therapists were female, one of them was 25, other

one was 27 years old. Both of them had same experience level for psychotherapy with children.

2.3 Setting and Treatment

During the therapy process, participants went through an extensive evaluation at intake, with repeated assessments in termination, including the assessment of problem behaviors, and psychosocial functioning. In intake sessions and at the termination parents were given Child Behavior Checklist to rate the child's current problem behaviors, then their ratings were calculated. Similar to the application of CBCL, considering the child's functioning in the initial evaluation and at the termination, therapist rated on the Global Assessment of Functioning. Children's assent and their parents' signed informed consent were obtained before videotaping the sessions.

Participants attended weekly 45-min sessions. Treatments were conducted in the clinic playroom, which was filled with a large number of toys suitable for play therapy with children. Treatments were psychodynamic and child-oriented. In general, interventions were mostly directed to provide a safe environment by standard rules in the playroom and by introducing structure. Therapists' interventions were mostly facilitative and supportive; they tried to facilitate the play activity by mirroring the child's actions, feelings or thoughts, making comments and joining the play. General approach by the therapist is to accept child's own regulation profile and to attune it in the same level. Therapists mostly

named or described children's emotional experiences to give reality value to them.

2.4 Measures

2.4.1 Children's Play Therapy Instrument

Children's Play Therapy Instrument (CPTI; Kernberg, et al., 1998) is a comprehensive psychodynamic-oriented measure to assess play activity in psychotherapy with children. CPTI provides to describe and analyze a child's play activity at different levels.

The first level is the segmentation of the activity. In this level child's activity is categorized as non-play, pre-play, play or interruption. Non-play activity includes a variety of activities or behaviors of the child outside the realm of the play activity. Pre-play activity refers to the child's activities for 'setting the stage' for the play. Play interruption can be defined as any cessation in play activity such as going to bathroom. Play activity, on the other hand, is being engaged in a playful activity which can be identified by an expression of intent or specific affects with actions indicating initiative. Focused concentration and use of toy objects or the physical surroundings also refer to indicators of play activity.

After the segmentation of child's activity, only play segments are rated. Dimensional Analysis examines the specified play segments in three dimensions. These dimensions are Descriptive, Structural and Functional. An outline of Dimensional Analysis is shown in Table 2. Each dimension

has subscales and these scales are rated using a 5-point Likert scale (5 shows Most Characteristic and 1 shows No Evidence).

Table2

Dimensional Analysis of Play Activity

DESCRIPTIVE ANALYSIS
Category of the Play Activity: *Sensory Activity, Exploratory Activity, Problem-Solving, Fantasy, Game Play, Art*
Script Description of the Play Activity: *Initiation of Play, Facilitation of Play, Inhibition of Play, Ending of Play*
Sphere of the Play Activity: *Autosphere, Microsphere, Macrosphere*
STRUCTURAL ANALYSIS
Affective Components of the Play Activity - Child's Affective Modulation: *Hedonic Tone, Spectrum of Affects, Regulation of Affect, Transition between Affects, Appropriateness of Affect to Content* - Affects Expressed by the Child: *Anger, Anxiety, Fear, Boredom, Pleasure, Sadness, Shame, Guilt*
Cognitive Components of the Play Activity - Level of Representation: *Complex Roles, Dyadic Roles, Solitary Roles* - Stability of Representations: *Stable/Fluid Transformations, Voluntary/Involuntary Transformations* - Style of Representation: *Realistic, Magical, Bizarre* - Use of Play Object: *Realistic, Substitution, Sensory*
Narrative Components of the Play Activity -Play Themes: *Aggression, Attachment (Nurture, Separation), Body, Cleaning, Competition, Construction / Destruction, Danger / Protection ,Death, Rules, Sex / Reproduction and Torture* - Level of Relationship Portrayed: *Self, Dyadic Relations, Triadic Relations, Oedipal Relations* -Quality of Relationship among Characters: *Autonomous, Parallel, Dependent, Twinning, Malevolent Control, Destruction and Annihilation* - Use of Language by the Child: *Silence, Sounds, Verbalization of Roles, Talking about the Play, Talking about Something Other than the Play, Talking about the Meaning of Play*
DEVELOPMENTAL ANALYSIS
Social Level of the Play Activity*: Isolated, Play Alone, Parallel Play, Reciprocal Play, Cooperative Play*
FUNCTIONAL ANALYSIS
Coping and Defensive Strategies *(Cluster 1: Adaptive, Cluster 2: Conflicted, Cluster3:Polarized, Cluster 4:Extreme Anxiety)*
Child's Awareness of Himself As Player

Descriptive analysis consists of category of play activity, script description, and sphere of the play activity components.

1. Category of play activity indicates the type of play activity which can be gross motor activity, exploration, manipulation, fantasy, game play, and art. Two most characteristic activities are selected as representative.
2. Script description component helps identify the contribution of child to the unfolding of the play by describing how the play is initiated, how it is sustained and how it ends.
3. Sphere of the play activity component looks at the spatial realm of the play as autosphere, microsphere, and macrosphere.

Structural analysis of the play consists of four components that combine to produce a play scene.

1. Affective component indicates the types, range, regulation and modulation of emotions brought by the child to the play activity. Ratings of affective analysis consist of Overall Hedonic Tone, Spectrum of Affects, Affect Regulation, Affective Transitions, and Appropriateness of the Affective Tone). In addition, eight types of emotions are coded.
2. Cognitive component looks at the level of role play in terms of representation as complex (more than two roles), dyadic (two roles that complement each other) and solitary (one role); stability of representation as stable, fluid or no transformation;

and type of transformation as voluntary, involuntary and mixed. Along with the representations, use of play object (realistic use of play object, substitution of play object and using object as sensory input), and the style of representation (realistic, magical and bizarre) are coded.

3. Narrative component looks at the theme of the play, the quality of relationship, and the use of the language in the play. While rating the theme of the play, rather than rating all themes whether they are absent or present as in the original version, two representative themes are selected among all themes which are Aggression, Attachment (Nurture, Separation, Body, Cleaning, Competition, Construction / Destruction, Danger / Protection , Death, Rules, Sex / Reproduction and Torture. The level of relationship between characters is also coded as Self (one character), Dyadic (two dependent characters), Triadic (several characters), Oedipal (several characters where there is awareness of difference in generations, difference in sex, etc.). Two most representative items for quality of relationship are chosen from autonomous, parallel, dependent, twinning, malevolent control, destruction and annihilation. Silence, Sounds/Utterances, Verbalization of Roles, Talking about Play/Describing the Play, Talking About the Meaning of Play, Talking about Something Other than Play items are also indicators of play narrative used by the child during the play.

4. Developmental component compares child’s play activity with the play of other children in terms of chronological age, gender, and social level. In this study we included only the social level because other developmental components were reported to have reliability problems related to the construct definition (Kernberg, Chazan, &Normandin, 1998). Social level of play indicates the level of interaction between child and the therapist as Isolated Play, Playing Alone, Parallel Play, Reciprocal Play and Cooperative Play.

Lastly, functional analysis of play activity is to assess the child’s coping/defensive mechanisms and child’s awareness of himself as a player.

1. Coping and defensive strategies are categorized as Defense Cluster 1 (Adaptive, i.e. adaptation, problem-solving, sublimation, humor), Defense Cluster 2 (Conflicted, i.e. intellectualization, doing and undoing, somatization, avoidance, Defense Cluster 3 (Polarized, i.e. splitting, projective identification, omnipotent control), Defense Cluster 4 (Extreme Anxiety, i.e. dispersal, fusion, dedifferentiation, autistic encapsulation, freezing).
2. Child’s awareness of himself as player indicates the child’s level of awareness of being in a state of play.

A reliability study done by Kernberg and colleagues (1998) found that reliability rate for the Segmentation of Play Activity is 0.72, and

interrater reliability for the Dimensional analysis ranged from acceptable to excellent (ICC = 0.52 - 0.89) and also for nominal variables of the scale, which involve play categories and themes (Kappa = 0.42 - 1.00).

In Turkey CPTI was translated and back translated by Sibel Halfon. The language and statement clarity were evaluated. The Interclass Correlation Coefficient (ICC) for ordinal variables ranged from good to excellent (ICC = 0.78 - 0.89) and likewise for the nominal variables of the scale involving themes of play (Kappa = 0.84 - 1.00)

An Exploratory Factor Analysis was computed for CPTI variables (Halfon, Çavdar, & Akırmak, 2015). Factor analysis deduced 5-factor solutions found to be statistically and theoretically more meaningful. (See Table3 for factor loadings and Table4 for factor structures). The internal consistencies for all factors were satisfactory.

Table 3

Cronbach Alpha Coefficients and Descriptive Statistics for Each Factor in CPTI.

	Number of Items	Cronbach Alpha	Mean	SD
F1: Isolated Relations	5	,87	1,78	0,86
F2: Complex Relations	4	,72	1,61	0,72
F3: Affect Modulation	5	,74	3,36	0,50
F4: Play Disorganization	6	,73	1,56	0,56
F5: Play Engagement	3	,63	4,02	0,59

Table4

Factor Structures of CPTI Variables

Factor	Variables
Factor1:Isolated Relations	Play Alone Solitary Roles Single Character Silence Reciprocal Play
Factor2: Complex Relations	Complex Roles Oedipal Relations Verbalizations of Roles Triadic Relations
Factor3: Affect Modulation	Awareness of Being in Play Defense Cluster1 Affect Transitions Affect Appropriateness Affect Regulation
Factor4: Play Disorganization	Magical Representations Realistic Representations Defense Cluster 4 Bizarre Representations Defense Cluster 3 Transformation of Roles
Factor5: Play Engagement	Inhibition of Play Hedonic Tone Facilitation of Play

Factor1: "Isolated Relations" shows the level of isolation of the child in the play; the child may just be with himself or there may be two characters in the play in a reciprocal relationship. While Factor1 is more of an earlier developmental stage, Factor 2 "Complex Relations" is developmentally more advanced form of relating. This factor represents the ability of the child to engage in a play in which there are more than two characters. These characters role definitions in play are verbalized by the child.Factor3 "Affect Modulation" reflects the child's capacity to modulate and regulate different affect states, to make transitions between them and

make use of more adaptive defenses such as problem solving rather than interrupting the play with abrupt transitions in the play.Factor4 “Play Disorganization” reflects the representation style of the child in the play and the extent in which the child refers to use primitive defenses. Factor5 “Play Engagement” shows how much engaged the child in the play by facilitating the play. Overall hedonic tone of the child and inhibition during play is also indicators of engagement in the play activity.

2.4.2 The Coding System for Mental State Talk in Narratives

The Coding System for Mental State Talk in Narratives (CSMST) was developed (Bekar, Steele, & Steele, 2014) to assess mental state talks in the narratives of adults and children. It was originally based on a measure derived from the analysis of ‘the Frog Story’ which has a wordless book providing opportunities to talk about the mental states of characters in addition to an attachment/separation theme at its conclusion. Originally mother and child are asked to tell a story by looking at the pictures.

For the analysis, narratives are transcribed. The narrative of the child and mother is analyzed separately by the manual.. Manual includes word counts for characters’ emotions (e.g. happy, sad, worried), cognitions (e.g. want, believe, think), perceptions (e. g. look, watch, hear), physiological states (e.g. to be sick, to be asleep, hurt), and mental state related actions which explicitly imply with cognitions, emotions or perceptions (e.g. hide, follow, try). These words are coded regarding the type of the words. This coding is done for the narrative related to the play

characters, to the narrator itself and to the listener. The number of referrals made by child and mother to the 'self' and to the listener's mental state is coded as 'self- related mental talk' and 'other-related mental talk'. Except from these word counts there is a sum of all counts which implies to mental state talks in the narratives. Additionally causal connections and uniqueness of the mental state words are counted. In the original analysis of mental state narrative for the Frog Story, there is a resolution part in which mother's resolution for the story is coded. The system has been used and validated with a high inter-rater reliability (.90; Bekar, 2014)

For this study, the manual for the analysis of mental state narratives was used but it required some modifications due to the differences in the setting and in practice. First of all the manual was used to assess mental state narratives in the psychotherapy session with the child and the therapist. Because the Frog Story was not used in the sessions, resolution part in the Frog Story assessment was also excluded. Rather than the story narrative, narratives in the sessions of the play segments which were specified during the CPTI codings, were coded. While pretend play was coded as same as the mental state narratives for play characters in the story, self and listener referrals between child and therapist were coded similarly as self- related mental state talk and other-related mental talk.

In the manual, word variance was restricted due to the fact that in the narratives of the story there was a limited frame of word diversity drawn by the pictures of the book. However in the therapy sessions children are engaged in a wide range of play activities and this required expanding the

word diversity in the manual. Therefore some subjunctions were made after discussions in the supervision. After training, certain amount of psychotherapy session transcriptions (including mother-child and father-child sessions) were coded by a group of trained students, and an inter-rater reliability of (.91) was reached for all categories of assessments. When needed, meetings with the supervisor were arranged or peer supervision was provided for the disagreements.

2.5 Procedure

In the very beginning of the psychotherapy, parents were informed about the research studies at the center. After taking their informed consent, they were asked for completing CBCL forms. After assessment sessions, therapists filled the intake forms of children and gave a Global Functioning Scale score for the children. At the end of the treatment, while parents rated on the CBCL regarding the child's current behaviors, therapists also gave a new score for the general functioning of the child. From their reports, change in the problem behaviors of the child was calculated through RCI.

Beginning from the assessment sessions, video or audio records of the sessions were taken. Sessions for the cases were recorded, then video and audio recordings of the cases were transcribed. During the treatment RNİ attended 41 sessions and CG attended 42 sessions. Number of sessions recorded was 23 for RNİ and 17 for CG. Sessions were mostly from the mid-phase to the end of the therapy process including 1 evaluation session for RNİ and 3 evaluation sessions for CG. Using the CPTI, the sessions

were segmented. The number of segments for one of the children (RNİ) is 128and for the other one (CG) is 97 in total. These segments were separated into four categories: Pre-play, Play Activity, Non-play, and Play Interruption.

Play segments were coded both for CPTI and for CSMST. While the factors were used in the analysis for CPTI, for mental state narrative, play-related mental state words were summed and composite scores for therapists and children were computed. Through these scores of CPTI and CSMST, Granger Causality Test was examined for predictive causal relationship between play factors and mentalization factors for both child and therapist. Granger Causality Test is a method that helps identify whether one time series is useful in estimating another. But it is assumed as predictive causality rather than 'true causality' because it does not account for latent confounding effects (Eichler, 2012). Granger causality test provides information about whether a particular variable can determine the future variables of another variable for a specified lag value.

Chapter 3: Results

3.1 Data Analysis

Descriptive statistics for children's and therapists' use of mental state words in play segments are indicated in Tables 5, showing means and standard deviations.

Table 5

Descriptive Statistics for Children's and Therapists' Use of Mental State Words

	For children		For therapists	
	Mean	SD	Mean	SD
Play-Related				
Emotion words	,81	2,30	1,65	3,61
Positive emotion unique words	,27	,65	,36	,72
Negative emotion unique words	,14	,59	,41	,91
Emotion causal words	0,0	0,0	,14	,52
Cognition words	1,18	4,32	1,40	3,41
Cognition unique words	,45	,95	,67	1,20
Cognition causal words	0,0	0,0	,01	,13
Perception words	,92	2,02	,94	2,09
Perception unique words	,49	,92	,47	,79
Perception causal words	,03	,18	,01	,13
Physiological words	1,01	2,37	1,69	3,67
Physiological unique words	,65	1,33	,80	1,45
Physiological causal words	,03	,18	,07	,32
Action-based words	1,92	3,35	3,30	4,31
Action-based unique words	1,50	2,54	2,05	2,57
Action-based casual words	,03	,18	,16	,46

Table 5 (cont.)

Descriptive Statistics for Children's and Therapists' Use of Mental State Words

	For children		For therapists	
	Mean	SD	Mean	SD
Self-Related				
Emotion words	,61	1,02	,29	,73
Cognition words	2,58	3,49	2,54	3,98
Perception words	,98	1,42	,74	,08
Physiological words	,12	,33	,07	,42
Action-based words	1,94	3,92	1,00	1,57
Self-related unique words	3,67	3,22	2,90	2,58
Self-related causal words	,07	,32	,05	,22
Other-Related				
Emotion words	,29	1,30	2,10	3,21
Cognition words	1,63	3,02	10,27	8,60
Perception words	2,83	7,02	3,03	4,21
Physiological words	,09	,34	,23	,66
Action-based words	1,21	2,54	3,74	4,89
Other-related unique words	2,61	3,78	8,14	6,18
Other-related causal words	,07	,32	,21	,87
Total words	19,03	19,27	34,10	26,66
Total unique words	,29	,68	,69	1,84
Total causal words	8,94	7,50	14,49	8,26
Total Self-Related words	6,25	6,90	4,78	6,03
Total Other-Related words	6,07	9,94	19,41	17,18

Because in this study we were concerned with the play-related use of mental state narrative of therapists and children in relation with complex relations and affect modulation in play, we used only play-related mental state words by taking the sums of play-related emotion, cognition, perception, physiological and action-based words for both therapists and children. In this way we calculated play-related mental state narrative scores for therapists and children. For the next analysis, these scores were used.

Play-Related Mental State Narrative consisted of child's emotion(e.g. 'she was *happy*', 'he felt *sad*' or as a play character 'I am *worried*'), cognition (e.g. 'she *knew* it', 'he *thought* that…' or as a play character 'I *guess*..'), perception(e.g. 'she *saw* it, 'he *heard* that' or as a play character 'I *watched* it'), physiological (e.g. 'she *gets hungry'*, 'he is *asleep*' or as a play character 'I *had cold'*) and action-based (e.g. 'she *waits for* him', 'he *tries* to…' or as a play character 'I was *crying*') mental state words regarding the play characters.

3.2 Granger Causality Test

Granger Causality tests were applied to Complex Relations and Affect Modulation factors of CPTI, play-related mental state narrative of children and play-related mental state narrative of therapists. For Granger Causality test, first of all Unit root and cointegration assumptions were tested for each cases' variables. Unit root test is needed to continue with the granger causality test because it shows whether the variables in the regression model are stationary or not. If the variables are not stationary then series can strongly influence its properties then the standard assumptions for asymptotic analysis will not be valid. Augmented Dickey-Fuller Test yielded all variables has not a unit root. In other words, all variables are stationary. Table 6 showed the t-values and probability values for two cases' variables.

Table 6

Statistical Values of Unit Root Test

	CG		RNİ	
	t-Statistic	Prob.	t-Statistic	Prob.
Complex Relations	-5.266	.0001	-7.531	.0000
Affect Modulation	-3.859	.0047	-6.316	.0000
Play-related mental state talk for child	-2.669	.0872	-8.572	.0000
Play-related mental state talk for therapist	-4.132	.0022	-7.487	.0000

Exogenous: Constant
Lag Length: 1 (Automatic – based on AIC, maxlag=1)

Augmented Dickey-Fuller Test yielded play-related mental state talk variable has a unit root. In other words, it was not stationary. Therefore, we converted our variable into stationary through First Difference. After first differences, Augmented Dickey-Fuller Test showed that our variable was stationary (t=-5.359, p<.001).

After meeting the assumption of Unit root, Johansen Cointegration Test with linear deterministic trend assumption was yielded to see variables have long-run associations among them or not. Johansen Cointegration Test also was conducted for both cases singularly. For the case of CG Johansen Cointegration Test showed that there were at least 4cointegrated equations (See Table7).

Table 7

Cointegration test values for CG

Hypothesized 0.05 No. Of CE(s)	Eigen Value	Trace Statistic	Critical Value	Prob.**
None*	0.493081	81.35103	47.85613	0.0000
At most1*	0.426554	50.77786	29.79707	0.0001
At most2	0.320267	25.75377	15.49471	0.0010
At most3*	0.169935	8.381288	3.841466	0.0038

Trace test indicates 4 cointegrating eng(s) at the 0.05 level
**denotes rejection of the hypothesis at the 0.05 level*
***MacKinnon-Haug-Michelis (1999) p-value*

For the case of RNİ Johansen Cointegration Test showed that there were at least 4cointegrated equations, as well (see Table 8).

Table 8

Cointegration Test Values for RNİ

Hypothesized 0.05 No. Of CE(s)	Eigen Value	Trace Statistic	Critical Value	Prob.**
None*	0.540284	103.6456	47.85613	0.0000
At most1*	0.404308	60.12536	29.79707	0.0000
At most2*	0.282525	31.11556	15.49471	0.0001
At most3*	0.200380	12.52263	3.841466	0.0004

Trace test indicates 4cointegrating eng(s) at the 0.05 level
**denotes rejection of the hypothesis at the 0.05 level*
***MacKinnon-Haug-Michelis (1999) p-values*

Following these results, if two variables are co-integrated, then there is surely at least one-way causal relationship among the study variables. Thus, granger causalities among the study variables were explored in detail.

Vector Autoregression (VAR) was used as a means of conducting granger causality test. VAR was used to see the linear interdependencies among multiple time series. In order to do this, first, optimal lag number for time series should be estimated. Akaike Information Criteria (AIC) was

used to determine optimal lag for the time series. To find optimal lag solution for the time-series used in this study, we used a stepwise strategy to get the lowest level of AIC. Because we found significant cointegration among the variables, we used vector error correction for VAR specification.

Vector Autoregression Estimates yielded that 2-lag would be optimal. For the 1-lag solution AIC= 15.808, for the 2-lag solution AIC = 15.992, and for the 3-lag solution AIC=16.471. As a result, 2-lag solution was selected for the further analyses for RNİ. Similar examination was done for the optimal lag selection of CG. For the 1-lag solution AIC=22.443, for the 2-lag solution AIC = 22.321, and for the 3-lag solution AIC=22.450. So, Granger causality is performed by fitting a VAR model with 2 time lags for both cases. At this point, VAR parameters are predictive of Granger causality. When a granger causality was suggested in the results of the analysis, it was considered as a merely an approximation of causality.

Aim1: To see the effect of therapist's use of play-related mental state narrative on the child's ability to mentalize.

Findings for CG: Granger causality test showed that therapist's use of play-related mental state words causes the child' use of play-related mental state narrative ($F(1,47)=6.87$, $p< .05$). When the therapist used emotion, cognition, perception, physiological and action-based mental state words about play characters or as a play character, this causes the child to use more mental state words in the play regarding the play characters.

Findings for RNİ: It was found that therapist's use of play -related mental state words does not cause child's use of play-related mental state talk ($F(1,59)=0.37$, $p>.05$).

Hypothesis 1 was partially confirmed showing for CG therapist's use of play-related mental state narrative caused child's use of play-related mental state narrative whereas for RNİ this hypothesis was not confirmed.

Aim 2: To see the relationship between the child's mentalizing and the capacity to play by looking at the Complex Relations and Affect Modulation

Findings for CG: Child's use of play-related mental state words does not cause Complex Relations ($F(1,47)=0.0409$, $p>.05$), and Affect Modulation ($F(1,47)=2.936$, $p>.05$).

Findings for RNİ: Granger causality test showed that child's play-related use of mental state words caused Affect Modulation ($F(1,59)=4.125$, $p< .05$). On the other hand, child's use of play-related mental state words did not cause Complex Relations ($F(1,59)=0.36$, $p> .05$).

Hypothesis 2 was partially confirmed, as well. Only significant relationship was found for RNİ showing that child's use of play-related mental state narrative caused Affect Modulation.

Aim3: To see the effect of therapist's use of play-related mental state narrative on the child's ability to play determining the CPTI factors.

Findings for CG: It was found that therapist's use of play-related mental state words caused Affect Modulation ($F(1,47)=3.303$, $p<.05$).But, therapist's use of play-related mental state words did not cause Complex Relations ($F(1,47)=0.222$, $p>.05$).

Findings for RNİ: Therapist's use of play related mental state words were found to cause Affect Modulation in the child's play ($F(1,59)=3.528$, $p< .05$). But, therapist's use of play-related mental state words did not cause Complex Relations ($F(1,59)=0.124$, $p>.05$).

Lastly, Hypothesis 3 was confirmed partially showing that therapist's use of play-related mental state narrative caused Affect Modulation for both cases. However, we could not find a significant relationship for Complex Relations in both cases.

In sum, we found that for CG, therapist's use of play-related mental state narrative caused child's play-related mental state narrative and child's affect modulation in the play. For RNİ, on the other hand, we found that therapist's use of play-related mental state narrative and child's use of play related mental state narrative caused affect modulation in the play. Complex relations were found that it was not caused by any particular variables.

3.3 Clinical Analysis

For the analysis of mental state narrative for both children and therapists, it was important to see the types of segment categories and type of plays and themes in the plays along with specific patterns in complex

relations, affect modulation and mental state narrative use. Before analyzing sessions in detail, frequencies for the components of play were taken.

Table9 showed the categories of children's activities. According to Table 6, although the total numbers of segments were different, percentages for categories of segments of both cases were close to each other.

Table 9

Categories of CPTI Segments for CG and RNİ

	CG		RNİ	
	N	%	N	%
Non-play activity	24	24,7	38	29,7
Pre-play activity	23	23,7	25	19,5
Play Activity	47	48,4	59	46,1
Interruption	3	3,1	6	4,7
Total	97	100	128	100

Frequencies for the types of plays were also examined. According to Table10 mostly used types of play for both cases were fantasy and game play.

Table 10

Types of Plays for CG and RNİ

	CG		RNİ	
	N	%	N	%
Gross-motor activity	6	12,8	5	8,5
Exploration	3	6,4	4	6,8
Manipulation	1	2,1	5	8,5
Fantasy	22	46,8	27	45,8
Game play	9	19,1	17	28,8
Art	6	12,8	1	1,7

Themes in fantasy play were also indicated for both cases (see Table11).

Table 11

Themes of Plays in Fantasy Play for CG and RNİ

		N	%
CG			
	Aggression	2	9,1
	Attachment	13	59,1
	Body	1	4,5
	Competition	1	4,5
	Construction/destruction	1	4,5
	Death	1	4,5
	Torture	1	4,5
	Danger/protection	1	9,1
RNİ			
	Aggression	8	29,6
	Attachment	8	29,6
	Competition	3	11,1
	Construction/destruction	4	14,8
	Death	2	7,4
	Danger/protection	2	7,4

It is clear that RNİ and CG were similar in the types of plays and themes they brought up in these plays. They worked on attachment issues which are related to their referral reason, as well, through fantasy play most of the time. However, although both children made use of different types of plays, we saw that RNİ played relatively more game plays than CG and CG focused more on fantasy play.

We investigated the types of plays and themes in these plays because they had a significant value determining the use of play-related mental state narrative. Although they showed similar patterns in the use of type of the play and the themes in these plays, characteristics of their play differed from each other and this was reflected to the content of their play. To better interpret and understand the use of mental state narrative in the play, the z-

scores of play-related mental state words in play segments with fantasy plays by children and therapists were calculated over the composite scores of play-related mental state word counts via SPSS and used for the visual presentation of the data. Segments of fantasy plays were examined particularly regarding the literature and the measure we used, due to the fact that play-related mental state narrative was based on the play characters. Therefore, in order to see the use of play-related mental state narrative, it was meaningful to look at only the plays included fantasy.

We investigated the higher points of the segments to better understand what happened in those plays. While investigating the high points of mental state use, we selected some sections from these segments to show examples of specific patterns we observed for the general of the therapy process.

3.3.1 Play Segments of CG

Play-related mental state narrative of therapist and child in fantasy play was shown in Figure1.

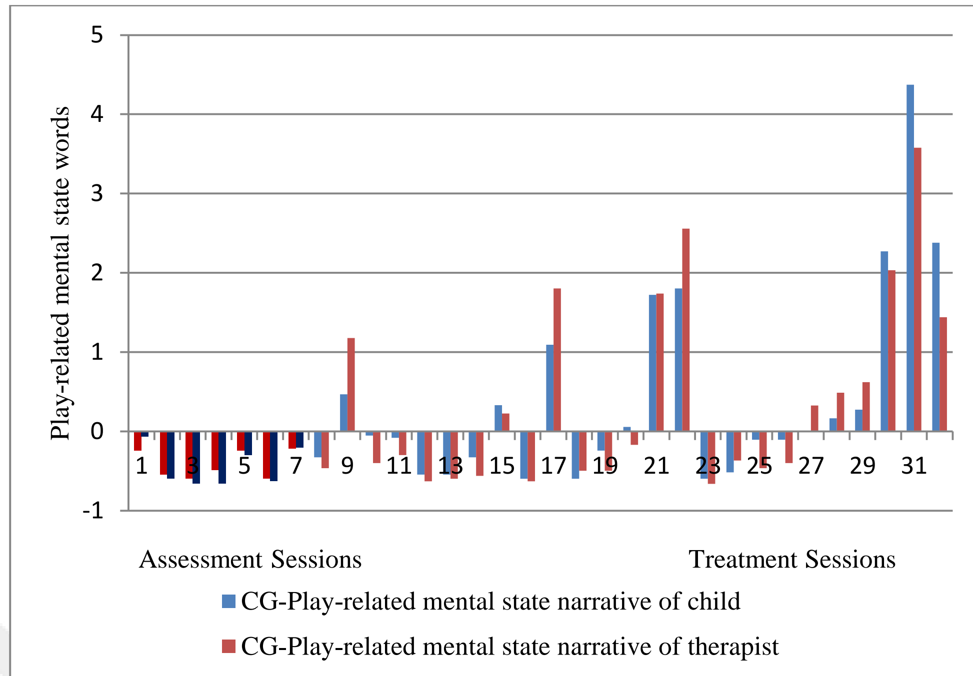

Figure 1. *Play-related mental state narrative of therapist and child for CG in fantasy play.*

In Figure 1, play segments of fantasy plays started with the play segments from assessment sessions and treatment sessions.

According to Figure 1, mental state narrative use of both therapist and child increased over time for CG. Most of the time, therapist's use of mental state narrative in the fantasy play was higher than the child's use and was in synchrony with the child's use. At some points both child's and therapist's use were above the mean. Also by the termination, child's mental state narrative use exceeded the therapist's.

Segment 9 was one of the segments high on the mental state narrative of the therapist and the child. This segment was important in the sense that it indicated some prominent patterns of CG. One of these patterns

was that in role playing, the child directed the therapist about what she was supposed to say and therapist repeated her. Another pattern was that, the child became the character itself rather than narrating a story and narrating the characters. Other pattern was that when she had difficulty controlling her impulses and regulating her emotions, she lost the line between pretend and reality. In this session the child was playing a pretend play in which the therapist was a mother and the child was a thief. The mother lost her daughter because a thief stole her daughter. When the mother found the thief and her daughter, she got angry and started to yell at the thief. At this point we observed that the child had difficulty controlling her impulses and regulate her emotions. Then she started to hit the therapist.

T: No, no help me!

C:Say 'The thief tries to steal my babies'

T: The thief tries to steal my babies!

C: Say 'my little babies'

T: My little babies!

C: (hit the therapist)

T: Ahhh!

C: I am sorry, I have forgotten the rule

T: Yes it was not pretending. Do you remember what our rule was?

C: Do not hit G. (therapist's name)

T: We are not supposed to hurt each other and toys, right?

C: Yes, (started to sing a lullaby). Now speak loudly and say 'The thief stole my babies' but in a normal way. Do not yell, this time.

At this point in the play the child became so involved in her fantasy world and her relationship with reality became tentative. On the other hand, she seemed to be afraid of her aggression because it felt too real. She was not able to regulate her aggression because it was fantasy. However, she realized that she was not supposed to hurt the therapist suddenly. Therapist, by introducing the reality by making the child remember the rules helped the child to deal with both reality and fantasy aspects of her experience.

In the segment 17, child and the therapist were painting. This play indicated the child's one of the characteristics about dealing with intense feelings by projecting them to the other. We observed that for the child there was again two characters; one of them was the therapist who was very clumsy and did not know anything about painting and the other one was the child who knew everything and did everything best.

T: Now I am a little girl who knows nothing? How a little girl would feel when she knows nothing?

C: You painted it wrong!

T: You did not like my painting? ..Are there times that you felt you are not liked as in now?

C: No, I do not.

T: How would someone feel about not being appreciated, you think? Maybe sad or inadequate?

C: No. She should try harder.

T: Him, when one feels inadequate, she must try harder.

C: Yes, she should please the other.

T: People may get tired to please others?

C: Keep your mouth shut and do your work!

T: (With a sad voice) I failed to please you.

C: Yes, because we are doing something important here.

T: We are doing something important, right.

C: (Silence for a second) Well done, you did it nice.

In this play situation, therapist was the child who was clumsy and unable to do good things. Therapist verbalized some feelings and invited the child to think about these feelings. At first, when the therapist asked the child directly the times she felt in this way, CG in a defensive way rejected this. CG did not mention about feelings of inadequacy or sadness but she emphasized trying hard. Regarding the problems she had at school, she could not talk about them. Therapist at this point brought these feelings of failure, inadequacy and sadness up to stage but not through the child. Rather, she verbalized these feelings through a little girl in the play. Because it involved the play character and not the child, it became more

acceptable by the child requiring being less defensive about these threatening feelings. Later on after this talk, the child stated to talk about the things she liked to do in a more calm and comfortable manner rather than previous commanding manner.

By the end sessions, especially in the segments 30, 31, and 32 we observed an increase in the use of play-related mental state narrative. We saw that intense use of mental state words by the child and therapist mostly based on dyadic play settings, especially monopoly in these last sessions. In this game child's feelings of aggression, anxiety and will to win were intense. The more intense her feelings about the play, the harder it was to step back and to be aware that it was just pretend, not real. In this kind of plays their use of mental state words increased. Another general feature of these sessions by the termination sessions was that, although they started a game play, as the affects get more intense and harder to deal with, the child made a transition to fantasy play in which she and the therapist became the pions of the monopoly.

In the segment 30, the child permanently changed the rules, and the therapist stated her confusion about the changing rules. The child ignored her confusion and commented how 'unlucky' the therapist was. She first immediately decided to be the banker who got angry at the therapist when she could not understand what to do and gave her punishments by taking her money. In this kind of a play she had difficulty differentiating the pretend and reality . So, then she decided to be the pion of the game, and made a shift to pretend play as a safer area. She created new characters but the

relationship was always dyadic, because rather than forming an other new character, she transformed herself as the new character. So the relationship was maintained dyadic, they could not go through a triadic relationship. Actually new characters she made up were just new names on the play, and their features stayed still as winners vs. losers or takers vs givers, etc. After a while theme of stealing came to the stage. Therapist commented on the confusion she had, the anger the child had, and her desire to take all the money through the play characters. We observed that there were fluctuations in the child's regulation. Sometimes she became calmer and emphasized it was just a play by saying "now you are taking the money but it is just pretending" or by instructing the therapist about her role by saying "now it is your turn and you must say…". However, at some point she lost the line of pretend play and for example yelled at the therapist by her name. We saw that although she was not in the pretend play, she was not in the reality, as well. At the end of the session, after the play ended, they had a conversation.

"T: How do you think people who do not have so much money feel?

C: Sad, I guess.

T: While we were playing, I thought that money-related issues bother you this week

C: Yes, because my parents did not get what I wanted them to buy

T: They couldn't buy all you want.

C: Kids in the school splurged that they were so rich

T: And you felt bad."

In this pretend play, therapist made use of feelings of play characters and her own during the play and the child's feelings at the end of the session. In this way the therapist took child's perspective and representation seriously and child felt understood. Different from the earlier sessions, in this session we saw that the child could start to talk about her feelings and thoughts. This can be seen as an indicator of the child thinking capacity about her own emotions and thoughts without becoming defensive.

In the last three high points of mental state narrative use in the Figure1, another common pattern was about the interventions of the therapist. In the earlier sessions, therapist's interventions was mostly based on the making a distinction between reality and fantasy and naming the affective experiences over the play characters to regulate child's emotions and impulses. By the termination sessions we saw that in addition to these interventions therapist made more interventions to comment on the child's mental content. While therapist repeated what CG said, she made some additions by describing the play and commented on mental content and processes of play characters and the child. This intervention by the therapist was seen mostly in the last 3 segments. Also in these last sessions we saw that CG started the play activity directly with fantasy play.

Segment 31 included good examples of these situations. In her play CG started directly with fantasy play. In the play there was a mother and her

daughter, as therapist and the child. But the characters made shifts, after a while CG became the child and teacher. But the relationship was generally between only two characters again. In this play a mother tried to save her daughter who was stuck in the school with her friends and teachers. The mother tried hard to reach her daughter and she was very anxious.

C: Now you are trying to wake me up.

T: My dear wake up wake up!

C: What happened? I don’t remember anything.

T: You went through a lot, but you do not remember. Maybe you experienced something you do not want to remember.

C: Ok. Now you should protect yourself.

T: I took myself under protection. There is a big danger outside.

C: I will use snowflakes as my super power. You pretend to be surprised.

T: Wow!

C: Sometimes I can do it with snowflake but sometimes I cannot

T: Sometimes you cannot do it, perhaps you feel inadequate. Maybe you can do it in time

C: But this bad force is so powerful so you will protect me like this.

T: I have to protect you from the danger and from the things threaten you.

In this play situation the child directs the play explicitly in a playful manner. While therapist repeating what she was supposed to say, she also added some comments on the mental content of the child in the play. By verbalizing the prominent themes of the play which were danger and feeling threatened, she showed the child that it was more than protecting each other. Then therapist made a comment on the child's representational world by saying 'You experienced something you do not want to remember'. At this point she both commented on a mental process of the child and she also connected the child's experience of being threatened without making a direct mirroring of this threat or fear. At the end, the child showed her need to be protected by the therapist. This can be seen as that the child still needed to be taken care of by therapist.

To sum up, for CG, although not in all sessions due to the nature of psychotherapy, there were some specific patterns related to her use of mental state narrative, her affect modulation and forming complex relations along with the therapist's interventions. CG mostly made use of fantasy plays during the treatment. Although she played other kinds of plays, in general she added a fantasy dimension or shifted to a fantasy play. CG had difficulty differentiating the pretend and reality and this influenced her ability to modulate affect states. Considering this, therapist's interventions were directed to affect modulation most of the time. They both made use of mental state narrative well in describing and naming cognitive and affective

states. However, towards the ends of the sessions we saw an increase in the comments of mental content and process of the child which was directed to develop mentalized affectivity. Yet, she had difficulty making sense of and understanding representations.

An interesting characteristic of the CG's play was that while playing she was the role player and inside the play character. This tendency, on the other hand, was considered to influence the role of therapist to join the pretend play most of the time rather than being an observer. When we looked at the relational patterns of CG, we observed that even though she brought different characters into the play scene, the relationship between these characters remained dyadic rather than triadic. In other words, the child was able to create more than two characters, but in terms of relating, she could not maintain a relationship with each of the other characters. Rather, she chose two of them and these two characters related to each other. Moreover, by the end sessions she showed a capacity to form different characters.

3.3.2 Play Segments of RNİ

Play-related mental state narrative of therapist and child in fantasy play was shown in Figure2.

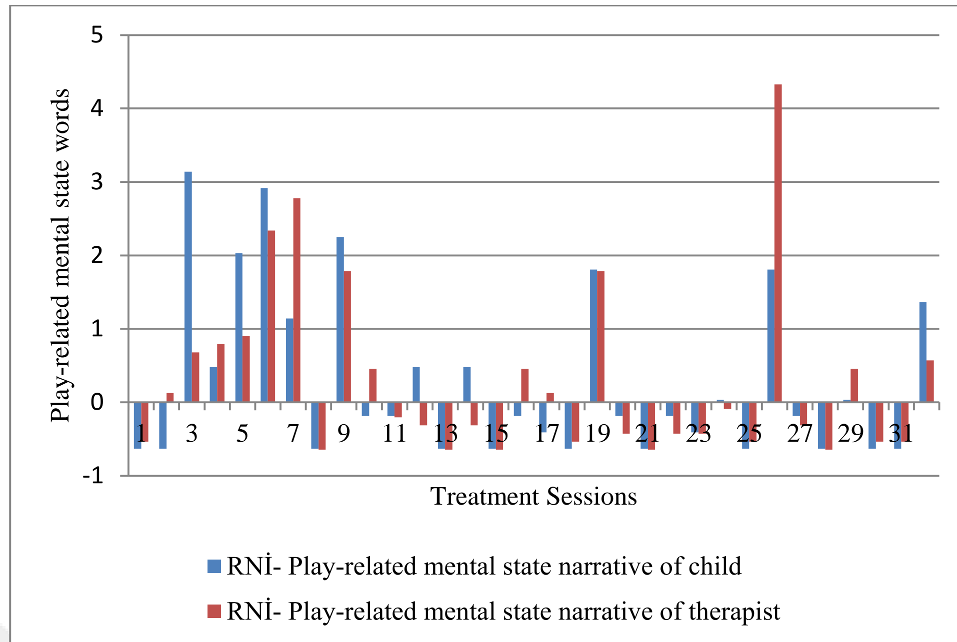

Figure 2. *Play-related mental state narrative of therapist and child for RNİ in fantasy play.*

In Figure2 play segments of fantasy plays included treatment sessions. According to Figure 2, mental state narrative use of both therapist and child was higher in the middle sessions. However, there were still higher points by the end sessions. Most of the time, child's use of mental state narrative in the fantasy play was higher than the therapist's. In general their use of mental state narrative was synchronized. At some points both child's and therapist's use were above the mean. We investigated these high points during the process.

When we looked at the sessions in detail one of the most striking point for the mental state narrative use of therapist was that there were a lot of statements in order for mentalizing the child. However, because these statements did not include the words specific to our coding system, they

were not coded as mental state narrative. There were plenty of examples of this type of use by the therapist.

In the segment 6 we saw that the child's and therapist's mental state narrative was higher, but the child's mental state use was higher than the therapist's. It was a shopping play in which the child was the customer and the therapist was the cashier. The child bought lots of things and while she tried to put things in the basket, she put them in an orderly fashion, like if they tumbled down they would spoil.

T: We are pretending in this play but everything is too realistic.

C: Yes

T: It is like we are really doing shopping. Everything was bought. Apples. Basket is still there, how nice it is a basket that can carry all of these things.

C: Yes, it is.

In her comment related to the basket, therapist actually made a comment on the feeling of containment to strengthen the secondary order representations, rather than commenting directly on the primary affect. By stating the content of the child's mental state in a symbolic way with the child's material, she made a mentalizing intervention which was not counted for the coding.

Another form of this kind of statements can be exemplified as that therapist emphasized the importance of things that the child insistently tried

to do. For example in the segment 9 when the child tried hard to level the sand to make a road, therapist emphasized the importance of the orderly fashion for the child by saying “I think now it is more important to make the road properly than to take the road, like we have forgotten the road.” If the child made something almost obsessively, therapist underlined this outstanding effort because it meant something for the child and therapist tried to focus on the content of the child’s mental state. In the segment 30.6, the child played with sand and tried to divide it into two. In a time when the child was obsessed with the sand therapist said “It is important for the sand to be in the same place at the same time without falling apart.”. This comment was directed to the child’s mental content about containment and separation in a dyadic relationship. Then the child continued silently for a while then said “Well, we can bring the trains now” and was able to play. There were lots of this kind of statements by the therapist which can be exemplified through the sessions.

The next session with high mental state narrative use was the segment7. We saw that RNİ played a game play, with intense attachment related issues. When we looked at the sessions of RNİ in general we saw that there were some kinds of plays that she preferred mostly. She mostly preferred attachment issues, about closeness, containment, leaving a mark in the room in a symbolic way through dyadic plays whether they are game or fantasy play. In general by the termination, in this kind of plays child’s affect states were observed as smoother, she was able to deal with the intensity of these themes with the help of therapist’s comments. But earlier

in the sessions it was more difficult for her to regulate these states and this session had a good example for her mental content about being the only one in the room, so leaving the play or play room for a while caused some anxiety for her. In this segment, while playing monopoly, she stood up and walk around the room.

C: You can continue with the game, I will come back; I am on a trip now. I am an adventurer

T: You are not in the game now, you are not looking at the game but you know that I'm playing.

C: Okay, yes

T: When you come back, the play will be going on. You want to see whether it ended or not. You are on a trip now but, at the same time you are looking here by binoculars. It is important for you to know whether the play goes on.

C: Yes, I am looking there.

T: Yes, with the binoculars you can look here very carefully, and I am still in the game.

C: I need to pee.

In this play situation we observed that the child could not leave the play at all. It was important to know what was going on when she was absent. Therapist emphasized the mental processes by stating her wish to

know and focused on what was important for the child. It was difficult for the child to go on, and she interrupted the play. Later in the therapy process, while playing, something (e.g. some noise or a something changed in the room) attracted the attention of the child and she obsessively wondered who played in this room or in this center before. We observed that child had difficulty regulating her curiosity about what was going on when she was not there. When the child stated her curiosity about others in the center or in the play room when she was gone, they were able to talk about that in a more detailed manner with the help of therapist's mirroring.

In the segment 19 we observed high use of mental state narrative by the child and therapist. In this play she played a fantasy role playing with complex relations. When her plays included complex relations rather than dyadic, there were also some specific patterns. One of the features of this kind of plays was that she preferred to play with characters rather than becoming a play character. So she created play characters and described what was happening in the play in a story narrative. Another feature of these plays was the theme of the plays. She generally brought the themes of danger, aggression, and punishment in her fantasy plays. Her complex plays were relatively shorter than the dyadic ones. This play segment indicated these patterns. In this section of the segment we saw the mentalizing intervention of the therapist over the play characters. Child prepared a setting for a grandmother and grandchildren who were on a train trip with dangers on the way. Child emphasized the unexpected danger awaited for them.

C: They are on this train. But, wait! We should prepare some dangers that they will not expect. Danger before they take the road.

T: There is no road without danger.

C: Yet, all roads are dangerous.

T: There is no dangerless, safe road.

C: It is a little bit scary and grandmother and grandchildren do not know that.

T: Dangers that they have no idea about.

C: They should not have come. What can we do? What is waiting for them is not just this; there will be some other unexpected dangers.

T: They deserved it, and it is an endless danger.

C: Yes, they are bad; they did evil, so they will find their punishments.

T: It is too harsh, every bad thing find a response.

This kind of a conversation went on for a while during the play segment. The child described the play for most of the time, talked about what kind of things would happen to the characters. Main theme was unexpected danger. Then the child made a shift by playing with sand to prepare a setting for the rest of the fantasy play. In this conversation it was seen that therapist used a few mental state words. However, by stating the theme and the content of the child's mental state she made a mentalizing

intervention. It was also seen that the child with the help of mentalizing narrative of the therapist which included explanations for what was in the child's mind by stating her mental content and mental process, so that the child was able to state the cause-effect relationship in the play narrative.

In a similar pretend play in the segment 26, child narrated the play where a train had a terrible accident and the passengers in it were hurt or died. She vocalized the characters and ended the play. Therapist verbalized the content of the play, emphasized the themes and affects in it. Then the child decided to play with bobo doll. By hitting and fighting with the bobo doll, she expressed how relaxing it was to hit bobo doll. She invited the therapist to join her and therapist joined the play. Therapist commented that it was exciting and relaxing to hit the bobo doll after an anxious play. When they stopped, the child said "It was too much fun, I am so relaxed". Although the affects were very intense at this play, she found a safe area to express her anxiety and aggression after an ominous play. So she was able to use play as a means of express her feelings in a convenient way with the therapist who accompanied her in her process.

In the segment 31, use of mental state narrative was high and as in the segment 26, we saw that the child started to find ways of using pretend as an adaptive way of expressing her feelings. In this play, the child tried to set the stage for the play. She tried to level the sand properly, but she could not do it.

T: We want to level it to make the play start, but it is like such kind of an order is not possible

C: Off, Okay then, let’s move, I’m bored with it.

T: You are bored and a little bit angry.

C: Yes, I get angry, so I leave it in this way.

T: You get angry; you could not do it as it was in your mind. But on the other hand, you have started to line the trains.

C: We need a security.

T: A security. Who is the security? From whom he will protect us?

C: No, not us. They are protecting the chateau. Okay, this is so nice.

T: What kind of a security is this?

C: For thieves etc.

T: This chateau needs to be protected. For it to be safe there should be two securities.

In this situation therapist described the behaviors in the play, named affective states, mental content and mental processes of the child. At some point therapist directed the comment from play characters to themselves and said “From whom they will protect us?”. She thought that the need for security is for the child herself. However, the child did not take this comment and continue with the pretend. Such a direct statement for the

intense need of security was unmodulated for the child so she modulated it by staying in the fantasy.

For RNİ, we may conclude that, the use of fantasy play and game play was clearer than CG. She played different kinds of plays in her treatment. Her use of game play was a way of searching a structured area for her mental states. Especially the dyadic nature of game plays and the opportunity for symbolic play they provided enabled RNİ to make shifts between those plays and complex fantasy plays. Both kinds of plays offered her to bring different kinds of themes and affects. She preferred to narrate the play characters in fantasy play different from CG, and this showed variability in their affect modulation and use of mental state narrative along with the role of the therapist. For the case of RNİ therapist was sometimes joined the play and sometimes she was the observer of the play. But most of the time therapist made comments regarding the mental content of the child for the mentalized affectivity, along with interventions based on affect regulation.

Differences in the themes and in the way the children made use of plays as a means of expressing their inner worlds showed both individual differences in their psychotherapy process, as well as the interventions provided by the therapist. Therefore, the effect of therapist's interventions varied for both cases. For CG therapist mental state narrative in the play caused child's use of mental state narrative and the affect modulation, whereas for RNİ therapist's and child's use of mental state narrative caused affect modulation in the play.

Chapter 4: Discussion

The first aim of this study was to examine the relationship between therapist's and child's use of mental state narrative. Particularly therapist's use of play-related mental state narrative was hypothesized to cause the child's play-related mental state narrative during the play therapy process. Second, it was expected to see the relationship between the child's use of mental state narrative and child's capacity to play regarding the child's complex relations and affect modulation. The last objective of the study was to observe that the therapist' play-related mental state narrative causes child's play considering complex relations and affect modulation. It was found that there are individual differences between two cases in terms of use of mental state narrative by the children and the therapists along with the patterns of their play components. For CG who did not showed any clinical change in the symptoms at the end of the therapy, therapist's use of mental state narrative caused both child's use of play related mental state narrative and affect modulation in the play. For RNİ who showed clinical change in the symptoms at the end of the therapy, child's and therapist's use of mental state narrative caused affect modulation. We could not find a relationship for the complex relations.

The prominent point in these results is that although RNİ's use of mental state words caused her affect modulation in the play, CG's use of mental state words did not cause affect modulation. When we considered the clinical change in the symptoms of the two children, these results seemed to be meaningful explaining this difference. We can understand this

difference in the results by looking at the way two children used mental state words in their plays.

When we considered RNİ, we saw that she was using mental state words to differentiate fantasy and reality or the line between self and other, to make sense of and organize her inner experiences. However, CG's use of mental state words was observed as similar to affective labeling in the sense that she tried to verbalize and express her inner experiences over play characters. Although she was able to put her experiences into words adequately, she was not able to link them to her actual experience (Verheugt-Pleiter et al., 2008). So, her use of mental state words was not directed to differentiate reality and fantasy. Moreover, as she used this kind of words to express herself, we observed that her inner world dispersed and she had difficulty organize herself. Fonagy and Target (1997) suggested that the differentiation of fantasy and reality helps the child being able to play. On the other hand, if the boundary is lost, then the child feels threatened by the ideas she experiences and it is going to be difficult for her to regulate the anxiety coming from this and to play with it. When CG could not integrate reality and fantasy, because she was not in the level of meaning making and mentalizing, she had still hard time modulating her affects. She needed to understand affect states beyond naming and describing them for affect modulation and to internalize the function of therapist.

So, we can conclude that while RNİ was able to play with the reality, CG lost the boundary between reality and fantasy which made using mental state narrative disorganizing for her. Therefore, it seems that RNİ's

use of mental state words contributed to affect modulation without a need for therapist by internalizing the function of the therapist whereas CG still needed for the help of the therapist.

The difference between the children's ability for affect modulation brings the question of why there was a difference in the child's ability for affect modulation. At his point therapists' interventions are of a significant value. We can say that this difference can be due to the difference in the therapists' language. There are two main points about this difference. One of them is that we observed RNİ's therapist making use of interventions aiming at mentalized affectivity most of the time. Mentalized affectivity as Fonagy, Gergely and their colleagues (2002) suggested, is the capacity to discover the subjective meaning in one's affective experiences. This capacity is more than naming and describing affective states and more about making sense of these affective experiences. So it was suggested as a higher level for the mentalization after the affect regulation (Verheugt-Pleiter, et al., 2008). Therefore, for the development of mentalized affectivity, therapist is expected to comment on the mental states and mental comments of the child rather than naming affects of the child (Verheugt-Pleiter, et al., 2008). When we analyzed the play segments of RNİ in detail, we observed that therapist commented on the child's mental contents by emphasizing the important themes and situations for the child or by focusing on the underlying affects in a play. So, RNİ with a developing capacity for mentalized affectivity was able to explore the meanings of her affective experiences. For CG, on the other hand, therapist's interventions were

mostly directed to attention regulation and affect regulation which are suggested to aim at inviting the child to the structured play area, bringing inner experiences to the stage and expressing them in an appropriate way (Verheugt-Pleiter et al., 2008). So CG was able to bring various kinds of affective states into the play, but she was not in a level in which she could explore the meanings of these affective states yet.

Another point for the difference in the therapist's use of mental state narrative was about marked mirroring. This can be seen as related to the rhythmic sense of markedness with a sense of differentiation in the children's affective experiences (Benjamin, 2004) through the therapist's marked mirroring which children rarely experienced before. While therapists did marked mirroring, they showed that they recognize and understand the child's affective experience rather than showing they actually experienced it (Fonagy, Gergely, et al., 2002) through verbally mediated reflections on the child's thoughts and feelings (Goodman, 2009). Therefore, borrowed from the early caregiver-child relationship marked mirroring can be seen as the basis for the linguistic communication in the psychotherapy (Goodman, 2009). However, although both therapists used marked mirroring which seemed to be effective in the affect modulation for both cases, we saw that RNİ's therapist was able to make more marked mirroring. Because in her plays RNİ preferred to narrate the play story rather than becoming the play character itself, she was able to look a step back forward to the experiences and the therapist was able to comment on and mirror by recognizing this distance. So it helped her to keep distance

between her inner world and the outer world in the play. Symbolic space and symbolic language that play provides to differentiate the one who mirrors and the one whose affective experiences are mirrored (Goodman, 2009). This in turn helps to differentiate self-other and fantasy-reality. Through this differentiation it seems that, second-order representations started to form and intentionality started to take place (Fonagy & Target, 1997) in the case of RNİ.

When we looked at CG's plays, although the therapist was able to make use of marked mirroring as possible, she generally mirrored directly the child in the plays. Because CG was playing by being the play character itself, she also wanted therapist to join her in the play as a play character and to repeate her sentences. When the therapist was supposed to say the same things to CG, it was harder for CG to step back and look what was going on in the play, and in her inner self. While this situation contributed to her inability to differentiate reality and fantasy in her plays most of the time, she had difficulty discover, understand and organize her inner world. Although therapist could help her modulate affects, she was inadequate in doing it on her own.

It was obvious that some interventions are more effective for mentalization and so for affect modulation. However, it seemed that same interventions were not possible to make use of for two different children. Considering the individual differences and two different developmental histories, therapists were required to use different interventions considering the children's developmental profiles. Although RNİ benefited from the

interventions regarding mentalized affectivity, CG needed more attention and affect regulation interventions because their profiles differed from each other. This difference can be understood from the early relational history. We knew that both children's mothers had traumatic experiences and problems in the early years of the children, full of losses or conflicts which made it difficult for them to approach the children in a more sensitive way and to make marked mirroring. However, for RNİ there was a stable attachment figure anyhow. For CG, as emphasized in her developmental history, she had a lot of changes of caregivers in the very early years of life. So there was not a stable figure for her to make meaning of her inner world and to give her mind back to her. So while RNİ was willing to differentiate the inner world of her own, CG was still in need for to form an inner world and then differentiate its separateness.

All in all, we can say that two children started the psychotherapy process in different levels, the way they played showed differences in this process and therapists made use of different kinds of interventions. Therefore, at the end, the level they reached was different for two children.

Along with all these differences we saw that both therapists' use of mental state narrative caused affect modulation. This result also can be seen as consistent with the role of play as a mental activity facilitating the regulation of emotions and the integration of experiences (Alessandri, 1991; Berk, Mann, &Ogan, 2006; Kernberg, Chazan, &Normandin, 1998). Verheugt-Pleiter explained (2008) what therapist should do in the therapeutic process as giving reality value to the child's mental states

through play figures or directly to share the feelings in its intensity and to make these feelings more acceptable for the child. So the relationship becomes safer for the child, gradually, and the child can start to internalize the function of the therapist as the representative of affects. For the cases of CG and RNİ therapists' high mental state narrative can be seen as a facilitator for the children to understand what they were playing was actually pretending. It can be suggested that due to the intense feelings during the play they were having difficulty step back from those feelings. By commenting on the play characters' mental states, therapist could differentiate what is real and what is pretending. By recognizing what is actual and what is pretend the children can integrate these two modes and after gaining awareness towards what they were playing, they gradually could start to regulate their affective states (Fonagy & Target, 2002). So, therapist's use of play-related mental state narrative can be considered as directed to provide this differentiation. When the child's negative emotions are facilitated by therapist who functions as other and by playfulness offered by the therapist, child can link them with reality (Verheugt-Pleiter et al., 2008).

Along with these findings, our first hypothesis was also partially confirmed. We found that while for CG therapist's use of mental state narrative caused child's use of mental state narrative in the play, this was not confirmed for RNİ.

CG was observed as more immature in the way she experienced her affect states, so the therapist was needed to take more active role in the play

to show the child her primary experience reflected on her own mind. Although therapist made direct mirroring most of the time, it seemed that even though it was rare, adding a different aspect to the child's mind and giving it back to the child in a more modulated form helped the child to see the representation of this affective experience. In time the child started to build her own internal world by using the mental state of the therapist (Verheugt-Pleiter et al., 2008). In this way they interchanged the affective states after therapist metabolized them. Therefore, child started to recognize different inner states and started to name and to describe them in the play, most of the time through the play characters. This can be possible in a relationship where ideas can be shared.

Findings from research also support this suggestion. It was suggested that conversations between friends or siblings enhances the likelihood of expression of shared thoughts (Brown et al., 1996). In addition to this it was proposed that conversations are helpful for the development of mentalization especially if they are regarding others (Brown & Dunn, 1991). Therefore, this can be considered as an indicator of the association between talking about mental states of play characters, sharing thoughts and the child's use of mental state narrative. Therapists' play-related mental state narrative can be seen as facilitator for the child's mental state narrative regarding the literature. Research also supports that children can learn from others in the play to take different points of view so that they can interpret mental states of others (Lillard, 1993; Brown et al., 1996; Hughes & Dunn, 1997; Youngblade & Dunn, 1995).

Although RNİ also had a similar process, we could not find a causal relationship between the child's and the therapist's use of mental state narrative. We saw that in general RNİ's use of play-related mental state narrative was higher than the therapist's. RNİ's level of capacity for symbolization was different than CG. When the therapist verbalized the mental states of play characters' or the child's, she used a more different narrative. She used a more symbolized narrative by using the child's play material. In other words, her interventions were mostly affectively symbolic (Grolnick, 1986), but most of the time her narrative did not involve mental state words. If the therapist did not use the mental state words included to the coding manual, these interventions were not counted as mentalizing. In other words, therapist's interventions regarding the representations of the child and her mental content were not coded. Although therapist mentalized the child's content and the child used mental state narrative, because some specific interventions of the therapist were not coded, it seemed like therapist used less mental state narrative than the child. This, in statistical terms may be seen as not causing the child's use of mental state narrative.

We also could not find any significant relationship regarding complex relations. We found that for both cases, children's and therapists' mental state narrative did not cause complex relations in the play. However, we expected to see a relationship between mental state talk in the play and the complex relations regarding the suggestion (Fonagy and Target, 1996; Tessier et al., 2016) that pretend play is efficient to enhance the capacity for mental state narrative through play characters. Because pretend play makes

it easier for the child to look from different perspectives through play characters it may encourage the mental state talk which stimulates cooperative interaction needed for pretend play. So our finding was not consistent with other research results, as well. This finding is also relevant to other research findings (Hughes and Dunn, 1997, Youngblade and Dunn, 1995; Brown et al., 1996). However, when we consider the development of mentalization we see that it starts with an affectively laden relationship with the caregiver. In this relationship caregiver tries to reflect on the child's mind and in this way she tries to regulate child's affective experiences. As the child starts to organize her inner experiences through the reality oriented perspective of the caregiver (Fonagy, 1995), the child can form second order representations and can start to develop her capacity to symbolize and mentalize. Therefore as in the development of mentalization, in therapeutic relationship also, the child needs to regulate affective experiences first. Then she is able to form second order representations.

When we consider our cases in this study we saw that they were dealing with the difficulties about affect regulation. So, after being able to modulate affective experiences, we would expect them to form complex relations. Later in the treatment if it would last longer, it might be possible to see associations between complex relations and their use of mental state narrative. Along with the children's use of mental state narrative, therapists' use also can be seen as directed to affect modulation. So we could not see any significant relationship between children's and therapists' use of mental state narrative and complex relations over the course of treatment.

To sum up, when we looked at our cases in this study, they had some specific similarities. Their referral reason was very similar in the sense that they both had difficulty in separation with mother which was a meaningful regarding their transitional experiences. In normal development transitional space provides the child to be able to deal with the anxieties of separation. However, for both cases the transitional experiences were disrupted. CG as we knew from her relational history could not see her own primary experience reflected enough in the mind of mother because mother was preoccupied with her own problems at that time. Because mother was unable to play with the frightening ideas and the caregivers were not stable in CG's life, what the child was unable to think remained unprocessed. So she confused the boundary between the separate identities in the play. For RNİ because the mother was attached to the child and they had a merged relationship, the primary experience of the child might be mirrored too closely. In this way the representation given back by the mother cannot help the child to define her own experience (Fonagy, Gergely, et al., 2002). So, RNİ's search for 'me' and 'not-me' can be understood by the earlier relationships with the mother. It means that what CG needed was to work out the boundary between her internal states and minds of others and to metabolize her feelings not as concrete realities but as states belonging to her own individual world and RNİ needed to understand the symbolic meanings of behaviors by differentiating her own representations and other's.

Play in this context serves as a transitional space because it also includes symbols and representations regarding the child's inner world. In the play the child can exist without making a distinction between inner and outer reality (Price, 1994). It is like being dependent on the mother but at the same time to be free from her by separately and creatively being in touch with the inner experiences. Transitional space at this point provides the child to form self and other representations so that he can be separated from mother and unified with her at the same time (Philips, 1988), so it is important in the separation process. At this point, the goal of the therapy with children by using the play is to provide this transitional space. Therapist, on the other hand functions as a good enough mother (Winnicott, 1971) allowing for the child to understand his anxieties (Bonovitz, 2008) from a position of containing the child's affective experiences with its projections and all. So therapeutic play should be affectively symbolic (Grolnick, 1986) and the therapist should be accepting the past traumatic events in the way they re-experienced by the child in the therapy (Bonovitz, 2008). Also through play, therapist can facilitate child to engage in more imagination, so that she is able to negotiate the boundary between real and pretend. However, therapeutic tools of the therapist are dependent on the child's ability to symbolize and think abstractly (Price 1994). Play can be understood by the therapist through the themes and the symbols (Slade, 1994). If the child's representational abilities are immature and not developed yet, the tools that the therapist can use will be different. So the therapist can make use of just playing by joining the pretend mode with the

child, and this can help discovering the meaning of play by integrating the emotional experiences (Slade, 1994).

4.1 Implications for the Place of Mentalization and Play in Clinical Setting and Psychotherapy Research

Overall, our study showed similar results as in the research. We found that play facilitated the mental state talk regarding the play characters, and along with the mentalization play is a fertile area for affect regulation, understanding emotions and integrating experiences (Brown, Donelan-McCall, & Dunn, 1996; Hughes and Dunn, 1997; Youngblade& Dunn, 1995; Tessier et al., 2016).

As it was suggested before, play is very effective for observing the process of the use of mental state narrative (Brown, Donelan-McCall, & Dunn, 1996; Youngblade& Dunn, 1995).Using single case study also made it possible to see the inter-personal and intra-personal differences between two cases (Aldridge, 1992). We could take advantage of single case study to see the complex structure of therapeutic relationship between therapists and the clients and the dynamic relations between various interventions.

This study has several clinical implications. First, we saw that therapist's use of mental state narrative in the play therapy contributes to the affect modulation as it was suggested by Verheugt-Pleiter and colleagues (2008). Mentalizing interventions of therapist's aiming at developing capacity for child's mentalization are of significant value. When the therapist uses mental state narrative in the play, she tries to show mental

states of others, and actually gives reality value to the child's inner experience. When the child feels understood, she can start to build an inner world (Fonagy, Gergely, et al., 2002) and can develop and use her mentalizing capacity.

However, use of mental state narrative can cause clinical change as long as it can imply affect modulation. Other than that, mental state narrative alone is inadequate to make a clinical change in the symptoms of the children. For this purpose, the child needs to internalize the interventions directed to affect modulation. Although there are some individual differences that we can observe regarding the process of mentalizing and the effects of this ability, mentalization helps children to modulate their affects. At this point play can be considered as an area that mentalization find a path to develop because the experience of secure play enables the integration of the pretend and psychic equivalence modes. While interpersonal process including the therapist's active mirroring and pretend play facilitates the child to link her feelings and thought with reality, she can also repair and develop a sense of self. In this way child's negative emotions are facilitated by the therapist to an optimum resolution and also reattunement of attachment bond enables child to cope with these kinds of negative emotions.

Therefore, therapist's interventions should aim at mentalized affectivity which can encourage the child to discover the meanings of her affective experiences. However, for this kind of interventions therapist should seek for the appropriate developmental profile of the child. If the

child is not ready in the level of mentalized affectivity, they are going to be useless for the child.

We can conclude that play in which children can represent their internal experience and can work on it with the presence of a therapist who has a real interest for the child’s internal world can help children to realize their inner sources (Slade, 1994). So integrating mentalization-based interventions with play may be helpful for the treatment of children.

In addition to the therapist-child relationship, when we consider the development of mentalization and limitations about it, caregivers are the most important component of this process. We saw that the secure relationship between therapist and child which encourages child’s affect modulation and mentalization can be very effective even the relationship is stricted to 45 minutes in a week. So, when we consider that the caregivers are the source of this mentalization process, inviting them to the sessions on a regular basis can be a crucial part of this therapeutic process. Intervening with parents to enhance and encourage their development of reflective capacities can contribute to the clinical change in the symptoms of children and to the psychological well-being of both children and parents (Slade,2010). This kind of an intervention helps develop both mentalizing capacities of parents and their abilities to encourage child’s development of mentalization.

Another implication for clinical experience may be that such the kind of measures we used in this study can be made use of by the clinicians

to observe the various trends in the psychotherapy and the effects of their interventions to better understand the therapeutic relationship.

4.2 Limitations and Recommendations for Further Research

For the time-series analysis, using Granger Causality brought some limitations. Granger causality does not refer to an exact causal relationship. Rather, it shows an approximation of causality and when we talk about significant causal relationships, they may be facilitated by unobserved variables. Also time-lagged associations were based on segment-to segment time steps, so at other time lags there may be other associations, as well.

In this study we made use of standardized measures, so that comparisons can be made for further analysis. Moreover, it was proposed that case studies may help developing and evaluating new assessment and treatment techniques (Nock, Mıchel, & Photos, 2002). Measures used in this study were selected due to the fact that they are comprehensive about what they measure. However, determining the relative novelty of play instrument and measure for mental state narrative, there has been still a need for developing them. So, this study offered an opportunity to see their strengths and limitations. Although CPTI gave us numbers about specific components of play, it offered a detailed description of complex play activities. Using CPTI provided to compare two different play profiles over therapeutic process through specified play components. By qualitatively observing each session, complex structures of play activity were able to be analyzed in detail which makes understanding these structures and their change over time easier. However, because it is based on observation and clinical

evaluation of the rater, there is a subjective aspect of rating in CPTI. Although it has a high inter-rater reliability, the subjective aspect can be a part of the interpretation of the results.

CSMST, on the other hand, was useful taking various forms of mental state narrative into account. So, we could differentiate mental state narrative whether it was regarding play, other or self. Along with this differentiation it also provided with the complex structure of mentalization by examining emotion, cognition, perception, physiological and action-based aspects. However, it has some limitations, as well. CSMST is based on counting the mental state words by leaving less space for subjectivity and so it is a more likely to be an objective measure of mentalization. In order to make it more standardized, there were some criteria for words such as that they should be verbs to count them as mental state words. For example while 'to pay attention' or 'to create' were counted for cognition words 'attentive' or 'creative' were not counted. Similarly, words such as 'frightening' or 'surprising' were not coded because they are adjectives and not clear in the sense to whom the underlining affects belong. Also, clinical evaluation was needed for specifying the mental state narrative whether it was used accurate or not. Sometimes even though the therapist or the child used the mental state narrative, they were not pointed for the accurate mental state of other.

Although counting words is more standardized and subjective and so more suitable for the empirical investigation of mentalization, at some point more than counting words was necessary to understand the concept.

Especially, interventions directed to develop mentalization proposed by Verheugt-Pleiter and colleagues (2008) mostly disregarded. Without using mental state narrative, therapist can help the child developing mentalization capacity by providing a safe environment, introducing structure in play, giving attention to the content of the play, attuning the child's level, describing interactions, joining the play visually or in gestures, describing behaviors, separating fantasy and reality, etc.. Along with this, especially while commenting on the child's mental contents a more symbolic narrative is appropriate to talk about representations. In this coding system if no mental state words were used, then this kind of interventions by the therapist was not coded. For further analysis, taking these interventions into account and including them in a structured framework may be a more comprehensive approach to understand the effect of interventions.

For further research it can be recommended that to see associations between mentalization and complex relations, advancing sessions of the therapeutic process can be taken especially with children having affect modulation problems regarding that without dealing with affect modulation problems, it is hard for the children to form complex relations in their plays.

In order to see stronger statistical relationships and to analyze sessions qualitatively better, beginning sessions also should have been coded. However, due to technical problems we could not have access to these sessions. Analyzing the whole process could have given a more coherent picture of the process.

For the coherency of the study, a more improved design for such studies can be recommended. We stated that children’s regulation profiles were different due to their developmental histories along with the way they played. However, we could not specify their differences in terms of emotion regulation, executive functioning or attachment type over the assessments in this process. Therefore, more detailed pre and posttest designs for the description of the children’s current profiles can be added for further studies. Related to developing competencies in early childhood, self-regulation, emotion regulation and theory of mind can be examined. In order to measure emotion regulation Emotion Regulation Checklist (ERC; Shields & Cicchetti, 1999), to measure maternal socialization of emotion the Coping with Children’s Negative Emotions Scale (CCNES; Fabes, Eisenberg, & Bernzweig, 1990), to measure temperamental characteristics of the child the Turkish version (Yagmurlu & Sanson, 2009) of Short Temperament Scale for Children (STSC; Prior, Sanson, & Oberklaid, 1989) can be used. For executive functioning different tasks can be utilized such as day-night task (Orta, Corapci, Yagmurlu, & Aksan, 2013), or Wisconsin Card Sorting Test (WCST; Heaton, et al., 1993).

Along with these, regarding mental state talk, receptive and expressive language of the children can be measured by using The Turkish Expressive and Receptive Language Test (Berument & Güven, 2010). Also, child rearing practices from the caregivers can be taken by using Turkish adaptation (Yagmurlu & Sanson, 2009) of Child Rearing Questionnaire (CRQ; Paterson & Sanson, 1999). Using Adult Attachment Interview (AAI;

George, Kaplan, & Main, 1985) or Parent Development Interview (PDI; Aber, Slade, Berger, Bresgi, & Kaplan, 1985) reflective function capacity of the mothers or attachment qualities can be assessed in the beginning. Using this kind of assessments in the beginning and at the end provides with the differentiation of the cases on a systematic basis and make comparison of the cases more robust.

In our study, children's profiles were different from each other, so that therapists' interventions also differed. For further research conducting a study with children who has similar profiles can help show differences in the therapist's interventions to understand the various interventions applications and the outcomes of these interventions.

CONCLUSION

The present study illustrates the complexities of mentalization and its dynamic relations with play over the course of a long-term psychotherapy. It demonstrates that how changes in the mentalization may relate to changes in the child's capacity to play in terms of affect modulation and complex relations in psychotherapy process. We have seen indications that these relationships are complex interactions that can also be seen in the assessment of the concepts. Through this study, we have seen that therapist's mentalizing approach may differ across different profiles of mentalization, but still effective in developing the capacity to mentalize, symbolize and regulate affects. Play at this point has a pivotal role as a mental activity which helps children to discover their inner world and to take steps for understanding and differentiating self and other. So, although we cannot change what children experienced in the past, in mentalization-based child therapy we have some tools to help them change the representations of these past experiences and to reinterpret their inner worlds and their bonds by showing them their resources.

As single case naturalistic research is seen as a promising area (Midgley, 2006) to identify change processes we also used it to understand individual differences in psychotherapy process and it provided us to realize the deep down effects of specific interventions and to identify effective ingredients of treatment. Therefore, even though this study has some limitations, the results suggest directions for further research and significant clinical implications. We hope that this study will encourage others to

research on the fertile area of play and mentalization as a great source for the well-being of the childhood and adulthood.

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APPENDIX

Appendix A. Child Behavior Checklist (CBCL)

6-18 YAŞ ÇOCUK VE GENÇLER İÇİN DAVRANIŞ DEĞERLENDİRME ÖLÇEĞİ

No:

ÇOCUĞUN ADI, SOYADI	EV ADRESİ ve TEL NO:	ANNE BABANIN İŞİ (Ayrıntılı biçimde yazınız). EĞİTİMİ (Toplam kaç yıl okula gittiğinizi yazınız)
		BABANIN İŞİ :............TEL NO :..........EĞİTİMİ:............YAŞI............
CİNSİYETİ: ❒ ERKEK ❒ KIZ	YAŞI:	ANNENİN İŞİ:............TEL NO :..........EĞİTİMİ:............YAŞI............
BUGUNUN TARIHI GÜN.........AY.........YIL.........	ÇOCUĞUN DOĞUM TARİHİ GÜN.........AY.........YIL.........	FORMU DOLDURAN: ❒ ANNE ❒ BABA ❒ DİĞER...............ÇOCUKLA OLAN İLİŞKİSİ..............................
SINIFI:---------- OKULA DEVAM ETMİYOR ❒	Çocuğunuzun davranışlarıyla ilgili bu formu lütfen görüşlerinizi yansıtacak biçimde yanıtlayınız. Her bir madde ile ilgili bilgi verebilir ve 2. sayfadaki boşluklara yazabilirsiniz. Lütfen bütün maddeleri işaretlemeye çalışınız. Teşekkür ederiz.	

I. Çocuğunuzun yapmaktan hoşlandığı sporları a, b, c şıklarına yazınız. Örneğin: Yüzme, futbol, basketbol, voleybol, atletizm, tekvando, jimnastik, bisiklete binme. güreş, balık tutma gibi.

❒ **Hiç yok**

	Çocuğunuz her birine ne kadar zaman ayırır ?				*Çocuğunuz her birinde ne kadar başarılıdır?*			
	Normalden az	**Normal**	**Normalden fazla**	**Bilmiyorum**	**Normalden az**	**Normal**	**Normalden fazla**	**Bilmiyorum**
a.__________	❒	❒	❒	❒	❒	❒	❒	❒
b.__________	❒	❒	❒	❒	❒	❒	❒	❒
c.__________	❒	❒	❒	❒	❒	❒	❒	❒

II. Çocuğunuzun spor dışındaki ilgi alanlarını, uğraş, oyun ve aktivitelerini a, b, c şıklarına yazınız. Örneğin: Bilgisayar, satranç, araba, akvaryum, el işi, kitap, müzik aleti çalmak, şarkı söylemek,resim yapmak gibi (Radyo dinlemeyi ya da televizyon izlemeyi katmayınız)

❒ **Hiç yok**

	Çocuğunuz her birine ne kadar zaman ayırır ?				*Çocuğunuz her birinde ne kadar başarılıdır?*			
	Normalden az	**Normal**	**Normalden fazla**	**Bilmiyorum**	**Normalden az**	**Normal**	**Normalden fazla**	**Bilmiyorum**
a.__________	❒	❒	❒	❒	❒	❒	❒	❒
b.__________	❒	❒	❒	❒	❒	❒	❒	❒
c.__________	❒	❒	❒	❒	❒	❒	❒	❒

III. Çocuğunuzun üyesi olduğu kuruluş, kulüp ya da takımları a, b, c şıklarına yazınız. Örneğin: Spor, müzik, izcilik, folklor gibi.

❒ **Hiç yok**

	Çocuğunuz her birinde ne kadar başarılıdır?			
	Bilmiyorum	**Az Aktif**	**Normal**	**Çok Aktif**
a.______________________	❒	❒	❒	❒
b.______________________	❒	❒	❒	❒
c.______________________	❒	❒	❒	❒

IV. Çocuğunuzun evde ya da ev dışında yaptığı işleri a, b, c şıklarına yazınız. Örneğin: Gazete alma, bakkala gitme, pazara gitme, bahçe-tarla işleri, hayvancılık, elektrik- su faturası yatırma, çocuk bakımı, sofra kurma-kaldırma, bir dükkanda çalışma gibi ödeme yapılan ve yapılmayan herşeyi katınız.

❒ **Hiç yok**

	Çocuğunuz her birinde ne kadar başarılıdır?			
	Bilmiyorum	**Normalden Az**	**Normal**	**Normalden Fazla**
a.______________________	❒	❒	❒	❒
b.______________________	❒	❒	❒	❒
c.______________________	❒	❒	❒	❒

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Türkçe Çeviri ve Uyarlaması Neşe Erol tarafından
T.M. Achenbach'ın izniyle yapılmış ve basılmıştır (2002, 2007, 2009).
Ankara Üniversitesi Tıp Fakültesi Çocuk Ruh Sağlığı ve Hastalıkları Anabilim Dalı

6-1-01 Baskısı-201

V. 1- **Çocuğunuzun yaklaşık olarak kaç yakın arkadaşı vardır? (Kardeşlerini katmayınız)**

Hiç yok	1	2 ya da 3	4 ya da fazla
☐	☐	☐	☐

2- **Çocuğunuz okul dışı zamanlarda haftada kaç kez arkadaşlarıyla birlikte olur? (Kardeşlerini katmayınız)**

1 den az	1 ya da 2	3 ya da daha fazla
☐	☐	☐

VI. Yaşıtlarıyla karşılaştırıldığında çocuğunuzun:

	Kötü	Normal Sayılır	Oldukça İyidir	Kardeşi Yoktur
a. Kardeşleriyle arası nasıldır?	☐	☐	☐	☐
b. Diğer çocuklarla arası nasıldır?	☐	☐	☐	☐
c. Size karşı davranışları nasıldır?	☐	☐	☐	☐
d. Kendi başına oyun oynaması ve iş yapması nasıldır?	☐	☐	☐	☐

VII. 1- Çocuğunuzun okul başarısı nasıldır? Çocuğunuz okula gitmiyorsa lütfen nedenini belirtiniz:________________

	Başarısız	Orta	Başarılı	Çok Başarılı
a. Türkçe / Türk Dili Edebiyatı	☐	☐	☐	☐
b. Hayat Bilgisi / Sosyal Bilgiler	☐	☐	☐	☐
c. Matematik	☐	☐	☐	☐
d. Fen Bilgisi	☐	☐	☐	☐

Diğer derslerde nasıldır? Örneğin: Yabancı dil, bilgisayar.
(Beden eğitimi, resim ve müziği katmayınız)

e. ________________	☐	☐	☐	☐
f. ________________	☐	☐	☐	☐
g. ________________	☐	☐	☐	☐

2- Çocuğunuz özel alt sınıf ya da bir özel eğitim kurumunda okuyor mu?

☐ **Hayır** ☐ **Evet- Ne tür bir sınıf ya da okul?** ________________

3- Çocuğunuz hiç sınıfta kaldı mı?

☐ **Hayır** ☐ **Evet- Kaçıncı sınıfta ve nedeni** ________________

4- Çocuğunuzun okulda ders ya da ders dışı sorunları oldu mu?

☐ **Hayır** ☐ **Evet- açıklayınız** ________________

Bu sorunlar ne zaman başladı? ________________

Sorunlar bitti mi?

☐ **Hayır** ☐ **Evet- Ne zaman?**

Çocuğunuzun herhangi bir bedensel hastalığı ya da zihinsel engeli var mıdır?

☐ **Hayır** ☐ **Evet- açıklayınız** ________________

Çocuğunuzun sizi en çok üzen, kaygılandıran ve öfkelendiren özellikleri nelerdir?

Çocuğunuzun en beğendiğiniz özellikleri nelerdir?

Lütfen yan sayfaya geçiniz

Aşağıda çocuk ve gençleri tanımlayan maddelerin bir listesi bulunmaktadır. Her bir madde çocuğun **şu andaki ya da son 6 ay** içindeki durumunu belirtmektedir. Bir madde çocuk için **çok ya da sıklıkla doğru ise 2, bazen ya da biraz doğru ise 1, hiç doğru değilse 0** sayılarını yuvarlak içine alınız. Lütfen tüm maddeleri işaretlemeye çalışınız.

0: Doğru Değil (Bildiğiniz kadarıyla) **1: Bazen ya da Biraz Doğru** **2: Çok ya da Sıklıkla Doğru**

0 1 2 1. Yaşından çok daha çocuksu davranır

0 1 2 2. Anne babanın izni olmadan içki içer

0 1 2 3. Çok tartışan bir çocuktur

0 1 2 4. Başladığı etkinlikleri (oyunu, dersleri, işleri) bitiremez

0 1 2 5. Hoşlandığı ya da zevk aldığı çok az şey vardır

0 1 2 6. Kakasını tuvaletten başka yerlere yapar

0 1 2 7. Bir şeylerle övünür, başkalarına hava atar

0 1 2 8. Bir konuya odaklanamaz, dikkatini uzun süre toplayamaz

0 1 2 9. Kafasından atamadığı, onu rahatsız eden bazı düşünceleri vardır (mikrop bulaşma, simetri takıntısı, okul sorunları, bilgisayar gibi) (açıklayınız) ____________

0 1 2 10. Yerinde sakince oturamaz, çok hareketli ve huzursuzdur

0 1 2 11. Gereken gayreti göstermeden, sırtını tamamen büyüklere dayayıp herşeyi onlardan bekler

0 1 2 12. Yalnızlıktan şikayet eder

0 1 2 13. Kafası karışık, zihni bulanıktır

0 1 2 14. Çok ağlar

0 1 2 15. Hayvanlara eziyet eder

0 1 2 16. Başkalarına eziyet eder, kötü davranır, kabadayılık eder

0 1 2 17. Hayal kurar, hayallere dalıp gider

0 1 2 18. Kendine bilerek zarar verdiği ya da intihar girişiminde bulunduğu olmuştur

0 1 2 19. Hep dikkat çekmeye çalışır

0 1 2 20. Eşyalarına zarar verir

0 1 2 21. Ailesine ya da başkalarına ait eşyalara zarar verir

0 1 2 22. Evde söz dinlemez

0 1 2 23. Okulda söz dinlemez

0 1 2 24. İştahsızdır

0 1 2 25. Başka çocuklarla geçinemez

0 1 2 26. Hatalı davranışından dolayı suçluluk duymaz, oralı olmaz, aldırmaz

0 1 2 27. Kolay kıskanır

0 1 2 28. Ev, okul ya da diğer yerlerde kurallara uymaz, karşı gelir

0 1 2 29. Bazı hayvanlardan, durumlardan (yüksek yerler), ya da ortamlardan (asansör, karanlık gibi) korkar (okulu katmayınız) (açıklayınız): ____________

0 1 2 30. Okula gitmekten korkar, okul korkusu vardır

0 1 2 31. Kötü bir şey düşünebileceği ya da yapabileceğinden korkar

0 1 2 32. Kusursuz, dört dörtlük ve her konuda başarılı olması gerektiğine inanır.

0 1 2 33. Kimsenin onu sevmediğinden yakınır

0 1 2 34. Başkalarının ona karşı olduğu, zarar vermeye, ya da açığını yakalamaya çalıştığı hissine kapılır

0 1 2 35. Kendini değersiz, önemsiz ya da yetersiz hisseder

0 1 2 36. Bir yerlerini kaza ile sık sık incitir

0 1 2 37. Çok kavga çıkarır, kavgaya karışır

0 1 2 38. Çok fazla sataşılır, dalga geçilir

0 1 2 39. Başı belada olan kişilerle dolaşır

0 1 2 40. Olmayan sesler ve konuşmalar işitir (açıklayınız):

____

0 1 2 41. Düşünmeden hareket eder, aklına eseni yapar

0 1 2 42. Başkalarıyla birlikte olmaktansa yalnız olmayı tercih eder

0 1 2 43. Yalan söyler, hile yapar, aldatır

0 1 2 44. Tırnaklarını yer

0 1 2 45. Sinirli ve gergindir

0 1 2 46. Kasları oynar, seğirmeleri ve tikleri vardır (açıklayınız):

____

0 1 2 47. Geceleri kabus görür

0 1 2 48. Başka çocuklar tarafından sevilmez

0 1 2 49. Kabızlık çeker

0 1 2 50. Çok korkak ve kaygılıdır

0 1 2 51. Başı döner, gözleri kararır

0 1 2 52. Kendini çok suçlu hisseder

0 1 2 53. Aşırı yer

0 1 2 54. Sebepsiz yere çok yorgun hissettiği olur

0 1 2 55. Fazla kiloludur

56. ***Sağlık sorunu olmadığı halde ;***

0 1 2 a. Ağrı ve sızılardan yakınır (baş ve karın ağrısı dışında)

0 1 2 b. Başağrılarından yakınır (şikayet eder)

0 1 2 c. Bulantı, kusma duygusu olur

0 1 2 d. Gözle ilgili şikayetleri olur (Gözlük, lens kullanma dışında) (açıklayınız):

____

0 1 2 e. Döküntü, pullanma ya da başka cilt hastalığı olur

0 1 2 f. Mide- karın ağrısından şikayet eder

0 1 2 g. Kusmaları olur

0 1 2 h. Diğer (açıklayınız):

____

Lütfen arka sayfaya geçiniz

0: Doğru Değil (Bildiğiniz kadarıyla) 1: Bazen ya da Biraz Doğru 2: Çok ya da Sıklıkla Doğru

0 1 2 57. İnsanlara vurur, fiziksel saldırıda bulunur

0 1 2 58. Burnunu karıştırır, derisini ya da vücudunu yolar, saç ve kirpiğini koparır (açıklayınız):

____

0 1 2 59. Herkesin içinde cinsel organıyla oynar

0 1 2 60. Cinsel organıyla çok fazla oynar

0 1 2 61. Okul ödevlerini tam ve iyi yapamaz

0 1 2 62. El, kol, bacak hareketlerini ayarlamada güçlük çeker, sakardır

0 1 2 63. Kendinden büyük çocuklarla vakit geçirmeyi tercih eder

0 1 2 64. Kendinden küçüklerle vakit geçirmeyi tercih eder

0 1 2 65. Konuşmayı reddeder

0 1 2 66. İstemeyerek de olsa, belli bazı davranışları tekrar tekrar yapar (ellerini defalarca yıkama, kapı kilidini tekrar tekrar kontrol etme gibi) (açıklayınız)

____

0 1 2 67. Evden kaçar

0 1 2 68. Çok bağırır

0 1 2 69. Sırlarını kendine saklar, hiç kimseyle paylaşmaz

0 1 2 70. Olmayan şeyleri görür (açıklayınız):

____

0 1 2 71. Topluluk içinde rahat değildir, başkalarının kendisi hakkında ne düşünecekleri ve ne söyleyecekleriyle ilgili kaygı duyar

0 1 2 72. Yangın çıkartır

0 1 2 73. Cinsel sorunları vardır (açıklayınız):

____

0 1 2 74. Gösteriş meraklısıdır, maskaralık yapar

0 1 2 75. Çok utangaç ve çekingendir

0 1 2 76. Diğer çocuklardan daha az uyur

0 1 2 77. Gece ve/veya gündüz diğer çocuklardan daha çok uyur (açıklayınız):

____

0 1 2 78. Dikkati kolayca dağılır

0 1 2 79. Konuşma problemi vardır (açıklayınız):

____

0 1 2 80. Boş gözlerle bakar

0 1 2 81. Evden birşeyler çalar

0 1 2 82. Ev dışındaki başka yerlerden birşeyler çalar

0 1 2 83. İhtiyacı olmadığı halde pek çok şeyi biriktirir (açıklayınız):

____

0 1 2 84. Tuhaf, alışılmadık davranışları vardır (eşyaların belli bir düzende ve sırada olmasını isteme gibi) (açıklayınız):

____

0 1 2 85. Tuhaf, alışılmadık düşünceleri vardır (bazı sayıları, sözcükleri tekrarlama ve bunları zihninden atamama gibi) (açıklayınız):

____

0 1 2 86. İnatçı ve huysuzdur

0 1 2 87. Ruhsal durumu ya da duyguları çabuk değişir

0 1 2 88. Çok sık küser

0 1 2 89. Şüphecidir, kuşku duyar

0 1 2 90. Küfürü ve açık saçık konuşur

0 1 2 91. Kendini öldürmekten söz eder

0 1 2 92. Uykuda yürür ve konuşur (açıklayınız):

____

0 1 2 93. Çok konuşur

0 1 2 94 Başkalarına rahat vermez, onlara sataşır, onlarla çok dalga geçer

0 1 2 95. Öfke nöbetleri vardır, çabuk öfkelenir

0 1 2 96. Cinsel konuları fazlaca düşünür

0 1 2 97. İnsanları tehdit eder

0 1 2 98. Parmak emer

0 1 2 99. Sigara içer, tütün çiğner

0 1 2 100. Uyumakta zorlanır (açıklayınız):

____

0 1 2 101. Okuldan kaçar, dersini asar

0 1 2 102. Hareketleri yavaştır, enerjik değildir

0 1 2 103. Mutsuz, üzgün ve çökkündür (depresyondadır)

0 1 2 104. Çok gürültücüdür

0 1 2 105. Sağlık sorunu olmadığı halde madde kullanır (içki ve sigarayı katmayınız) (açıklayınız):

____

0 1 2 106. Çevresindeki kişi ve eşyalara kasıtlı olarak zarar verir, zorbalık eder

0 1 2 107. Gündüz altını ıslatır

0 1 2 108. Gece yatağını ıslatır

0 1 2 109. Mızırdanır, sızlanır

0 1 2 110. Karşı cinsiyetten biri olmayı ister

0 1 2 111. İçine kapanıktır, başkalarıyla kaynaşmaz

0 1 2 112. Evhamlıdır, her şeyi dert eder

113. Çocuğun yukarıdaki listede belirtilmeyen başka sorunu varsa lütfen yazınız:

____

0 1 2 ____________________

0 1 2 ____________________

0 1 2 ____________________