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EXPLORING THE DEVELOPMENT OF PARENTAL MENTALIZATION IN MENTALIZATION-BASED TREATMENT FOR CHILDREN (MBT-C)

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Exploring the Development of Parental Mentalization in Mentalization-Based Treatment for Children (MBT-C)

Çocuklar için Zihinselleştirmeye Dayalı Terapide (MBT-C) Ebeveyn Zihinselleştirme Becerisinin Gelişiminin İncelenmesi

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ABSTRACT

Mentalization is the ability to understand mental states like emotions, thoughts, and intentions in oneself and others. Studies have shown that parents who have high abilities to think about their own and their children's mental states have lower levels of stress and difficulties in emotion regulation. It has been observed that parents in mentalization-focused interventions show improved reflective functioning. This thesis examined changes in parental reflective functioning during Mentalization-Based Therapy for Children (MBT-C) and the Parenting and Social Skills Group (ÇABA). It was hypothesized that MBT-C parents would show greater improvement in mentalization skills. Furthermore, increased reflective functioning scores were expected to correlate with decreases in children's behavioral and emotional problems and reductions in parental stress and emotion regulation difficulties. The study included 59 mother-child pairs in MBT-C and 58 in ÇABA, from a randomized controlled trial at Istanbul Bilgi University. Parental reflective functioning was assessed using five-minute segments from the first and last therapy sessions, evaluated with the Reflective Functioning Scale (RF Scale). The Five-Minute Speech Sample Procedure (FMSS) guided sequence selection, adhering to psychotherapy study criteria. Children's issues were measured with the Child Behavior Checklist (CBCL) and Me and My Feelings Scale (MMF), while parental stress was measured with the Parenting Stress Index (PSI), and emotion regulation difficulties with the Difficulties in Emotion Regulation Scale-Brief Form (DERS). The study results indicated no significant difference in parental mentalization skills between the two groups, though MBT-C parents showed a trend toward increased child-focused mentalization. No significant relationship was found between parental reflective functioning and therapy outcomes. These findings highlight the importance of studying and developing parental mentalization skills in child therapy.

Keywords: Parental Reflective Functioning, Mentalization, Emotional - Behavioral Problems, Parental Stress, Emotion Regulation

ÖZ

Zihinselleştirme, kişinin kendisinin ve başkalarının duygu, düşünce ve niyet gibi zihinsel durumlarını anlama yeteneğidir. Yapılan çalışmalar, kendisi ve çocuğuna dair zihinsel durumları düşünebilme becerisi yüksek olan ebeveynlerin daha düşük stres seviyelerine ve duygu düzenleme zorluklarına sahip olduğunu göstermiştir. Zihinselleştirme odaklı müdahalelere katılan ebeveynlerin yansıtıcı işleyiş becerilerinde (PRF) iyileşme gözlemlenmiştir. Bu tez, Çocuklar için Zihinselleştirmeye Dayalı Terapi (MBT-C) ve Ebeveynlik ve Sosyal Beceriler Grubu (ÇABA) sırasında ebeveyn yansıtıcı işlevselliğindeki değişiklikleri incelemiştir. MBT-C grubunda PRF skorunun daha yüksek bir artış göstermesi beklenmiştir. Ayrıca, artan PRF skorlarının çocukların davranışsal ve duygusal sorunlarındaki azalmalar ve ebeveynlerin stres ve duygu düzenleme zorluklarındaki azalmalar ile ilişkili olacağı öngörülmüştür. Çalışma, İstanbul Bilgi Üniversitesi'nde gerçekleştirilen randomize kontrollü çalışmadan MBT-C'de 59 ve ÇABA'da 58 anne-çocuk çiftini içermektedir. PRF becerisi, ilk ve son terapi seanslarından beş dakikalık sekanslar kullanılarak, Yansıtıcı İşleyiş Ölçeği (RF Ölçeği) ile ölçülmüştür. Beş Dakikalık Konuşma Örnek Prosedürü (FMSS) ve seans içi zihinselleştirme ölçen çalışmalardan faydalanılarak kodlanacak sekanslar seçilmiştir. Terapi sonuçları çocuklar için Çocuk Davranış Değerlendirme Ölçeği (CBCL) ve Ben ve Duygularım Ölçeği (MMF) ile, ebeveynler için Ebeveyn Stres İndeksi (PSI) ve Duygu Düzenleme Zorlukları Ölçeği (DERS) ile ölçülmüştür. Çalışma sonuçları, iki grup arasında PRF değişimi açısından anlamlı bir fark göstermemiştir, ancak çocuk odaklı PRF'in MBT-C grubunda bir artış trendi gösterdiği bulunmuştur. PRF skorundaki değişim ile terapi sonuçları arasında anlamlı bir sonuç görülmemiştir. Çalışma, ebeveyn zihinselleştirme becerilerinin incelenmesi ve geliştirilmesinin önemini vurgulamaktadır.

Anahtar kelimeler*:* Ebeveyn Yansıtıcı İşleyiş Kapasitesi, Zihinselleştirme, Duygusal ve Davranışsal Sorunlar, Ebeveyn Stres Düzeyi, Duygu Düzenleme Becerisi

INTRODUCTION

Mentalization is described as one's capacity to interpret the underlying mental states of oneself and others (Fonagy & Target, 1996). It involves understanding observed behaviors by considering emotions, beliefs, desires, and intentions (Allen & Fonagy, 2006). Luyten et al. (2017) further elaborate that mentalization refers to one's ability "to look at oneself from the outside and at others from the inside" (p. 4). This ability to interpret mental states helps provide meaning for one's experiences by considering inner mental processes and the outer world. This helps create a safer social environment in which unobservable mental states underlying behaviors are comprehensible and predictable (Midgley et al., 2017). In this thesis, the terms mentalization and reflective functioning are used interchangeably. Reflective function is the operationalized concept of mentalization, which refers to one's observable capacity for mentalizing (Slade, 2005).

Mentalization capacity plays a critical role in various aspects of human development. These include the regulation of emotions, the development of the sense of self, and the ability to engage in and maintain social relationships (Midgley et al., 2017). On the other hand, research has shown that individuals with low levels of mentalization are more likely to experience a range of psychological disorders. These disorders include autism spectrum disorder, eating disorders, borderline personality disorder, and depression (Fonagy & Target, 1998; Fischer-Kern et al., 2013; Midgley et al., 2017). It is reported that people with one of these psychological disorders are likely to show imbalances in their mentalization ability. Various therapeutic approaches have been employed to enhance an individual's mentalization skills in the treatment of these disorders. These treatments aim to improve self-awareness, emotional regulation, and interpersonal relationships.

Mentalization-based Treatment (MBT) mainly aims to develop and increase one's mentalization capacity. MBT, developed by Bateman and Fonagy (2004), was originally designed to address the needs of adults diagnosed with borderline personality disorder. Today, various types of MBT are designed to be directed at

different client groups, including children, families, and adolescents (Byrne et al., 2020). These treatments are designed to enhance the capacity for mentalization and improve emotional regulation and interpersonal relationships within each respective client population. Mentalization-based Treatment for Children (MBT-C) aims to enhance the mentalization capacity of both parents and children. This, in turn, improves emotion regulation capacity and enhances parental supportiveness toward their children. The foundation of MBT-C originates from research highlighting the significance of attachment and social relationships on the development of mentalization capacity (Midgley et al., 2017).

While every individual is born with the innate capacity for mentalization, it is crucial to note that the development of this capacity is significantly influenced by one's social relationships (Fonagy et al., 2002). Interactions with family members, friends, and others ensure the experiences and feedback that contribute to improving social cognition and recognizing others' mental states. This influence of the social world on shaping and refining an individual's mentalization abilities begins as early as the first year. It was proposed that young children attempt to make sense of the outer world and their mental states by using modeling of parents who understand that their children have separate minds (Ensink et al., 2016).

This thesis investigates the change and influence of parental reflective functioning (PRF) in therapy settings. The narratives obtained from parent sessions were examined to compare the PRF change between Mentalization-Based Treatment for Child (MBT-C) and Parenting and Social Skills Group (control group). The importance of increasing parental mentalization in children's and parents' therapy outcomes has been investigated. It was hypothesized that increased PRF scores during parent sessions would predict a decrease in child problem behaviors and parenting problems.

The following section will present a literature review on parenting reflective functioning. Next, assessment tools for PRF will be discussed. As shown by prior studies, the effects of PRF on child and parent functioning will be examined. Lastly, the importance of PRF in child psychotherapies will be discussed.

LITERATURE REVIEW

1.1. THE DEFINITION AND DEVELOPMENT OF PARENTAL REFLECTIVE FUNCTIONING

Parental reflective functioning (PRF) is a parent's capacity to reflect on the mental states of their own and their children (Slade, 2005). Parental reflective functioning (PRF) facilitates parents in better understanding the internal experiences of their children, such as emotions, thoughts, wishes, and desires. It enables them to recognize the interplay between these internal experiences and the observed behaviors of their children (Luyten et al., 2017). PRF capacity allows parents to anticipate the children's thoughts, affects, emotions, and demands; therefore, children's behaviors and certain responses might become more meaningful to them. Parental reflective capacity is a sign of reflective parenting, which considers children as individuals with separate minds and different emotional experiences (Fonagy & Target, 1997).

Midgley et al. (2017) listed some characteristics of reflective parenting as follows: Reflective parenting involves being curious and interested in the inner experiences of their children. Parents with high reflective functioning capacity are more motivated to understand their children's mental states, such as emotions, thoughts, and desires. They are expected to be attentive to their children's emotional experiences and be emotionally available when needed. Additionally, reflective parents also have a higher awareness of the mutual relationship between their own minds and their children's minds. This means that children's behaviors and mental states can impact the parents' internal experiences, while the parents' emotional experiences can influence their children's mental states and behaviors.

When a parent lacks interest and curiosity about their children's mental states and have trouble defining children's mental states, they might experience mentalizing difficulties (Slade, 2005). Those parents temporarily or chronically struggle to reflect upon their own or their children's minds (Midgley, 2017). Temporarily, mentalization struggles might be context-specific. When parents are triggered by children's behaviors or the current external situation, they might be

unable to consider the underlying mental processes of themselves or their children. This type of mentalization breakdown might be seen in stressful environments. On the other hand, the literature showed that chronic non-mentalization is related to parents' history of abuse, attachment problems, parental mental illness, and difficulty (Ensink, et al., 2015; Ensink, Berthelot, Bernazzani, Normandin, & Fonagy, 2014) Parents' mental illness or traumatic experiences might affect their reflective functioning so that they might even not be aware that their own or others' emotional states. Allen and Fonagy (2006) explained that those struggles of parental mentalization might create a vicious cycle in the family. Parents' chronic or context-specific lack of mentalization or low mentalization capacity may lead to a decrease in children's emotion regulation and mentalization capacity. This vicious cycle provides a clear example of how parents influence their children's capacity for mentalization.

The term parental reflective functioning (PRF) emerged from attachment theory and mentalization studies. Fonagy et al. (2002) displayed that children's mentalization capacity is related to their secure attachment to their parents. This indicates that an emotional and comprehensive relationship with parents can positively influence children's cognitive and emotional development. Children's ability to comprehend their own emotions and the world around them could be improved by internalizing their parents' representations of the children and their experiences (Midgley et al., 2017). Parents play a significant role in helping children understand and manage their emotions and behaviors. In this way, emotions and the relationship between their emotions and behaviors begin to occur in children's minds. These representations help children to gain insight into their own feelings and actions and develop the skills to navigate their emotions in a healthy way. Since secure attachment and parents' representations affect children's mentalization capacity, parents' mentalization capacity is found to be an important concept for understanding one's development of mentalization skills. The cognitive and emotional frameworks within parents may affect their capacity to recognize and interpret their children's mental states (Fonagy et al., 1991).

Parental reflective functioning has self and child-focused aspects; the concept explains parents' ability to make meaning of their own mental states as well as their children's. Self-focused reflective functioning is parents' capacity to reflect upon their own emotional process to make meaning of their behaviors and their effects on children (Borelli et al., 2016). Self-focused reflective functioning is found to be linked to parental sensitivity and behaviors (Suchman et al., 2010). Reflective parents are more likely to regulate their emotions better and respond sensitively to their children during stressful times. Child-focused reflective functioning is defined as parents' ability to comprehend children's actions and underlying mental states (Borelli et al., 2016). A higher level of child-focused reflective abilities increases their ability to understand children's emotional and behavioral cues (Fonagy et al., 2016).

1.1.1. How to assess Parental Reflective Functioning?

Research studies on parental reflective functioning use direct or indirect assessments to examine parents' ability to understand their own and their children's mental states. Direct assessments involve interview-based measurement tools that require parents to express their level of reflective functioning verbally. Indirect assessments are typically observed by a clinician during child-parent interactions or through session narratives of the parents. In this thesis, session narratives from parent sessions were used. Below, the most common direct assessment tools are described. Later, the assessment of in-session PRF is explained.

Adult Attachment Interview is a semi-structured measure developed to investigate parents' reflectiveness on the relationship with their children, considering their representation of their own attachment figures (George et al., 1985). Considering the intergenerational aspect of attachment, parents' reflections on their early childhood experiences are expected to explain their current reflective functioning towards themselves and others (Ensink et al., 2016). Slade (2005) suggests RF rated on AAI interprets one's overall mentalization ability, rather than parental reflective functioning capacity. This led to the development of Parent Development Interviews (PDI) which focuses on one's current experiences as a

parent and their reflective capacities of understanding their children's underlying mental states. Although PDI developed based on AAI, this assessment was explicitly formulated to appraise a mother's contemporary interpretations concerning her child, her identity as a parent, and her relationship with the child in depth (Schiborr et al., 2013).

While assessing parental reflective functioning by using Parent Development Interviews and Adult Attachment Interviews is a common and clinically rich way, using these measurements in larger sampled studies might be costly in terms of time and effort (Luyten et al., 2012). Adkins and Fonagy (2017) suggested a new and shorter way to examine parental reflective functioning, developed by using an adjusted version of the Five-Minute Speech Sample protocol by Gottschalk and Gleser (1969). The Five-Minute Speech Sample (FMSS) procedure involves asking a parent to talk about their relationship with their child for five minutes to code reflective functioning in parents (Adkins & Fonagy, 2017). During the procedure, the interviewer's role is limited to asking questions, and they should not interfere with leading questions or interpretations. Parents are invited to describe their children and discuss any recent challenges they may be facing regarding parental experiences. Their responses are evaluated using RFS, which emphasizes the use of mental state words. In FMSS, parents who acknowledge their children's underlying emotional experiences and demonstrate curiosity and understanding about their children's mental states receive higher scores.

The first FMSS assessment was conducted in the Family Minds Project between 2011 and 2014 (Adkins and Fonagy, 2017). The initial study hypothesized that at the end of the study, only the parents who attended mentalization-based intervention programs would show increased parental reflective functioning (Adkins et al., 2018). In this study, the FMSS procedure and the Parental Reflective Functioning Questionnaire (PRFQ; Luyten et al., 2017) were used to measure parental reflective functioning before and after the intervention and control treatments. Since PRFQ demonstrates good reliability and validity, the aim was to determine the relationship between the results from PRFQ and FMSS. The results indicated that during the study, the treatment group showed a significant increase

in PRF scores in all three dimensions (self-focused RF, child-focused RF, and global RF) from pre- to post-levels. This significant increase was displayed in both PRF scores based on PRFQ and PRF scores based on FMSS coding. This study is important as it presents promising findings for the use of FMSS as a new measure of parental reflective functioning.

Besides FMSS, another indirect assessment of RF is in-session coding. It was developed to decrease the possible fatigue effect of structured/semi-structured methods of measuring RF scores and consider therapy variables' influence on RF (Talia et al., 2019). Similar to the FMSS protocol, in-session parental reflection coding aims for a more practical and less time-consuming assessment method. One can better understand the mental processes underlying reflective functioning by analyzing session narratives. While structured or semi-structured methods, as explained above, have specific questions, in-session RF coding allows researchers to investigate the effect of the therapy process on the clients' RF level based on session flow. In addition to structured measurement methods, in-session PRF also explores other session components, such as the therapist's requests for mentalization and the client's current emotional state (Karlsson & Kermott, 2006).

In-session RF coding might be useful for examining how different therapies affect changes in RF scores and the relationship between RF and therapy outcomes. Similar to the other assessment methods, the most common coding system for in-session RF is the Reflective Functioning Scale (RFS; Fonagy et al., 1998). Selective sessions are transcribed and coded at the statement or block level to rate clients' RF during sessions. Researchers may choose to rate every sentence or create blocks for client speech and rate each block based on the research question. Most of the studies on in-session RF have been focused on adult psychotherapies. Below, these studies on adult psychotherapy are included, and studies examining in-session PRF in child therapies are examined under the heading “Parental Reflective Functioning in Child Psychotherapy”.

In 2016, Möller et al. undertook a study to examine the correlation between in-session RF coding scores and baseline RF scores obtained from the Adult Attachment Interview (AAI) in patients undergoing MBT therapy. The findings

revealed a moderate correlation between the RF scores obtained from AAI and those derived from session narratives (Möller et al., 2016). This study underscores the parallel results of RF scoring based on session narratives and AAI, thereby validating the use of session narratives for rating reflective functioning. Talia (2019) examines the validity and reliability of a new, more structured method for rating in-session RF developed by Josephs et al. (2004). In this method, clients' narratives are divided into blocks of 150 words, and each block is rated based on the RFS (Fonagy et al., 1998). A global RF score is then determined by combining these block scores. The study's results demonstrated a correlation between in-session RF scores and baseline AAI-based RF scores (Talia, 2019). Similar to the findings of Möller et al. (2016), this study suggests that using session narratives to examine reflective functioning is a suitable method for clinical practice. It is worth noting that while Möller et al. (2016) and Talia (2019) found a correlation between in-session coding and direct assessment scores, other studies have reported no such correlation (Kivity et al., 2021). The inconsistency in the literature sparked a discussion on in-session RF assessment. It was discussed that Adult Attachment Interview (AAI) focuses on past experiences and one's relationship with their parents, while in-session RF assessment does not require recalling these experiences. It may take longer to develop the capacity to reflect at the moment and understand others' thoughts and feelings during sessions than reflecting on one's earlier experiences (Kivity et al., 2021).

1.2. EFFECTS OF PARENTAL REFLECTIVE FUNCTIONING ON CHILD AND PARENT OUTCOMES

Research suggests that a higher level of parental reflective functioning (PRF) contributes to positive outcomes for both children and parents. This includes improvements in the social, emotional, and behavioral aspects of both children and parents. When parents are able to reflect on their own and their children's mental processes, it can lead to healthier family dynamics and individual well-being.

The high reflective capacity of parents appears to be associated with their children's enhanced emotion regulation, self-regulation, and secure attachment

development (Luyten et al., 2017). Parents can improve their relationship with their children by improving parental mentalization capacity, which involves gaining a better comprehension of their children's thoughts and feelings (Slade, 2005). Parents who can understand the underlying emotions and thoughts behind their child's behavior can approach the relationship with more empathy and sensitivity. Children who feel understood and supported by their parents are more likely to develop a safer and closer relationship with their parents. Parents' capacity to comprehend both their own and their children's mental states enables them to establish an environment where the children feel physically and psychologically secure (Slade et al., 2005). Interpreting and reflecting on children's emotions and thoughts gives parents the opportunity to create a safer environment for their children and display the containment they need when facing difficult emotions. In this safe relationship with their caregiver, observing parents' attempts to make children's behavior meaningful might help kids reflect on their mental states better and improve their reflective functioning ability (Luyten et al., 2017). This can help children develop healthy coping mechanisms for dealing with challenging emotions in the future. Parents who are attuned to their children's emotions and thoughts can play an important role in their children's emotional development and well-being.

Besides its effects on children, PRF has also been found to be related to many parenting skills. Parents' mentalization capacity is important for comprehending what children's behaviors, emotions, or thoughts evoke in parents. It means that parents' reflective capacity allows them to identify their own feelings and thought patterns when faced with a problem related to parenting. Reflective parents are more likely to detect their own feelings facing a parental issue, therefore they are more likely to regulate their own behaviors and affect during these times (Laranjo et al., 2008; McMahon & Meins, 2012; Rutherford et. al, 2013). Some studies have also examined the relationship between PRF and parental stress, as one's ability to regulate their emotions and understand underlying behavioral processes may impact their stress levels. Parents' capacity for mentalization may influence their ability to tolerate their children's behaviors during stressful experiences, which in turn may impact stress levels (Rutherford et al., 2013).

Midgley et al. (2019), found that parents who attended mentalization-based interventions displayed a significant decrease in parental stress. Byrne et al. (2019) also support that interventions that aim to increase parental reflective functioning decrease the parents' stress level during the treatment.

Below, studies that examine the relationship between PRF and child functioning will be discussed. Later, studies on PRF and parental functioning are displayed.

1.2.1. Parental Reflective Functioning as a Predictor of Child Outcomes

Research to date suggests that the reflective capacity of parents is strongly associated with their children's attachment style. Slade et al. (2005) investigated the intergenerational transmission of attachment and the effect of maternal reflective functioning. The results showed that securely attached mothers have higher parental reflective function scores, and their children are more likely to have secure attachment at 14 months. The study highlights the crucial mediating role of parental reflective functioning in understanding the transmission of attachment styles between parents and children. In a recent study, Borelli et al. (2016) replicated these findings on a sample of school-aged children and their parents. The result suggested that children of reflective parents are more likely to have a higher level of attachment security. Parents who focus on their children's outer and inner experiences increase children's sense of security.

There are also studies that displayed the relationship between PRF and child behavioral problems. Parents with higher mentalization capacity are more likely to observe and understand their children's emotional and behavioral struggles. Suchman et al. (2017) designed a randomized clinical trial to investigate the effectiveness of a mentalization-based individual therapy that aims to increase mothers' parental reflective functioning. It was predicted that, compared to the control group (who received parental education), therapy participants would have higher parental reflective functioning at the follow-ups. The results indicate that interventions aimed at enhancing parents' reflective capacity resulted in increased sensitivity to children's emotional and behavioral well-being compared to the

control group. This heightened sensitivity could potentially impact children's self-regulation skills, thereby affecting the observed behavioral issues. Below, we will discuss some of the studies that have investigated this relationship.

Studies show that higher Parental Reflective Functioning (PRF) is associated with higher self-regulation skills and lower externalizing and internalizing problems in children and adolescents (Benbassat & Priel, 2012; Ensink et al., 2016). Senehi et al. (2018) displayed that a parent's capacity for mentalization, as measured by their use of mental state words, is linked to their children's self-regulation skills, even at a young age. In the study, mothers and children were investigated in their home settings. Mothers' use of mental state words and representational mind-mindedness were evaluated to understand parents' mentalization-related behaviors and infants' self-regulation skills. The results showed that the mother's mentalization strategies, like using mental state talk, making causal inferences of mental descriptive words, and explaining the causality between the children's actions and mental states, are related to children's use of self-regulation strategies. It is suggested that parents' reflections on their children's mental states assist children in making sense of and regulating their own emotions. Therefore, children with reflective mothers are more likely to regulate their emotions and behaviors. The study by Centifanti et al. (2016) primarily focused on the effects of parents' mentalization skills on behavioral regulation. It was demonstrated that parents' ability to reflect on children's emotions is linked to children's externalizing behaviors. In the study children's externalizing behaviors were measured by having callous-unemotional (CU) traits, which include a lack of remorse, an absence of concern for shared values, and a deficit in emotional expression (Centifanti et al., 2016). Callous-unemotional traits (CU) are defined as "limited prosocial emotions" in the 5th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5; American Psychiatric Association [APA], 2013). The results showed that parents' use of mind-related comments at early ages predicts children's lower symptoms of callous-unemotional (CU) traits at age 10. Parents' attempts to make meaning of children's emotions may increase their sense of empathy, decreasing the development and frequency of externalizing problems.

Most of the findings on the predictive role of PRF on child outcomes are based on studies on mentalization-based interventions. Those interventions might target families, parent-child dyads, or only parents. Since intervention programs that only involve parents focus solely on improving parental reflective functioning, this section mainly represents the studies on these interventions.

Menashe-Grinberg and Meiri (2021) conducted a study on mentalization-based interventions for parents. In the study, the researchers investigated the self-regulation skills and problem behaviors of children whose parents participated in the intervention. The intervention aimed to increase parental engagement and enhance the attention and understanding of one's own and children's inner world by using psychoeducation, group discussion, and exercises. The intervention program led to an increase in the mother's reflective functioning capacity, which in turn resulted in children displaying fewer behavioral problems and higher self-regulatory skills. Moreover, when assessments were made six months after the end of the intervention, these positive effects were still recorded. The study showed that parental reflective function is crucial for children's ability to regulate their behaviors since the intervention focuses only on parental work. Results of an increase in mothers' ability to reflect upon children's underlying mental states might affect children's ability to understand their actions, emotions, and needs. This study demonstrates that even without any child-focused treatment, parent-focused interventions that enhance parental reflective capacity play a crucial role in regulating children's behaviors.

These findings were replicated by Enav et al. (2019) in a study with the parents of untypically developing children. In a study for parents of children with autism, parents attended mentalization intervention which consisted of psychoeducation on emotion regulation, group discussions, practices, and homework assignments for four weeks. Parents' ability to understand their own and their children's underlying mental states and affect regulation skills were aimed to be increased during the treatment. It is important to note that just like in the study Menashe-Grinberg and Meiri (2021), the study only focused on parental work; there is no treatment for children. Enav et al. (2019) showed that when the intervention

and control groups' pre- and post-symptom reports were compared, parents who attended the treatment showed an increase in their reflective functioning skills and their belief in the malleability of emotions. Moreover, it was observed that children of the intervention group exhibited fewer behavioral and affective problems.

It is crucial to acknowledge that there is an inconsistency in the literature. There are also some studies showing that mentalization-based interventions reduced reported child behavior problems but had no predictor effect of PRF. In these studies, mentalization enhancing interventions were used and resulted in the reduction of child problem behaviors. However, no significant direct effect of parents' mentalization capacity on this reduction is reported. One of these studies were conducted by Ordway et al. (2014). It was hypothesized that mentalization-based interventions would increase parents' mentalization capacity and decrease child behavior problems. The study showed that interventions that aim to increase parental mentalization had an enduring positive improvement in PRF and child behaviors. It is important to note that although children from the intervention group displayed reduced externalizing problems, no direct or mediator effect of PRF was found.

1.2.2. Parental Reflective Functioning as a Predictor of Parent Outcomes

The concept of parental reflective functioning is rooted in the ability to understand and process one's own mental states as well as the mental states of others. Therefore, it was expected that this capacity would be connected to parents' well-being. In the studies, parents' well-being is generally investigated based on their level of self-efficacy, the ability to regulate their emotions and their stress levels. The literature suggests that when mothers engage in self-focused mentalization, it plays a crucial role in regulating their emotions and subsequently soothing their children. However, this behavior can also indicate a high level of self-control, depressive symptoms, or a reduced tolerance towards their children's behaviors and emotions (Smaling et al., 2016). This study examines parent outcomes in terms of parental stress levels and their ability to regulate emotions.

Below, studies on the effects of PRF on parental stress and emotion regulation capacity are discussed.

Many studies have explored the impact of parental mentalization improvement on their emotion regulation skills and parental stress levels (Adkins et al., 2018; Enav et al., 2019, Byrne et al., 2019). Mentalization-based interventions were commonly utilized in these studies. Midgley et al. (2019) conducted a significant study on this subject. In the study, foster parents participated in a group intervention designed to enhance parental mentalization skills. The intervention aimed to help the parents better understand their own and their children's thoughts, feelings, and behaviors. The study results showed that the group that received the intervention displayed increased RF and reduced stress levels. This suggests that therapeutical attempts to increase parental reflective functioning also affect managing their own stress levels. These findings were also replicated by McMahon et al. (2012) for the parents of younger children. Their study investigated the relationship between parental mentalization, parenting behaviors, and stress levels. The results suggested that mothers who use more mental state words regarding their children show less parenting stress and less aggression during the interaction with their children. The findings from both of these studies provide compelling evidence that the level of parental stress experienced can be significantly influenced by the quality of parental reflective functioning (PRF). This influence has been observed through the use of different types of PRF assessments, indicating the diverse ways in which parental reflective functioning can impact levels of stress experienced by parents.

Higher parental reflective functioning is also linked to parents' higher emotion regulation abilities (Byrne et al., 2018). Making meaning of one's own emotional process and comprehending the emotional motivations behind others' behaviors may enable parents to effectively control and manage their emotional reactions in various parenting situations. In a study conducted by Luyten et al. in 2017, it was observed that parents with higher levels of Parental Reflective Functioning (PRF) demonstrated enhanced emotion regulation skills. The researchers found that parents' curiosity and interest in mental states, along with

their certainty about mental states, were particularly associated with higher scores in emotion regulation. This suggests that the willingness and active engagement of parents in mentalization processes play a crucial role in comprehending and effectively managing emotional processes. Similar to these findings, Schultheis et al. (2019) found that parents with lower levels of emotional awareness were likely to report less interest and curiosity towards children's mental states. Additionally, they reported that greater emotion regulation difficulties in parents were associated with pre-mentalizing modes in parents. This suggests a potential link between difficulties in parental emotional regulation and difficulties in mentalizing.

1.2.3. In-Session Parental Reflective Functioning in Child Psychotherapy

Most studies examining the changes in parental reflective functioning usually assess parenting reflective functioning (PRF) scores using structured interventions. These studies investigate if the change in PRF rated on AAI at the beginning and the end of the therapy process would be a predictive factor for therapeutical outcomes. Additionally, they contribute to clinical practices by examining effective mentalizing interventions in parent sessions. Therapists can use the results of these studies to determine which interventions are best suited for certain clients. Factors such as the session context and the therapist's approach have been found to be related to changes in RF during therapy (Kivity et al., 2021). Therefore, studies that focus on therapy as a process are more likely to use in-session ratings to measure PRF.

Best to our knowledge, there are limited studies investigating changes in parental reflective functioning and their influences on therapeutic outcomes based on child and parent session narratives. Georg et al. (2019) conducted a single case qualitative study on an 8-month-old infant and his depressed mother who received focused parent-infant psychotherapy (fPIP). Focused parent-infant psychotherapy (fPIP) aims to increase parents' reflective capacity in four sessions over 12 weeks. Mentalizing interventions were utilized during the sessions and are studied to determine which interventions are most effective in improving one's Parental Reflective Function (PRF). Results showed a slight increase in PRF between the

first and the last session. This slight change was discussed as a significant mechanism that led to an improved relationship with the child and an important change in the child's behavioral and emotional regulation capacity (Georg et al., 2019). The study also suggested that providing a supportive stance and establishing a positive therapeutic alliance by the therapist is one of the most effective mentalizing interventions for this case. Since PRF is evaluated based on the narratives provided by parents, they might reflect on their own and their children's mental states more easily in a supportive environment. When parents feel understood and supported, they are more likely to share their emotions and thoughts freely, which can result in more accurate evaluations of the child's mental state.

Following these results, Georg and colleagues (2023) conducted another study examining the changes in mothers' reflective capacities across and within sessions. Eleven infants with regulatory disorders and their mothers participated in a randomized controlled trial on brief dyadic-focused parent-infant psychotherapy. For coding in-session PRF, the procedure proposed by Josephs and colleagues (2004) was used; four sessions from each participant were transcribed and rated on the Reflective Functioning Scale (RFS; Fonagy et al., 1998). The study's findings revealed that significant increases in PRF were only observed only from the first session and the second session. However, there was a significant decrease in in-session PRF in the last session. There is a difference between these results and those presented in the study of Georg et al. in 2019. The observed discrepancy may be due to differences in sample size and analysis type since the earlier was a single-case qualitative study.

1.3. CURRENT STUDY

Numerous studies have investigated the effects of different therapy types on reflective functioning. However, it has been suggested that further studies should be conducted using the MBT-C therapy type to see how it would affect the results. This suggestion was made by Luyten et al. in 2020 and Georg et al. in 2023. Furthermore, these studies have also recommended an increase in sample size for

future research. This thesis aims to contribute to the existing literature by considering these suggestions.

The objective of this study is to investigate the changes in Parental Reflective Functioning among parents participating in Mentalization-Based Treatment for Child (MBT-C) and a control group with a focus on therapeutic narratives. The change in these skills will be compared for two different therapeutic models by examining narratives obtained from within the therapy. It was hypothesized that (1) when examining the narratives of parents in therapy, the change in parental reflective functioning among parents participating in MBT-C will be higher than the control group, (2) the change in PRF will predict a decrease in behavioral and emotion regulation problems in children, (3) the change in PRF will predict decrease in parental stress and emotion regulation problems of parents.

METHOD

2.1. RANDOMIZED-CONTROLLED TRIAL

This thesis that focuses on the changes in Parental Reflective Functioning in MBT-C and the Parenting and Social Skills (ÇABA) group therapy has been conducted within the scope of a randomized controlled trial at Istanbul Bilgi University. The randomized Controlled Trial titled “The Effectiveness and Change Mechanisms of Mentalization Based Therapy for Children (MBT-C)” received ethical approval (no: 2021-40024-48). The randomized controlled trial aimed to test the effectiveness of MBT-C compared to the control group (the Parenting and Social Skills group therapy). The trial was a parallel-group, single-blind study. Written consent was obtained from the parents who accepted the study, and verbal assent was obtained from the children. The sample used in this thesis was the participants randomly assigned to one of the two intervention arms (MBT-C or ÇABA).

First, the design of the randomized control trial, sample selection criteria, and intervention arms will be discussed. Later, the current thesis's data collection tools and procedure will be explained.

2.1.1. Randomized Control Trial Sample Selection

The sample of the randomized control trial started to be recruited in March 2022. The study's announcement was made through the social media accounts of Istanbul Bilgi University Psychotherapy Research. Participants applied to study via online form and telephone. Details of the sample selection process are presented in The CONSORT (Consolidated Standards for Reporting Trials) Flow Diagram (see Appendix A). In total, 644 families who applied to participate in the study completed the initial screening by an online link that included the Child Behavior Checklist (CBCL; Erol & Şimşek, 1995), Brief Symptom Inventory (BSI; Şahin and Durak, 1994), BAPIRT Alcohol and Substance Scales (Ögel et al., 2017), and Schedule for Affective Disorders and Schizophrenia for School-Age Children (K-SADS; Gökler et al., 2004). After completing the initial screening, participants were selected if they met the inclusion criteria and did not meet any of the exclusion criteria.

The randomized trial had two inclusion criteria; both relate to the child referred to therapy. The inclusion criteria were (a) children showing clinical-level problems based on the Turkish version of Child Behavior Checklist (CBCL; Erol & Şimşek 1995), (b) children being between the ages of 5-12. The exclusion criteria for the study were: (a) parents showing risk to themselves or others, psychosis level, and alcohol-substance use disorder as determined by the Turkish versions of Brief Symptom Inventory (BSI; Şahin and Durak, 1994) and BAPIRT Alcohol and Substance Scales (Ögel et al., 2017), (b) children showing Autism Spectrum Disorder, Psychosis, Eating Disorder, Conduct Disorder, Alcohol/Substance Use, risk to themselves and others as measured by the Schedule for Affective Disorders and Schizophrenia for School-Age Children (K-SADS; Gökler et al., 2004), (c) ongoing cases of physical and sexual abuse in the family as determined in diagnostic interview with parents, (d) cognitive impairment in the child and participating parents as indicated by the Kaufman Brief Intelligence Test (KBIT-2; Kaufman and Kaufman, 1990). Families who were found to be not suitable for the study were not accepted and referred to external therapy sources if needed.

In total, 419 families attended the diagnostic interview. After the diagnostic interview and applications, 222 clients met the criteria and were accepted to the study. Participants were randomly assigned in strata (age/sex/problem type) to either one of the treatment groups. 111 (50%) of the participants were assigned to the MBT-C intervention group, and 111 (50%) of them were assigned to the ÇABA control group. After the randomized assignment, 11 clients (5 from the MBT-C intervention group and 6 from the ÇABA control group) decided not to start the treatment and were excluded from the process analyses. As a result, 106 participants completed the MBT-C while 105 received control group intervention.

Below are details of the randomly assigned Mentalization-Based Therapy for Children (MBT-C) and Parenting and Social Skills (ÇABA) group therapy interventions.

2.1.2. Mentalization-based therapy for Children (MBT-C)

Mentalization-Therapy for Children (MBT-C) is a short-term intervention, lasting for 15 weeks, that is designed for children between ages 5 and 12 and their parents. MBT-C aims to enhance the mentalization skills of children and parents by using various interventions that are based on psychodynamic and attachment principles (Midgley et al., 2017). Two therapists who cooperate and support each other in parallel sessions conduct children and parent sessions.

MBT-C therapy in the study consisted of 3 family sessions and 12 individual sessions. Although it is possible for some clients to apply MBT-C therapy up to 36 weekly sessions, it has been limited to the original version of 15 sessions in this study. Families were referred to long-term therapy at the end of the study if necessary.

The first session of the MBT-C was a family session in which both therapists were present. In this session, the main aim was to get to know family members and better understand the reason for referral from the perspective of all family members. In family therapy sessions, therapists used various methods, such as having family members introduce each other or choosing an animal to represent each family member, to understand family dynamics better. At the end of the session, the

therapists introduced the concept of mentalization to the family in a way that was appropriate to the child's age and family's level of understanding. The session was concluded by planning the following sessions.

In the second session, the parents and the child had individual parallel sessions with their own therapists. These sessions aimed to develop the client-therapist relationship and further understand the reason for referral. In the child session, a therapy calendar was introduced to the child. The child filled out the therapy calendar in each session and was allowed a reflective area in which the child could narrate how they see the sessions. Free play was also used to gather information about the child and the problem area. In parent sessions, parents' perceptions of the problem and child were considered one more time when the child was absent.

After an individual session, two therapists and the family gathered for a review meeting. The therapists shared the focus formulation in this session based on their observations in two prior sessions for the referred problem. The focus formulation is an important tool in MBT-C for a better understanding of the problems that the family is experiencing. This formulation aims to give a family a different and external perspective on the issue by using metaphors and stories suitable for the family's cognitive development level. By using focus formulation, the therapy goals and planned interventions were determined with the contributions of the family members.

The 11th session was the third and last family meeting. Up to this session (sessions 4-10), various mentalization interventions were applied to enhance the child's and parents' mentalization skills in individual sessions. These interventions were applied to increase mentalization skills, develop awareness and sensitivity against mentalization breakdowns, and subsequently enhance emotion regulation skills. Interventions in both parent and child sessions were associated with the three fundamental steps of mentalization: attention control, emotion regulation, and explicit mentalizing. Interventions that help people become more aware of their own or others' behaviors and bodily sensors are called attention control interventions (Midgley et al., 2017). Mirroring, creating joint attention, and

describing the current situation are some of the attention control interventions. Having a capacity for attention control helps children and parents to focus on embodied internal and external experiences (Ensink et al., 2016). Emotion regulation interventions aim to identify and regulate one's emotions. Awareness and curiosity about patients' feelings, naming and validating emotional states are some of the emotion regulation interventions that could take part in sessions. Since the patients might have struggles to understand and regulate their emotions, therapists attempt to make sense of those internal feelings as external support. Lastly, explicit mentalization interventions assist patients in having higher mentalizing abilities. Playing with perspective or mentalizing the therapeutic relationship are some interventions that demanding explicit mentalizing. For parent sessions, there are also mentalized affectivity interventions and techniques like interrupting pre-mentalizing and restoring mentalizing. All interventions in MBT-C were implemented with the therapist's stance, which includes the therapist making comments at a level suitable for the client's developmental level, maintaining a non-judgmental stance, using ostensive cues, having a curious attitude, possessing a playful stance, and being responsive to the parent's epistemic trust. By developing and maintaining this stance, therapists can apply the most suitable technique and intervention considering the clients' developmental levels and issues.

In the 11th session, which was a review meeting with the family and two therapists, the therapy process and observed developments are shared with family members. The focus formulation created at the beginning of the therapy was reviewed, and the current state was explained. The therapists considered the family's thoughts and feelings on the observed changes and development. The therapist informed the family about the remaining four sessions, marking the start of the final phase of therapy.

In the individual sessions between 12 and 15, therapy ending was worked on with the child and parents separately. In the child therapy sessions, a calendar was utilized to remind the child of the remaining sessions and to review the games and topics discussed during the process. The clients' developed mentalization skills were highlighted to encourage using these skills after the sessions end. A therapy

calendar or a drawing by the therapist was given to the child, aiming to make the child-therapist relationship and therapy process more permanent. The therapy process was reviewed in the last parent session, and parents' reflections on the ending were discussed. If it was thought to be necessary, the family was referred for long-term therapy or other support in the last session.

In this randomized control trial, MBT-C was applied by 16 therapists who were between 25 and 41 (M = 29), 90% women, and with an experience level of 1-5 years (M = 2.96). They completed a standard MBT-C training (6 sessions of 3 hours each) provided by Anna Freud Center instructors Dr. Emma Morris and Dr. Holly Dwyer Hall. The therapists are regularly supervised by the same instructors.

2.1.3. Parenting and Social Skills (ÇABA)

Parenting and Social Skills (ÇABA) group therapy was applied as a control group intervention in a randomized trial. Group therapy sessions were conducted for 12 weeks in separate but parallel sessions for parents and children. Two therapists worked as a team for parent sessions and two for child sessions. Parenting and Social Skills (ÇABA) group therapy consisted of structured sessions and was applied to each group in the same context and contents (Söylemez & Göcek, 2022). Considering the age difference and various interests of children, alternative games and activities were used in child sessions. For this study, groups were created from randomly assigned 111 participants while children's age, gender, and family availability for group time were considered for each participant.

In the first session, one of the child group's therapists and one of the parent's therapists met with each family individually for an online meeting. This meeting aimed to gain information about the client and the referred problem through structured questions. In the first section of the meeting, the therapists interviewed with parents and discussed their reason for referral, how the issued problem affects the family, and how parents feel about facing these problems. In the second section of the meeting, the therapists interviewed the child only to introduce themselves and the therapy process to the child. Some questions about the school he/she attends, his/her best friend was asked to develop a relationship with the child. After

the referred problem was discussed with the child, parents were invited to the meeting for a 10-minute play/talk time (according to the child's age) with the child. Observations made during this time give the therapists important information about family dynamics and the child's playing skills.

In the first group session, all parents and children attended, in addition to all four therapists. The aim of this session for each group member was to meet one another and familiarize themselves with the group settings. Some warm-up games were used to increase children's attendance and interest and to create a group relationship. At the end of this session, both children and parents shared their expectations from group therapy.

The following sessions between 3 and 10 were conducted separately. In parent sessions, parents were informed about child development and discussed basic principles such as communication with children, affect control, setting limits, and parental discipline in each group meeting. The basic principles of effective communication with children are discussed, including how to actively listen to children, and how to use play as a communication way. Parents are also taught strategies for affect control, including how to manage their own emotions in order to create a calm and supportive environment for their children. In addition, parents are given guidance on setting limits, including how to create and enforce reasonable rules and boundaries that are appropriate for their child's age and developmental stage. In-child sessions aimed to develop better social skills such as communication, playing skills, empathy, and anger management. Communication skills are developed through activities that encourage children to express themselves clearly and effectively, such as role-playing exercises, group discussions, and storytelling. Playing skills are developed through games and activities that encourage cooperation, sharing, and turn-taking, as well as creative problem-solving and imaginative play.

In the 11th session, parents and children joined together for the last group session. Both children and parents were asked to share and reflect on the parts they liked most about group sessions they attended and the changes they observed in themselves or their families.

The last session with families was conducted online as an individual online meeting similar to the first session. The two therapists interviewed the parents and children separately to discuss their thoughts on the therapy process and suggestions for possible further studies. A 10-minute play/talk time was repeated to observe therapeutical outcomes in a play setting. The therapists gave their feedback and shared their observations about the therapy process with the child and parents. In this last session, if it was considered necessary, long-term therapy or other therapy options were presented to the family.

ÇABA group therapies were conducted by 36 therapists who attended the required training provided by Dr. Yudum Söylemez and Dr. Elif Göcek. Training for ÇABA was completed in 6 sessions, 3 hours each. Therapists were in the age range of 23-38 (M = 27) and at the experience level of 1-5 years (M = 3.36). 95% of the therapists in group therapies were women. Dr. Yudum Söylemez and Dr. Elif Göcek provided supervision for the therapists.

2.2. DATA COLLECTION

Demographic information and measurements were first received before treatment and at the end of the treatment (12th week for ÇABA and 15th week for MBT-C). While parent scales were collected via online link sent to the clients, the child scales were collected through phone calls. Below, the data collection tools used in this thesis are explained.

2.2.1. Sociodemographic Information Forms

Sociodemographic Information Form was completed by participants in RCT. It consists of information regarding the children's age, gender, past therapy experiences, and the family's education level, socio-economic level, and marital status.

2.2.2. The Child Behavior Checklist (CBCL)

The scale developed by Achenbach (1991) is commonly used to identify

behavioral and emotional issues in children and teenagers**.** Parents were responsible for filling out the checklist, considering their observations of their children. CBCL has two different versions for different age groups; for ages between 1.5 and 5, there are 99 items in the checklist, and for ages between 6 and 18, there are 112 items. These items are parts of three main subscales: externalizing (attention deficits, aggressive behaviors, etc.), internalizing (somatic problems, anxiety/depression, etc.), and total problems. The scale is scored on a 3-point Likert system: 0 for not true, 1 for sometimes or somewhat true, and 2 for very or often true.

The internalizing, externalizing, and total problem subscales demonstrated strong internal consistency and test-retest reliability in the original study by Achenbach and Rescorla (2001) (αs= .90, .94, and .97, rs = .91, .92, and .94, respectively). Turkish adaptation of CBCL for 6-18 age was made by Erol and Şimşek (2010). In this adaptation, internal consistency (αs = .87, .90, and .94 respectively) and test-retest (*rs = .93*) values were found to be adequate (Erol & Şimşek, 2010). The Turkish version of the CBCL for ages 1.5-5 is presented in Appendix B and for ages 6-18 is displayed in Appendix C. In this randomized controlled trial, participants' scores for internal, external, and total problems were .87, .91, and .95, respectively.

In this study, raw scores for the internalizing, externalizing, and total problems subscales were converted to standardized T-scores (Achenbach, 1991). According to this calculation, children who scored between 60 and 65 T-scores were classified as borderline clinical level, and those who scored between 65 and 100 were classified as clinical level.

2.2.3. Me and My Feelings Scale (MMF)

The scale developed by Deighton and colleagues (2013) aims to measure children's emotional awareness and well-being. Children's capacity to understand emotions like anger, happiness, fear, and sadness and to be aware of their behaviors related to these emotions were assessed by this scale. The Me and My Feelings Scale can be used for children between the ages of 8 and 19. The scale is a self-

report questionnaire with a total of 16 short items, which are further divided into two sub-scales: 10 items related to emotional difficulties and 6 items related to behavioral difficulties (Deighton et al., 2013). Children are asked how often they feel the items are suitable for them. They rate each item as "0" if it is never expressed, "1" if it is sometimes expressed, and "2" if it is always expressed.

The scale has good internal reliability for the clinical sample; the Cronbach's alpha for the emotional difficulties subscale was .84, and for the behavioral difficulties subscale, it was .82 (Patalay et al., 2014). It was also found that the scale had good cross-informant agreement with the parent-reported scale (Strengths and Difficulties Questionnaire parent version; SDQ; Goodman, 1997) (*r* = .30). Turkish adaptation of the scale was prepared by İlnem (2020) and the scale was found to have a high internal reliability and good internal consistency (α = .92, rs = 041). This adaptation of the MMF used in this study is illustrated in Appendix D.

2.2.4. The Difficulties in Emotion Regulation Scale-Brief Form (DERS-16)

This scale, developed by Gratz and Roemer (2004), aims to measure one's capacity for emotion regulation and the difficulties in this process. DERS, suitable for ages 18 and over, is used to understand one's ability to identify, recognize, and control one's emotions and acceptance skills. Besides these skills, the scale measures impulse control difficulties and difficulties engaging in goal-directed behavior. There are 36 items and 6 subscales to assess one's difficulties in emotion regulation: Nonacceptance of Emotional Responses, Difficulties Engaging in Goal-Directed Behavior, Impulse Control Difficulties, Lack of Emotional Awareness, Limited Access to Emotion Regulation Strategies, and Lack of Emotional Clarity. The short version of the scale (DERS-16) was generated by Bjureberg et al. (2016). The awareness subscale was removed from the original scale, and the item number was reduced to 16 from 36. The items are rated on a 5-point Likert scale from 1 (almost never) to 5 (almost always), with higher scores indicating a difficulty in emotion regulation.

DERS-16 was found to have a high internal consistency and good reliability (α = .92, *r* = .93) (Bjureberg et al. 2016). Turkish adaptation of the scale was transformed by Yiğit and Guzey Yiğit (2019). In this adaptation, the scale's internal consistency for the total score was adequate (α =.92) (Yiğit & Guzey Yiğit, 2019). The Clarity, Goals, Impulse, Strategies, and Non-Acceptance subscales show good internal consistency in the Turkish sample (respectively; α =.84, .87, .87, .78). In this study, the total DERS score was calculated by summing the subscale scores. The scale was found to have good internal reliability and internal consistency. Appendix E presents the Turkish version of the Difficulties in Emotion Regulation Scale-Brief Form.

2.2.5. Parental Stress Index (PSI) – Short-Form

Parental Stress Index is a scale developed by Abidin (1995) and commonly used to measure parental stress. The purpose of the scale is to assess parents' stress levels when they are experiencing child-related problems. The PSI Short Form was developed to ensure clinicians' and researchers' demands for a brief measurement tool for assessing parenting stress. Castaldi's (1990) factor analysis of the original PSI was used while developing The PSI Short Form. It can be used for parents of children 12 years or younger.

There are 36 items and 3 subscales: Parental Distress, Difficult Child, and Parent-Child Dysfunctional Interaction (Abidin, 1995). Items in the Parental Distress subscale aim to report parents' feelings of support, capability, contradiction, and depression. The difficult child subscale aims to understand how the parent perceives their children, whether they perceive the child as easy or challenging to care for. In the Parent-Child Dysfunctional Interaction Subscale, parents' satisfaction level with their relationship as a parent-child duo is assessed. The scale measures not only subscale scores but also the overall level of parental stress. The scale was rated on a 5-point Likert-type scale (from 1 = 'strongly agree' to 5 = 'strongly disagree').

The scale demonstrated strong internal consistency and reliable test-retest results (αs ranging from .80 and .91; *rs* ranging from .68 to .85). A Turkish version

was prepared by Mert et al. (2008). The Turkish version of the scale also displayed good internal consistency and reliable test-retest results (α = 0.71; *rs* ranging from .88 to .95). The scale that is used in this study is presented in Appendix F.

2.2.6. Reflective Functioning Scale

Reflective Functioning Scale, developed by Fonagy and colleagues (1998), measures one's awareness of mental states (emotions, thoughts, desires, etc.) about oneself or others and the relationship between these mental states and their behaviors. In this thesis, the Reflective Functioning Scale (RFS) was used to assess parents' reflective functioning capacity at the beginning and end of the treatment. The RFS coding system measured the five-minute sections in which parents discussed their children and the referred problem from the first and the last sessions. While determining the sections to be coded, the Five-Minute Speech Sample procedure created by Adkins and Fonagy (2017) was used. The Five-Minute Speech Sample (FMSS) is a procedure for coding reflective functioning in parents, which involves asking a parent to speak for five minutes about their relationship with their child (Adkins & Fonagy, 2017). Some questions that can be used in FMSS are: "Can you briefly talk about the recent challenges you have faced? Who or what supported you during these challenges?" and "Could you introduce your children in a few sentences?". Parents' answers to these questions or their speech on similar topics are selected to be coded. Since the FMSS is an interview-based procedure in which parents are alone while giving their speech, it was not found to be completely suitable for this study in which therapy narratives are used. While creating the coding procedure for this study, other studies that used therapy narratives by Georg and colleagues (2021; 2022) and Talia and colleagues (2015) were used.

According to the FMSS coding manual (Adkins and Fonagy, 2017), coders rate parents' reflective functioning between -1 (Negative RF; anti-reflective or bizarre) and 9 (Full or Exceptional RF). It was considered as low RF if the parent only referred to a mental state without giving any details. The score -1, known as negative RF, shows parents have a bizarre or hostile attitude towards questions or therapists or a hostile or anti-reflective attitude towards their children. If a parent

focuses on children's behaviors rather than his/her mental states, it is commonly rated as 1 or 2. The score 3 (questionable or low RF) is given if parents use mental state words regarding themselves or their children, however, do not provide any details regarding the nature of these mental states or relational aspects. The RF score of 5 (definite or ordinary RF) or above is expected to indicate awareness of the nature of the mental state in question and its relationship with other mental states or behaviors. To receive these scores, parents' statements must consider at least one of the indicators of reflective functioning with an adequate explanation (Fonagy et al., 1998). These indicators include understanding the nature of mental states, making an effort to understand the emotions underlying behaviors, recognizing the effects of developmental processes on mental states, or reflecting on mental states relevant to the therapist. Explanations that include these indicators and include a sophisticated narrative are coded as marked RF, that is, 7 points. For 9, full or exceptional RF, the parent is expected to have a full awareness of the mental states mentioned and to explain the mental states with their relational and behavioral effects in a sophisticated language.

FMSS Procedure allows the coding of parental reflective functioning in 3 different aspects: self (parent) RF, child RF, and global RF. These aspects are based on the multidimensional structure of mentalization (Smaling et al.,2016). Self-focused reflective functioning is parents' ability to reflect upon their own mental states to comprehend their actions and their effects on children (Borelli et al., 2016). This skill involves an understanding of the thoughts, feelings, and motivations that drive their actions and how these actions can impact their children's emotional and psychological well-being. On the other hand, child-focused reflective functioning is defined as the capacity to understand children's behaviors and underlying emotional processes. It involves the capacity to reflect on the thoughts, feelings, and motivations that drive children's actions and to appreciate the unique perspectives and experiences that shape their development. Global score includes not only self and child RF but also mentalization of other people, therapist, and the therapy process.

2.3. PROCEDURES

Demographic information and measurements were first received before treatment and at the end of the treatment (12th week for ÇABA and 15th week for MBT-C). While parent scales were collected via an online link sent to the clients, the child scales were collected through phone calls.

Within the scope of this thesis, after all treatments ended, the first and last sessions of the parent therapies were transcribed. From the obtained transcripts, the first and last sessions of parent therapy of 211 clients who participated in MBT-C or group therapy were examined, and sections were prepared for five-minute coding. In group sessions, the sections where parents answer the following structured questions are selected: "Can you briefly talk about the difficulties you have experienced recently?", "Who or what supported you during these challenges?", "Could you introduce your children in a few sentences?". In MBT-C sessions, the first and last sessions are examined to select five-minute samples in which parents discuss similar topics to ÇABA sessions. If no speech is similar to these topics, one individual session is examined before or after the first and last session.

The criteria taken into consideration while determining participants for the study were as follows: (a) Since the mothers' PRF scores were examined, the mother should be present at the therapy; (b) For MBT-C participants, parents were required to attend the individual session before the focus formulation and the last two individual sessions; (c) For ÇABA group therapy, parents were expected to participate the first and last individual meetings; (d) Since the PRF coding was completed on transcriptions, recordings of the first and last sessions were required.

Among the participants of the randomized-controlled trial, 35 of the 105 clients who participated in group therapy did not attend to the last session. Eight parents were not included in the coding since there was no record of their last session, and 1 mother was not included in the coding because they had their children next to them in their last online session. Three participants were excluded from the current study because mothers' narratives in sessions were much less than five

minutes. For this thesis, the in-session PRF scores of 58 mothers who participated in group therapy were coded. In the MBT-C intervention, 21 participants did not show up on the last sessions of the therapy, therefore they were excluded from the current study. Twenty-two sessions could not be included in the data due to a lack of relevant statements to the selected FMSS questions. Two participants were excluded because their mothers did not attend the initial sessions, and two others were excluded because the children were present in the first sessions. A total of 59 mothers were included in the current study. The demographic information of the study sample is represented in Table 2.1.

Table 2.1. Demographic Information of the Sample (N = 117)

Treatment Arm		*Category*	*n*	*M*	*SD*	*Range*
MBT-C	Child Age			8.22	1.99	5.00-12.00
	Child Gender	Female	25	1.58	0.49	1.00-2.00
		Male	34			
	Problem Type	Internalizing	27	1.92	0.91	1.00-3.00
		Externalizing	10			
		Comorbid	22			
	Mother Age			38.36	4.66	29.00-50.00
	Mother Education	Primary school	6	5.07	1.50	2.00-7.00
		Middle school	3			
		High school	9			
		Associate degree	14			
		Undergraduate education	17			
		Graduate education	10			
Control	Child Age			7.71	1.86	5.00-12.00
	Child Gender	Female	17	1.71	0.45	1.00-2.00
		Male	41			
	Problem Type	Internalizing	25	2.00	0.93	1.00-3.00
		Externalizing	8			
		Comorbid	25			
	Mother Age			38.14	4.74	25.00-50.00
	Mother Education	Primary school	6	5.16	1.50	2.00-7.00
		Middle school	2			
		High school	8			
		Associate degree	13			
		Undergraduate education	19			
		Graduate education	10			

Note. MBT-C = Mentalization-Therapy for Children. Control = Parenting and Social Skills.

Five-minute therapy narratives were coded by 4 undergraduate Clinical Psychology students at Istanbul Bilgi University who completed Child Attachment Interview coding training. This training was given by one of the faculty members of Laval University Prof. Dr. Karin Ensink and clinical psychologist Dr. Josée Duval lasted for 21 hours as a theoretical and applied course. Since the Reflective Functioning Scale is used in both Child Attachment

Interview and parental reflective functioning, the coders were considered suitable for PRF coding. The in-session PRF procedure created for the thesis was explained to the coders by the thesis author, and the written procedure was also shared. During the ratings of in-session PRF, information indicating the identity of the clients or the applied treatment arm was hidden, and session sections were prepared ready for blind-coding. Good inter-rater reliability was observed for in-session PRF. Afterwards, the coding was completed by three coders making separate pairwise matches with the thesis author.

RESULTS

3.1. COMPARING THE CHANGES OF PARENTAL REFLECTIVE FUNCTIONING BASED ON TREATMENT ARM

Descriptive statistics, including means, standard deviations, maximum and minimum values, skewness, and kurtosis, were examined to assess normality. Table 3.1 displays descriptive statistics for the Parental Reflective Functioning Scores of mothers.

Table 3.1. Descriptive Statistics for the Parental Reflective Functioning Scores

Treatment Arm		*n*	*M*	*SD*	*Range*	*Skewness*	*Kurtosis*
MBT-C	Baseline PRF Self	59	3.44	0.77	1.50-5.50	-0.02	0.51
	Final PRF Self	59	3.92	1.16	1.75-7.00	0.32	-0.07
	Baseline PRF Child	59	4.06	0.95	2.00-6.50	0.37	-0.07
	Final PRF Child	59	3.67	0.73	2.00-5.00	-0.17	-0.78
	Baseline PRF Global	59	3.56	0.69	2.00-5.00	-0.28	-0.38
	Final PRF Global	59	3.99	0.99	2.00-6.50	0.26	-0.16
	Valid N (listwise)	59					
Control	Baseline PRF Self	58	3.15	0.88	1.50-5.00	0.15	-0.80
	Final PRF Self	58	3.77	0.81	2.00-6.00	0.66	0.76
	Baseline PRF Child	58	3.45	0.79	1.00-5.00	-0.36	0.89
	Final PRF Child	58	3.35	0.88	2.00-6.00	0.57	0.14
	Baseline PRF Global	58	3.25	0.81	1.75-5.50	0.44	-0.39
	Final PRF Global	58	3.61	0.70	2.00-5.50	0.25	0.34
	Valid N (listwise)	58					

Note. PRF = Parent Reflective Functioning. MBT-C = Mentalization-Therapy for Children. Control = Parenting and Social Skills.

A repeated measures ANOVA was conducted to analyze the impact of the treatment arm on changes in Parental Reflective Functioning (PRF) scores from initial sessions to final sessions. This analysis controlled for problem type, child

age, child gender, mother's age, and mother's education as covariates. The initial PRF global scores and final PRF global scores were assessed as the within-subject variables to observe the change in PRF scores. Before conducting the repeated measures ANOVA, the assumptions of normality and equal variances were evaluated to ensure the validity of the results. Normality was assessed by inspecting the Q-Q plots for each time point. The Q-Q plots suggested that the data were approximately normally distributed for each time point. Levene's Test for homogeneity of variance was performed to assess the equality of variances across the groups. The test indicated that the assumption of homogeneity of variance was met, $F(1, 115) = 1.749$, $p = .189$ for baseline PRF scores and , $F(1, 115) = 2.396$, $p = .124$ for final PRF scores. Thus, the variances were equal across the groups, justifying the use of ANOVA. Table 3.2 represents the results of the analysis.

The repeated measures ANOVA revealed a significant main effect of the treatment arm on PRF global scores ($F(1,110) = 7.16$, $p < .05$, $\eta^2 = .045$). Post hoc tests using the Bonferroni correction indicated that the PRF scores of MBT-C ($M = 3.77$, $SE = .08$) were significantly higher than the PRF scores of the control group ($M = 3.43$, $SE = .08$ $p < .01$). However, there was no significant main effect of time ($F(1,110) = 7.16$, $p = .524$, $\eta^2 = .004$). Additionally, the interaction between the change in PRF scores and the treatment arm did not reach statistical significance ($F(1,110) = .495$, $p = .48$, $\eta^2 = .004$). No significant interaction existed between covariate variables and PRF scores.

Table 3.2. Summary of Repeated Measures ANOVA Examining the Impact of Treatment Arm on Change in PRF Global Scores

Measure	*df*	*F*	η²	*p*
Between – Subjects				
Intercept	1	31,006	0,220	0,000
Treatment Arm	1	7,163	0,061	0,009
Error	110			
Within - Subjects				
Time	1	0.409	0.004	0.524
Time * Problem Type	1	1.231	0.011	0.270
Time * Child Gender	1	0.198	0.002	0.657
Time * Child Age	1	2.533	0.023	0.114
Time * Mother Age	1	0.007	0.000	0.932
Time * Mother Education	1	2.445	0.022	0.121
Time * Treatment Arm	1	0.495	0.004	0.483
Error	110			

As a follow-up analysis, since there was no significant interaction for PRF global scores, separate repeated measures ANOVAs were conducted to examine changes in PRF child and PRF self over time. Results showed no significant main effect of time on the PRF self scores across time ($F(1,110) = .491$, $p = .48$, $\eta^2 = .004$; Table 3.3). However, a marginally significant main effect was observed for the treatment arm on the PRF self scores across time ($F(1, 110) = 2.81$, $p = 0.09$). This result did not reach statistical significance. Additionally, there was no significant interaction between the treatment arm and the change in PRF ($F(1,110) = .206$, $p = .65$, $\eta^2 = .002$).

Table 3.3. Summary of Repeated Measures ANOVA Examining the Impact of Treatment Arm on Change in PRF Self Scores

Measure	*df*	*F*	η^2	*p*
Between - Subjects				
Intercept	1	21.785	0.165	<0.001
Treatment Arm	1	2.816	0.025	0.096
Error	110			
Within - Subjects				
Time	1	0.491	0.004	0.485
Time * Problem Type	1	0.880	0.008	0.350
Time * Child Gender	1	0.013	0.000	0.909
Time * Child Age	1	2.346	0.021	0.128
Time * Mother Age	1	0.036	0.000	0.850
Time * Mother Education	1	2.455	0.022	0.120
Time * Treatment Arm	1	0.206	0.002	0.651
Error	110			

The repeated measures ANOVA revealed a significant main effect of the treatment arm on the PRF child scores across time ($F(1,110) = 11.80$, $p < .00$, $\eta^2 = .097$). Post hoc tests using the Bonferroni correction indicated that the PRF child scores of MBT-C ($M = 3.85$, $SE = .08$) were significantly higher than the PRF child scores of the control group ($M = 3.41$, $SE = .08$ $p < .00$; Table 3.6). The results displayed no significant main effect of time ($F(1,110) = .170$, $p = .68$, $\eta^2 = .002$). However, a marginally significant interaction between the change in PRF child scores and the treatment arm was observed ($F(1,110) = 3.313$, $p = .07$, $\eta^2 = .029$; see Table 3.4). No significant interaction existed between covariate variables and PRF child and PRF self scores.

Table 3.4. Summary of Repeated Measures ANOVA Examining the Impact of Treatment Arm on Change in PRF Child Scores

Measure	*df*	*F*	*η²*	*p*
Between - Subjects				
Intercept	1	33.911	0.236	0.000
Treatment Arm	1	11.805	0.097	0.001
Error	110			
Within - Subjects				
Time	1	0.170	0.002	0.681
Time * Problem Type	1	1.053	0.009	0.307
Time * Child Gender	1	0.496	0.004	0.483
Time * Child Age	1	1.597	0.014	0.209
Time * Mother Age	1	0.003	0.000	0.959
Time * Mother Education	1	1.374	0.012	0.244
Time * Treatment Arm	1	3.313	0.029	0.071
Error	110			

3.2. PREDICTIVE EFFECT OF PRF ON THERAPY OUTCOMES OF CHILD

Descriptive statistics, including means standard deviations, maximum and minimum values, skewness, and kurtosis, were examined to assess normality. Table 3.5 presents descriptive statistics for Child Behavior Checklist (CBCL), Me and My Feelings Scale, The Difficulties in Emotion Regulation Scale (DERS), and Parental Stress Index (PSI).

Table 3.5. Descriptive statistics for Child Behavior Checklist (CBCL), Me and My Feelings Scale, The Difficulties in Emotion Regulation Scale (DERS), and Parental Stress Index (PSI)

Treatment Arm		*n*	*M*	*SD*	*Range*	*Skewness*	*Kurtosis*
MBT-C	Baseline CBCL	59	68.44	5.68	56-80	-0.12	-0.85
	Final CBCL	58	60.98	9.18	42-78	-0.17	-0.45
	Baseline MMF Total	55	11.76	5.67	1-25	0.20	-0.58
	Final MMF Total	55	10.58	4.54	1-20	-0.22	-0.61
	Baseline PSI	59	96.10	17.47	62-139	0.26	-0.74
	Final PSI	58	91.45	15.98	63-130	0.43	-0.57
	Baseline DERS	59	36.49	12.40	19-62	0.54	-0.72
	Final DERS	58	32.88	11.94	16-60	0.52	-0.73
	Valid N (listwise)	54					
Group	Baseline CBCL	58	68.34	5.91	54-79	-0.36	-0.41
	Final CBCL	55	58.31	11.53	30-79	-0.36	-0.27
	Baseline MMF Total	54	11.59	5.63	0-30	1.18	2.99
	Final MMF Total	50	11.04	5.28	2-29	0.96	2.09
	Baseline PSI	58	97.05	18.07	36-139	-0.15	1.96
	Final PSI	55	90.22	18.79	50-125	-0.18	-0.46
	Baseline DERS	58	34.59	10.29	16-60	0.54	-0.16
	Final DERS	55	31.64	9.76	16-55	0.45	-0.36
	Valid N (listwise)	49					

Note. MBT-C = Mentalization-Therapy for Children. ÇABA = Parenting and Social Skills. CBCL = Child Behavioral Checklist. MMF = Me and My Feelings Scale. PSI = Parental Stress Index. DERS = The Difficulties in Emotion Regulation Scale-Brief Form (DERS-16)

A hierarchical regression was conducted to investigate the relationship between the change in PRF scores and children's therapy outcomes. The hypothesis was that the change in in-session parent reflective functioning would predict a decrease in behavioral and emotion regulation problems in children, as well as a decrease in parental stress and emotion regulation problems for parents. The scores of the Child Behavior Checklist (CBCL) and Me and My Feelings Scale (MMF) at the end of the therapy were used to measure behavioral and emotional regulation problems. Control variables such as problem type, child age,

child gender, mother age, mother education, and baseline scores were examined. A difference score for each participant was computed by subtracting the initial PRF score from the final PRF score. First, control variables were entered into the regression analysis, and the PRF difference score was added in the second step.

Hierarchical regression results for CBCL revealed that in the first step, problem type, child age, child gender, mother age, mother education, and baseline CBCL score significantly contributed to the regression model ($F(6,106) = 4.43$, $p < .00$, $\eta^2 = .201$; Table 3.6). Adding the PRF Global difference score as a predictor to the regression model in the second step explained 22% of the variation ($F(7,105 = 4.42$, $p < .00$, $\eta^2 = .228$). Additional coefficients were further assessed to interpret the influence of the PRF Global Difference score on the CBCL Total score. The results revealed that the PRF Global Difference score was not a significant predictor of the CBCL Total score. However, there was a trend towards significant ($\beta = -.169$, $p = 0.058$). Examining the control variables, only CBCL baseline scores had a significant and positive impact on CBCL final scores ($\beta = .384$, $p < .00$).

Table 3.6. Summary of Hierarchical Regression Predicting Final CBCL Scores by Problem Type, Child Age, Child Gender, Mother Age, Mother Education, Baseline CBCL, Change in PRF Scores

Intercepts and Predictors	Model 1					Model 2				
	B	*SE*	*β*	*t*	*p*	*B*	*SE*	*β*	*t*	*p*
Constant	5.15	15.08		0.34	0.73	4.54	14.90		0.30	0.76
Baseline CBCL	0.69	0.21	0.37	3.28	0.00	0.72	0.21	0.38	3.43	<0.00
Child Age	0.03	0.49	0.00	0.06	0.95	-0.10	0.49	-0.02	-0.21	0.82
Child Gender	1.82	1.89	0.08	0.96	0.33	1.63	1.87	0.07	0.87	0.38
Problem Type	0.89	1.23	0.07	0.72	0.47	0.95	1.21	0.08	0.78	0.43
Mother Age	0.10	0.19	0.04	0.54	0.58	0.11	0.19	0.05	0.55	0.57
Mother Education	-0.49	0.61	-0.07	-0.81	0.41	-0.30	0.61	-0.04	-0.50	0.61
Change in PRF						-1.99	1.04	-0.16	-1.91	0.05

Note. CBCL = Child Behavior Checklist. PRF= Parental Reflective Functioning. Model 1: $R^2 = .201$, $F(6, 106) = 4.433$, $p < .001$.
Model 2: $R^2 = .228$, $F(7, 105) = 3.662$, $p = .058$

When a similar regression analysis model was conducted for MMF total scores, results showed that problem type, child age, child gender, mother age, mother education, and baseline MMF scores contributed significantly to the regression model ($F(6,98) = 6.15$, $p < .00$, $\eta^2 = .27$). However, adding the PRF Global difference score as predictor to the regression model in the second step displayed that, the PRF Global Difference score was not a significant predictor of MMF total score ($\beta = -.040$, $p = .937$). The results are shown in Table 3.7.

Table 3.7. Summary of Hierarchical Regression Predicting Final MMF Scores by Problem Type, Child Age, Child Gender, Mother Age, Mother Education, Baseline MMF, Change in PRF Scores

Variable	Model 1					Model 2				
	B	*SE*	*β*	*t*	*p*	*B*	*SE*	*β*	*t*	*p*
Constant	0.94	4.54		0.20	0.83	1.28	4.59		0.28	0.78
Baseline MMF	0.47	0.08	0.54	5.95	<0.00	0.47	0.08	0.54	5.88	<0.00
Child Age	0.05	0.23	0.02	0.24	0.81	0.02	0.24	0.01	0.11	0.91
Child Gender	0.66	0.87	0.06	0.75	0.45	0.61	0.88	0.06	0.69	0.49
Problem Type	-0.13	0.45	-0.02	-0.29	0.76	-0.10	0.45	-0.02	-0.22	0.81
Mother Age	0.01	0.09	0.01	0.18	0.85	0.01	0.09	0.01	0.17	0.86
Mother Education	0.46	0.30	0.14	1.55	0.12	0.48	0.30	0.14	1.61	0.11
Change in PRF						-0.30	0.51	-0.05	-0.59	0.55

Note. MMF = Me and My Feelings Scale. PRF= Parental Reflective Functioning. Model 1: $R^2 = .274$, $F(6, 98) = 6.152$, $p<.001$.
Model 2: $R^2 = .276$, $F(7, 97) = 5.288$, $p <.001$

3.3. PREDICTIVE EFFECT OF PRF ON THERAPY OUTCOMES OF PARENTS

The linear regression results for DERS revealed that in the first step, problem type, child age, child gender, mother age, mother education, and baseline DERS score significantly contributed to the regression model ($F(6,106) = 13.327$, $p < .001$, $\eta^2 = .430$; Table 3.8). Adding the PRF Global difference score as a predictor in the second step explained 45% of the variation ($F(7,105) = 12.363$, $p < .001$, $\eta^2 = .452$). Further analysis of the coefficients revealed that the PRF Global Difference score was a significant predictor of the DERS scores ($\beta = -.153$, $p < .05$). It suggests that as parents' reflective capacity increased, their difficulty in regulating emotions decreased. This result shows that the third hypothesis was supported.

Examining the control variables, only DERS baseline scores significantly and positively impacted DERS final scores (β = .384, $p < .001$).

Table 3.8. Summary of Hierarchical Regression Predicting Final DERS Scores by Problem Type, Child Age, Child Gender, Mother Age, Mother Education, Baseline DERS, Change in PRF Scores

Variable	Model 1					Model 2				
	B	*SE*	*β*	*t*	*p*	*B*	*SE*	*β*	*t*	*p*
Constant	10.14	7.97		1.27	0.20	10.41	7.86		1.32	0.18
Child Age	-0.59	0.42	-0.10	-1.39	0.16	-0.71	0.42	-0.12	-0.12	0.09
Child Gender	-1.81	1.72	-0.08	-1.05	0.29	-2.13	1.70	-0.09	-1.25	0.21
Problem Type	1.83	0.87	0.15	2.10	0.03	1.94	0.86	0.16	2.26	0.02
Mother Age	0.14	0.17	0.06	0.80	0.42	0.14	0.17	0.06	0.83	0.40
Mother Education	-0.24	0.54	-0.03	-0.45	0.65	-0.08	0.53	-0.01	-0.16	0.87
Baseline DERS	0.62	0.07	0.63	8.34	<0.00	0.64	0.07	0.65	8.69	<0.00
Change in PRF						-1.89	0.92	-0.15	-2.04	0.04

Note. DERS = The Difficulties in Emotion Regulation Scale-Brief Form (DERS-16). PRF= Parental Reflective Functioning.

Model 1: $R^2 = .430$, $F(6, 106) = 13.327$, $p < .001$.

Model 2: $R^2 = .452$, $F(7, 105) = 12.363$, $p < .001$

When a similar regression analysis model was conducted for PSI scores, results showed that problem type, child age, child gender, mother age, mother education, and baseline PSI scores contributed significantly to the regression model ($F(6,106) = 17.757$, $p < .00$, $\eta^2 = .501$). However, adding the PRF Global difference score as a predictor to the regression model in the second step displayed that the PRF Global Difference score was a marginally significant predictor of the final PSI score (β = -.128, $p = .068$). The results are shown in Table 3.9.

Table 3.9. Summary of Hierarchical Regression Predicting Final PSI Scores by Problem Type, Child Age, Child Gender, Mother Age, Mother Education, Baseline PSI, Change in PRF Scores

Variable	Model 1					Model 2				
	B	*SE*	*β*	*t*	*p*	*B*	*SE*	*β*	*t*	*p*
Constant	18.86	12.49		1.51	0.13	20.19	12.37		1.63	0.10
Child Age	0.49	0.63	0.05	0.77	0.43	0.33	0.62	0.03	0.52	0.59
Child Gender	1.87	2.49	0.05	0.75	0.45	1.64	2.47	0.04	0.66	0.50
Problem Type	3.37	1.33	0.18	2.53	0.01	3.58	1.32	0.19	2.71	0.00
Mother Age	-0.01	0.26	-0.00	-0.07	0.94	-0.01	0.26	-0.00	-0.04	0.96
Mother Education	-0.13	0.80	-0.01	-0.17	0.86	0.09	0.80	0.00	0.11	0.90
Baseline PSI	0.61	0.07	0.63	8.84	<0.00	0.61	0.06	0.62	8.85	<0.00
Change in PRF						-2.52	1.36	-0.12	-1.84	0.06

Note. PSI = Parental Stress Index. PRF= Parental Reflective Functioning.
Model 1: $R^2 = .501$, $F(6, 106) = 17.757$, $p < .001$.

Model 2: $R^2 = .485$, $F(7, 105) = 16.050$, $p < .001$

3.4. ADJUSTING FOR TYPE 1 ERROR IN THE ANALYSIS OF PARENTAL REFLECTIVE FUNCTIONING

To examine the relationships between in-session parental reflective functioning (PRF) and therapy outcomes multiple regression analyses were conducted. Given the multiple comparisons, a Holm-Bonferroni correction was applied to control for the increased risk of Type 1 error. Holm-Bonferroni correction is a modified version of Bonferroni correction that aims to decrease the possibility of getting false statistically significant results (Holms, 1979). Compared to the Bonferroni correction, Holm-Bonferroni correction found to be statistically more powerful.

The initial p-values were as follows: CBCL (p = .06), MMF (p = .94), DERS (p = .04), and PSI (p = .07). After applying the Holm-Bonferroni correction, none of the relationships reached the adjusted significance levels. The adjusted thresholds were .01, .02, .02, and .05 for the four comparisons, respectively. The initial p-values are higher than the adjusted p-values. Therefore, the relationships between PRF and therapy outcomes (CBCL, MMF, DERS, PSI) were not statistically significant after correcting for multiple comparisons.

The initial p-values indicated some potential significant relationships between PRF and the scales, with p-values of .043 for DERS and .058 for CBCL suggesting a trend towards significance. However, after adjusting for multiple comparisons using the Holm-Bonferroni correction, these relationships did not hold. This suggests that the observed relationships might have been due to chance rather than a true effect.

DISCUSSION

The current study aimed to compare in-session parental reflective functioning of mothers who participated in Mentalization-Based Treatment for Child (MBT-C) or a Parenting and Social Skills Group (control group). The study also examined how parental mentalization predicted the outcomes of therapy. Specifically, we examined child-focused PRF, child PRF, and global PRF scores. The analysis revealed that the child-focused PRF scores showed a trend towards significance, indicating a potential change over time, although this result did not reach conventional levels of statistical significance. In contrast, no significant changes were found in self focused PRF and global PRF scores, with p-values above the threshold for significance. These findings suggest that while there may be a trend towards improvement in child-focused PRF, further research with a larger sample size or different methods may be needed to conclusively determine the impact of MBT-C group therapy on PRF scores. When the predictive effect of PRF on child and parent therapy outcomes was examined, it was seen that none of the relationships reached the adjusted significance levels. While the uncorrected *p*-values suggested possible relationships between PRF and therapy outcomes, the application of the Holm-Bonferroni correction revealed that these findings were not statistically significant. This highlights the importance of using appropriate statistical corrections when conducting multiple comparisons to ensure the validity and reliability of research findings.

4.1. CHANGE IN PARENTAL REFLECTIVE FUNCTIONING COMPARING MBT-C AND CONTROL GROUP

The current study partially supported the literature, as only child-focused PRF showed a trend level of greater improvement in MBT-C participants compared to the control group. Suchman et al. (2017) found that parents who participated in the mentalization-based intervention group showed a greater positive change on PRF compared to those who attended the parental psychoeducation group. A study demonstrated that parents experience positive outcomes from mentalization

interventions in therapy settings. Another study found that parents who attended a mentalization-based intervention group showed a greater increase in PRF compared to the control group who were placed on the waiting list (Enav et al., 2019). Focusing on mentalization-based interventions during therapy showed increased PRF in both studies. The results of our current study did not fully support the findings from previous research. It is crucial to recognize that the methodologies and designs used in the previous studies differed from the approach we employed in our study.

Our study primarily focused on examining in-session Parental Reflective Functioning (PRF) as opposed to using interview-based measures of PRF, such as the Parent Development Interview, which was utilized in the studies conducted by Suchman et al. (2019) and Enav et al. (2017). In-session PRF is an observer-based rating that allows us to examine the change in PRF during the therapy process by focusing on the flow of the sessions (Talia, 2018). Therefore, in-session PRF is more likely to show us temporal changes of PRF. Best to our knowledge, there is limited research on in-session PRF change in child psychotherapy. Georg and colleagues (2023) conducted a randomized controlled trial on brief dyadic-focused parent-infant psychotherapy to examine the change of in-session PRF. The study found that parents' capacity for reflective functioning, as measured by their session narratives, increased from the first session to the second session. However, there was a significant decrease in the last session. These results suggest that there may be a nonlinear change in parents' reflective functioning during the treatment course (Georg et al., 2023). It was discussed that the nature of the last session might affect the parents' narratives. They may be hesitant to provide detailed reflections due to the awareness that the therapy session had ended. This might be one of the reasons for observing non-significant changes in PRF in the current study. In recent adult psychotherapy research studies, the investigation of the correlation between baseline in-session Reflective Functioning (RF) and Adult Attachment Interview (AAI)-based RF scores has provided valuable insights. The findings suggest that utilizing session narratives to assess reflective functioning is an effective and appropriate approach for measuring reflective functioning (Talia, 2018; Möller,

2016). These results supported the argument although in-session RF is a reliable measurement of PRF, the nature of the session might affect the observed parental reflective capacity. For future research, the current study may be replaced by adding another time point for middle sessions to investigate the linearity of the parental reflective functioning during the therapy process.

In adult psychotherapy research, Kivity and colleagues (2021) conducted a study on how various therapy arms improve one's reflective functioning by using session narratives. When therapy focuses more on past experiences and relationships, in-session RF scores were reported to increase. It was noted that developing the capacity to reflect in the moment and to understand others' thoughts and feelings may take longer. For future research, measuring parental reflective functioning in follow-up assessments after the treatment might help us to observe the change over a longer period. Additionally, parents who participated in the current study and were recommended longer therapy after treatment may be evaluated to determine if increased reflective functioning necessitates longer therapy sessions.

4.2. PREDICTIVE EFFECT OF PARENTAL REFLECTIVE FUNCTIONING ON CHILD THERAPY OUTCOMES

The current study showed that an increase in the change in parental mentalization marginally predicted child therapy outcomes. The results showed no effect of the change in parental reflective functioning on the reduction in behavioral and emotional problems in children.

Best to our knowledge, there are no study that examined the effect of change on in-session on behavioral and emotional problems in children. However, there are many studies that suggests increase in parenting mentalization during mentalization-based interventions. Our results contradicted with some of these studies that found an influence of parental reflective functioning on child therapy outcomes. Menashe-Grinberg and Meiri (2021) found that children display low behavioral problems and higher self-regulatory skills after their mother's reflective functioning capacity increased at the end of the intervention program. These

findings are important to show that even only parents participated to the intervention program, children were significantly benefitted from these interventions. The study we are discussing was different from the current one in that it also involved child therapy. However, it did not delve into analyzing the effects and results of this child therapy. It is worth considering that the changes in children could potentially be better explained by the effects of child therapy rather than parental work. As a relevant point, Enav and colleagues (2019) found that children of parents in the treatment group who participated in mentalization-based intervention exhibited fewer affective and behavioral problems at the end of the treatment compared to the control group. This suggests that child therapy may have a significant impact on children's well-being.

Parents might be less likely to describe child difficulties as “problems” when their mentalization capacity increases. As discussed by Menashe-Grinberg and Meiri (2021) even if the observed change in child-related problems was the parental perception, this perception might lead to more positive parenting skills, which helps children to regulate their behaviors and emotions better. On the other hand, studies in the literature suggest that observed behavioral and emotional problems in children are associated with their mentalization capacities rather than their parents’ ability to mentalize (Borelli et al., 2016; Ordway et al., 2014). In our study, unlike the studies of Menashe-Grinberg and Meiri (2021) and Enay et al (2019), both child and parent sessions were conducted as parallel sessions. Therefore, it is possible to observe a change in the children’s mentalization capacity, which is suggested to explain the change in child-related problems. It would be beneficial for future studies to thoroughly examine the outcomes of child therapy in order to gain a better understanding of the effects of the changes observed in children during the therapy process.

4.3. PREDICTIVE EFFECT OF PARENTAL REFLECTIVE FUNCTIONING ON PARENT THERAPY OUTCOMES

The current study investigated parent therapy outcomes based on the parents’ reported levels of parenting stress and emotion regulation. The results

displayed no effect of parental reflective functioning on predicting decreased parental stress and emotion regulation problems.

Similar to our findings, Hetzmann et al. (2016) found that the change in parental stress did not differ between the Mentalization-based treatment and control group. Although a reduction was observed, no significant differences were noted between the groups. As both treatment groups showed decreased levels of parental stress, it is possible that the intervention of the control group affected parental stress to a similar extent as the MBT group. In the current study, the control group aimed to enhance parents' understanding of their own and children's emotion regulation capacities. Parenting strategies for difficult situations, such as limit setting and anger issues, were discussed in a group setting. In this setting a safe and acceptable environment was aimed to be created for group members. They observed the different perspectives from different group members. This aspect of the control group may enhance parents' ability to mentalize and regulate their emotions in stressful situations. Previous research has not addressed the effects of the control group on these factors. For future research, it may be important to select a control group that has no interventions related to mentalization capacity.

One potential reason behind the relationship between high PRF and low parental stress might also be related to parental sensitivity. McMahon and colleagues (2012) also showed that parents who have higher PRF scores reported higher sensitivity scores by their children. Suchman and colleagues (2010) found that self-focused parental reflective functioning was associated with parental sensitivity and behaviors. Reflective parents are more likely to regulate their own emotions and respond to their children sensitively during stressful times. This suggests that a parent's reflective abilities can have a positive impact on their interactions with their children, especially in times of stress or difficulty. Similar to these findings, the results of a randomized clinical trial conducted by Suchman (2017), interventions directed to increase parents' reflective capacity increased their sensitivity to children's emotional and behavioral status. To have a further understanding of the direction of the relationship between parental mentalization and parental stress, it would be meaningful for future studies to include parental

sensitivity. Additionally, since parental stress and emotion regulation abilities were assessed by structured assessments, they might reflect subjective experiences of parenting stress. To have more objective assessments, child-reported or therapist-reported measurements could be used in future studies.

4.4. CLINICAL IMPLICATIONS

The study results indicated a trend-level increase in the change of child-focused parental mentalization in the MBT-C group compared to the control group. This aligns with the current study's findings of trends towards improved child-focused PRF in the MBT-C group. Studies by Sadler et al. (2006) and Ordway et al. (2014) demonstrated similar findings. The current results are partially supported by literature indicating the potential for mentalization-based interventions to enhance parental RF. This supports the idea that interventions focusing on mentalization can positively influence parental reflective functioning.

While there is a trend-level higher increase in the change of child-focused PRF in MBT-C, it is important to note that there was no difference in the change of global and self-focused PRF. Adkins et al. (2018) found that while participants reported increased reflective capacity, quantitative measures did not show significant changes. This contrasts with the current study's trend-level improvements but underscores the complexity and variability in measuring RF changes. This suggests that there may be diverse factors at play when assessing RF changes. In the future, it may be beneficial for studies to give equal consideration to self-reported assessment tools alongside quantitative measures to gain a comprehensive understanding of the subject.

In the future, we could conduct a mediation analysis to examine the effects of changes in parental mentalization on children's behavioral and emotional problems. The statistical significance of the change in Parental Reflective Functioning (PRF) on child therapy outcomes indicates the possibility of the existence of a mediator variable that can explain the relationship between PRF and therapy outcomes for children. This suggests that there may be an underlying factor that influences how PRF impacts the effectiveness of therapy for children. Variables

that could be considered for mediation analyses are changes in parental stress and parents' emotion regulation capacities, as these variables predicted the change in PRF scores in the current study.

For future analysis, it would be meaningful to examine the therapists' narratives to have a further understanding of which mentalization interventions played a more important role in improving parental reflective functioning. The analysis might be run by considering baseline PRF level of the participants. This will provide a richer and more nuanced understanding of the specific mentalization interventions that played important role in improving parental reflective functioning. In adult psychotherapies, studies revealed that using a supportive stance towards the client and using demand questions to encourage mentalization were found to be more common in the therapies in which clients showed a higher increase in mentalization ability (Kasper et al., 2024; Möller et al., 2017). This suggests that these specific approaches may play a crucial role in enhancing mentalization skills during therapy sessions.

4.5. LIMITATIONS OF THE CURRENT STUDY AND SUGGESTIONS FOR FUTURE RESEARCH

The current study has many strengths. First, the data was taken from within the scope of a randomized controlled trial at Istanbul Bilgi University. A randomized controlled trial provides researchers an opportunity to randomly assign patients to the treatment arms. ensuring that each patient has an equal chance of receiving any particular treatment. This random assignment helps to minimize the influence of confounding variables and allows for a more accurate assessment of the effectiveness of the treatments being compared (Kivity et al., 2021). Another strength of this study is that parental mentalization is assessed using in-session PRF scores. This method allows us to obtain observer based PRF scores. By relying on observer-based measures rather than self-reported ones, we can minimize the influence of subjectivity in the assessment process. Other assessments of parental mentalization, such as the Adult Attachment Interview and Parental Development Interview, are typically conducted in experimental settings, where parents are aware

that they are being assessed. Although the purpose of the questions is generally not disclosed to the participants, it could be assumed that the topics of the questions might be leading. On the other hand, in-session PRF codings were assessed from the therapy narratives, which gives parents comfort in the therapy flow. This approach enhances the objectivity and reliability of our measurements, making the results more robust and dependable. Additionally, PRF scores during the session were coded blindly by the coders, with all demographic information such as name, age, and treatment arm being concealed.

The design of the current study also had some limitations. The study did not consist of any therapist or therapy-related variables. While examining the effect of PRF change on therapy outcomes, therapy-related variables was not included to the study. There are many research on adult psychotherapy revealed the effect of intervention type and therapist stance (Kasper et al., 2024; Möller et al., 2017). Some studies have also discussed that epistemic trust is an important therapy component, as it is developed through mentalizing the therapeutic relationship (Zeeck et al., 2022). Therefore, for future studies, it is recommended to include intervention type, therapist stance, and epistemic trust as variables in order to gain a more comprehensive understanding of their potential impact on the outcomes being studied. This will allow for a more nuanced analysis and interpretation of the results, ultimately contributing to a more robust and insightful body of research.

Another limitation of the study is that in-session parental mentalization was assessed only at two time points: at the beginning and the end of the therapy. Baseline and final scores of PRF were assumed to be enough since change throughout the treatment was aimed to assess. In this analysis, we expected that there is a significant linearity between the baseline PRF scores and final PRF scores. However, the study showed no statistically significant change in PRF Global scores compared to the treatment arm. This suggests that the treatment did not have a measurable impact on the change of PRF Global scores as observed in the study. On the other hand, some research in both child psychotherapy (Georg et al., 2023) and adult psychotherapy (Zeeck et al., 2022) suggested that there may be a nonlinear change in parents' reflective functioning during the treatment course.

Therefore, adding a new assessment of PRF scores in the middle session could give us a further understanding of the change over the treatment course.

In-session parental mentalization was measured based on the parents' session narratives. These narratives depend on parents' verbal expressions and their verbal descriptions of the children. Therefore, we could only analyze mentalization skills that were explicitly expressed. Explicit mentalization is the process of consciously reflecting on and considering the mental states, thoughts, and emotions of oneself or others. This involves actively acknowledging, understanding, and interpreting the inner experiences and perspectives of individuals, as well as recognizing and evaluating one's own cognitive and emotional processes (Allen et al., 2008). On the other hand, implicit mentalization is an automatic and non-verbal form of processing the mental states of oneself and others. The future study could concentrate on evaluating implicit mentalization in addition to explicit mentalization to gain a more comprehensive understanding of parental mentalization.

The current research had two treatment arms: time-limited mentalization-based therapy and control (ÇABA) group therapy that lasted for 12 weeks. Kivity and colleagues (2021) discussed that developing the capacity to reflect in the moment and to understand others' thoughts and feelings may take longer. To investigate the predictive value of the change in PRF scores on child and parent therapy outcomes, it is recommended to explore other therapy types such as long-term child psychotherapy. Studying the impact of long-term child psychotherapy on changes in PRF scores could offer a more comprehensive understanding of the effectiveness of such interventions. Therefore, it is important for prospective studies to conduct in-depth analyses to gain valuable insights into this area.

CONCLUSION

The study examined the change of parental mentalization among parents participating in Mentalization-Based Treatment for Child (MBT-C) and Parenting and Social Skills Group (control group), with a focus on therapeutic narratives. The predictor effect of the change in parental reflective functioning (PRF) on child and parent therapy outcomes was also investigated. Our findings demonstrated that improvement of child-focused PRF among parents participating in MBT-C was higher than the control group, although there was no statistical significance. Additionally, it was found that the change in global Parental Reflective Functioning (PRF) did not found to be related on children's emotional and behavioral problems, parental stress, and parental emotion regulation capacity.

This study was designed to offer additional evidence and insights to reinforce the existing body of literature regarding the essential role of parental engagement in the treatment process. It was aimed to explore how parental mentalization positively impacts treatment outcomes. Considering the limitations of this study, future research could focus on identifying which mentalization interventions have a greater impact on positive changes in parental reflective functioning.

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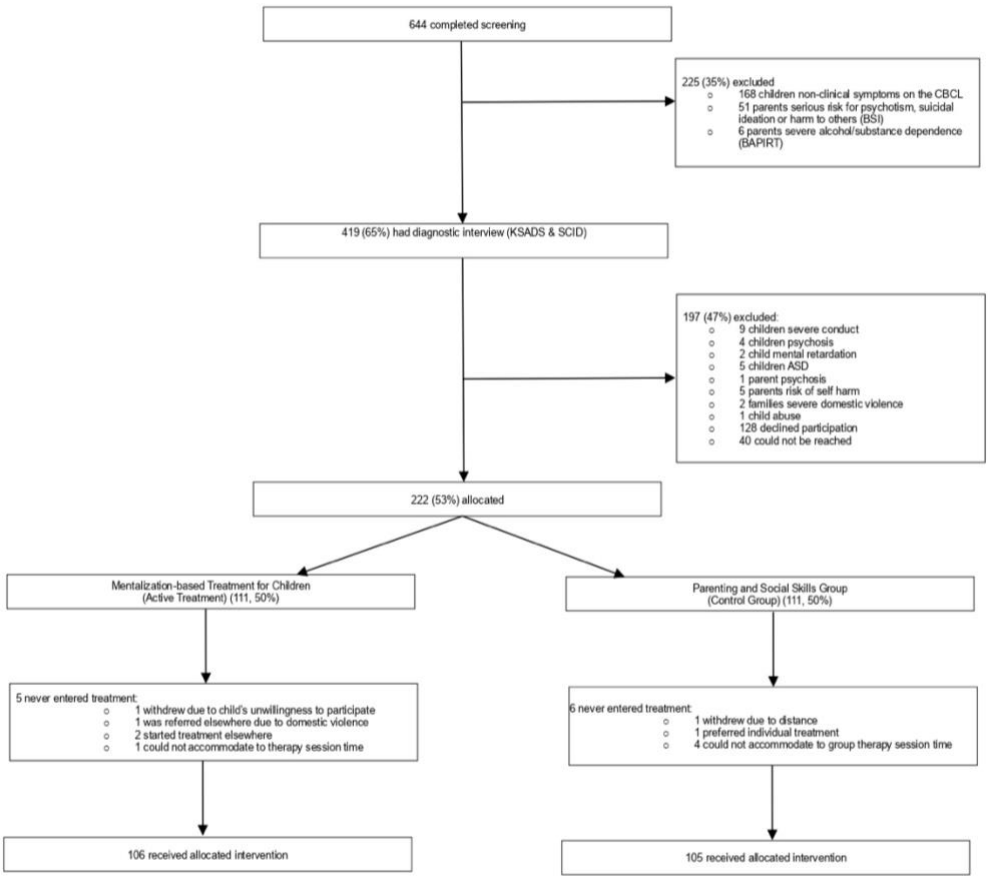
APPENDICES

APPENDIX A: Consort Flow Diagram



APPENDIX B: Child Behavior Checklist For Ages 1.5-5 (CBCL/1.5-5)

ÇOCUĞUN;
Cinsiyeti: ___ ERKEK ___ KIZ
Yaşı:
Doğum Tarihi: GÜN___AY___YIL_____
Kreşe, anaokuluna gidiyor mu?
___ HAYIR ___EVET (Okulun adı: _____)

ANNE BABANIN İŞİ (Ayrıntılı bir biçimde yazınız, örneğin emekli, ilk okul öğretmeni, şoför, oto tamircisi, avukat gibi)
EĞİTİMİ (Son bitirilen okula göre eğitim durumunuz)
BABANIN
İŞİ: _____ EĞİTİMİ: _____YAŞI: ____
ANNENİN
İŞİ: _____ EĞİTİMİ: _____YAŞI: ____

FORMU DOLDURAN:
___ Anne
___ Baba

Aşağıda çocukların özelliklerini tanımlayan bir dizi madde bulunmaktadır. Her bir madde çocuğunuzun **şu andaki ya da son 6 ay** içindeki durumunu belirtmektedir. Bir madde çocuğunuz 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. Ağrı ve sızıları vardır (tıbbi nedenleri olmayan).
0 1 2	2. Yaşından daha küçük gibi davranır.
0 1 2	3. Yeni şeyleri denemekten korkar.
0 1 2	4. Başkalarıyla göz göze gelmekten kaçınır.
0 1 2	5. Dikkatini uzun süre toplamakta ya da sürdürmekte güçlük çeker.
0 1 2	6. Yerinde rahat oturamaz, huzursuz ve çok hareketlidir.
0 1 2	7. Eşyalarının yerinin değiştirilmesine katlanamaz.
0 1 2	8. Beklemeye tahammülü yoktur, her şeyin anında olmasını ister.
0 1 2	9. Yenmeyecek şeyleri ağzına alıp çiğner.
0 1 2	10. Yetişkinlerin dizinin dibinden ayrılmaz, onlara çok bağımlıdır.
0 1 2	11. Sürekli yardım ister.
0 1 2	12. Kabızdır, kakasını kolay yapamaz (hasta değilken bile).
0 1 2	13. Çok ağlar.

0: Doğru değil (Bildiğiniz kadarıyla) 1: Bazen ya da biraz doğru 2: Çok ya da sıklıkla doğru

0 1 2 14. Hayvanlara eziyet eder.
0 1 2 15. Karşı gelir.
0 1 2 16. İstekleri anında karşılanmalıdır.
0 1 2 17. Eşyalarına zarar verir.
0 1 2 18. Ailesine ait eşyalara zarar verir.
0 1 2 19. Hasta değilken bile ishal olur, kakası yumuşaktır.
0 1 2 20. Söz dinlemez, kurallara uymaz.
0 1 2 21. Yaşam düzenindeki en ufak bir değişiklikten rahatsız olur
0 1 2 22. Tek başına uyumak istemez.
0 1 2 23. Kendisiyle konuşulduğunda yanıt vermez.
0 1 2 24. İştahsızdır. (açıklayınız): _____
0 1 2 25. Diğer çocuklarla anlaşamaz.
0 1 2 26. Nasıl eğleneceğini bilmez, büyümüş de küçülmüş gibi davranır.
0 1 2 27. Hatalı davranışından dolayı suçluluk duymaz.
0 1 2 28. Evden dışarı çıkmak istemez.
0 1 2 29. Güçlükle karşılaştığında çabuk vazgeçer.
0 1 2 30. Kolay kıskanır.
0 1 2 31. Yenilip içilmeyecek şeyleri yer ya da içer (kum, kil, kalem, silgi gibi). (açıklayınız)_ _____
0 1 2 32: Bazı hayvanlardan, ortamlardan ya da yerlerden korkar. (açıklayınız): _____
0 1 2 33. Duyguları kolayca incinir.
0 1 2 34. Çok sık bir yerlerini incitir, başı kazadan kurtulmaz.
0 1 2 35. Çok kavga dövüş eder.
0 1 2 36. Her şeye burnunu sokar.
0 1 2 37. Anne-babasından ayrıldığında çok tedirgin olur.
0 1 2 38. Uykuya dalmakta güçlük çeker.
0 1 2 39. Baş ağrıları vardır (tıbbi nedeni olmayan).
0 1 2 40: Başkalarına vurur.
0 1 2 41. Nefesini tutar.
0 1 2 42. Düşünmeden insanlara ya da hayvanlara zarar verir.
0 1 2 43. Hiçbir nedeni yokken mutsuz görünür.
0 1 2 44. Öfkelidir.
0 1 2 45. Midesi bulanır, kendini hasta hisseder (tıbbi nedeni olmayan).
0 1 2 46. Bir yerleri seyirir, tikleri vardır (açıklayınız): _____
0 1 2 47. Sinirli ve gergindir.
0 1 2 48. Gece kabusları, korkulu rüyalar görür.
0 1 2 49. Aşırı yemek yer.
0 1 2 50: Aşırı yorgundur.
0 1 2 51. Hiçbir neden yokken panik yaşar.
0 1 2 52. Kakasını yaparken ağrısı, acısı olur.
0 1 2 53. Fiziksel olarak insanlara saldırır, onlara vurur.
0 1 2 54. Burnunu karıştırır, cildini ya da vücudunun diğer taraflarını yolar. (açıklayınız):

0: Doğru değil (Bildiğiniz kadarıyla) 1: Bazen ya da biraz doğru 2: Çok ya da sıklıkla doğru

0 1 2 55. Cinsel organlarıyla çok fazla oynar.
0 1 2 56. Hareketlerinde tam kontrollü değildir, sakardır.
0 1 2 57. Tıbbi nedeni olmayan, görme bozukluğu dışında göz ile ilgili sorunları vardır. (açıklayınız): _____
0 1 2 58. Cezadan anlamaz, ceza davranışını değiştirmez.
0 1 2 59. Bir uğraş ya da faaliyetten diğerine çabuk geçer.
0 1 2 60. Döküntüleri ya da başka cilt sorunları vardır (tıbbi nedeni olmayan).
0 1 2 61. Yemek yemeyi reddeder.
0 1 2 62. Hareketli, canlı oyunlar oynamayı reddeder.
0 1 2 63. Başını ve bedenini tekrar tekrar sallar.
0 1 2 64. Gece yatağına gitmemek için direnir.
0 1 2 65. Tuvalet eğitimine karşı direnir. (açıklayınız): _____
0 1 2 66. Çok bağırır, çağırır, çığlık atar.
0 1 2 67. Sevgiye, şefkate tepkisiz görünür.
0 1 2 68. Sıkılgan ve utangaçtır.
0 1 2 69. Bencildir, paylaşmaz.
0 1 2 70. İnsanlara karşı çok az sevgi, şefkat gösterir.
0 1 2 71. Çevresindeki şeylere çok az ilgi gösterir.
0 1 2 72. Canının yanmasından, incinmekten pek az korkar.
0 1 2 73. Çekingen ve ürkektir.
0 1 2 74. Gece ve gündüz çocukların çoğundan daha az uyur. (açıklayınız): _____
0 1 2 75. Kakasıyla oynar ve onu etrafa bulaştırır.
0 1 2 76. Konuşma sorunu vardır. (açıklayınız): _____
0 1 2 77. Bir yere boş gözlerle uzun süre bakar ve dalgın görünür.
0 1 2 78. Mide-karın ağrısı ve krampları vardır (tıbbi nedeni olmayan).
0 1 2 79. Üzgünken birden neşeli, neşeli iken birden üzgün olabilir.
0 1 2 80. Yadırganan, tuhaf davranışları vardır. (açıklayınız): _____
0 1 2 81. İnatçı, somurtkan ve rahatsız edicidir.
0 1 2 82. Duyguları değişkendir, bir anı bir anını tutmaz.
0 1 2 83. Çok sık küser, surat asar, somurtur.
0 1 2 84. Uykusunda konuşur, ağlar, bağırır.
0 1 2 85. Öfke nöbetleri vardır, çok çabuk öfkelenir.
0 1 2 86. Temiz, titiz ve düzenlidir.
0 1 2 87. Çok korkak ve kaygılıdır.
0 1 2 88. İşbirliği yapmaz.
0 1 2 89. Hareketsiz ve yavaştır, enerjik değildir.
0 1 2 90. Mutsuz, üzgün, çökkün ve keyifsizdir.
0 1 2 91. Çok gürültücüdür.
0 1 2 92. Yeni tanıdığı insanlardan ve durumlardan çok tedirgin olur. (açıklayınız): _____
0 1 2 93. Kusmaları vardır (tıbbi nedeni olmayan).
0 1 2 94. Geceleri sık sık uyanır.

0: Doğru değil (Bildiğiniz kadarıyla) 1: Bazen ya da biraz doğru 2: Çok ya da sıklıkla doğru

0 1 2 95. Alıp başını gider.
0 1 2 96. Çok ilgi ve dikkat ister.
0 1 2 97. Sızlanır, mızırdanır.
0 1 2 98. İçe kapanıktır, başkalarıyla birlikte olmak istemez.
0 1 2 99. Evhamlıdır.
0 1 2 100. Çocuğunuzun burada değinilmeyen başka sorunu varsa lütfen yazınız:
0 1 2_____
0 1 2_____
0 1 2_____

LÜTFEN TÜM MADDELERİ YANITLAYINIZ.

SİZİ KAYGILANDIRAN MADDELERİN ALTINI ÇİZİNİZ.

APPENDIX C: Child Behavior Checklist For Ages 6-18 (CBCL/6-18)

ÇOCUĞUN;
Cinsiyeti: ___ ERKEK ___ KIZ
Yaşı:
Doğum Tarihi: GÜN___AY___YIL_____
Sınıfı: _____ Okula devam etmiyor ____

ANNE BABANIN İŞİ (Ayrıntılı bir biçimde yazınız, örneğin emekli, ilk okul öğretmeni, şoför, oto tamircisi, avukat gibi)
EĞİTİMİ (Son bitirilen okula göre eğitim durumunuz)
BABANIN
İŞİ: _____ EĞİTİMİ: _____ YAŞI: ____
ANNENİN
İŞİ: _____ EĞİTİMİ: _____ YAŞI: ____

FORMU DOLDURAN:
___ Anne
___ Baba
___ Diğer (Çocukla olan ilişkisi: _____)

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?

	Normalden az	Normal	Normalden Fazla	Bilmiyorum
a._____	O	O	O	O
b._____	O	O	O	O
c._____	O	O	O	O

Çocuğunuz her birinde ne kadar başarılıdır?

	Normalden az	Normal	Normalden Fazla	Bilmiyorum
a._____	O	O	O	O
b._____	O	O	O	O
c._____	O	O	O	O

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?

	Normalden az	Normal	Normalden Fazla	Bilmiyorum
a._____	O	O	O	O
b._____	O	O	O	O
c._____	O	O	O	O

Çocuğunuz her birinde ne kadar başarılıdır?

	Normalden az	Normal	Normalden Fazla	Bilmiyorum
a._____	O	O	O	O
b._____	O	O	O	O
c._____	O	O	O	O

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?

	Normalden az	Normal	Normalden Fazla	Bilmiyorum
a._____	O	O	O	O
b._____	O	O	O	O
c._____	O	O	O	O

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 her şeyi katınız.

___ Hiç yok.

Çocuğunuz her birinde ne kadar başarılıdır?

	Normalden az	Normal	Normalden Fazla	Bilmiyorum
a._____	O	O	O	O
b._____	O	O	O	O
c._____	O	O	O	O

V. a. Çocuğunuzun yaklaşık olarak kaç yakın arkadaşı vardır? (Kardeşlerini katmayınız).

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

b. Çocuğunuz okul dışı zamanlarda haftada kaç kez arkadaşlarıyla birlikte olur? (Kardeşlerini katmayınız).

1'den az	1 ya da 2	3 ya da daha fazla
O	O	O

VI. Yaşıtlarıyla karşılaştırıldığında çocuğunuzun:

a. Kardeşleriyle arası nasıldır?

Kötü	Normal Sayılır	Oldukça İyidir	Kardeşi Yoktur
O	O	O	O

b. Diğer çocuklarla arası nasıldır?

Kötü	Normal Sayılır	Oldukça İyidir	Kardeşi Yoktur
O	O	O	O

c. Size karşı davranışları nasıldır?

Kötü	Normal Sayılır	Oldukça İyidir	Kardeşi Yoktur
O	O	O	O

d. Kendi başına oyun oynaması ve iş yapması nasıldır?

Kötü	Normal Sayılır	Oldukça İyidir	Kardeşi Yoktur
O	O	O	O

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

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

2. Çocuğunuz özel alt sınıf ya da bir özel eğitim kurumunda okuyor mu?
O Hayır O Evet – Ne tür bir sınıf ya da okul? _____

3. Çocuğunuz hiç sınıfta kaldı mı?
O Hayır O Evet – Kaçıncı sınıfta ve nedeni: _____

4. Çocuğunuzun okulda ders ya da ders dışı sorunları oldu mu?
O Hayır O Evet – Açıklayınız: _____

Bu sorunlar ne zaman başladı? _____
Sorunlar bitti mi?
O Hayır O Evet – Ne zaman?_____

Çocuğunuzun herhangi bir bedensel hastalığı ya da zihinsel engeli var mıdır?
O Hayır O Evet – Açıklayınız: _____

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

Çocuğunuzun en beğendiğiniz özellikleri nelerdir?

Aşağıda çocukların özelliklerini tanımlayan bir dizi madde bulunmaktadır. Her bir madde çocuğunuzun **şu andaki ya da son 6 ay** içindeki durumunu belirtmektedir. Bir madde çocuğunuz 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 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 her şeyi 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: Doğru değil (Bildiğiniz kadarıyla) 1: Bazen ya da biraz doğru 2: Çok ya da sıklıkla doğru

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. Baş ağrılarından 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):_____
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 (elini defalarca yıkama, kapı kilidini tekrar tekrar kontrol etme gibi) (açıklayınız):_____

0: Doğru değil (Bildiğiniz kadarıyla) 1: Bazen ya da biraz doğru 2: Çok ya da sıklıkla doğru

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 bir şeyler çalar.
0 1 2 82. Ev dışındaki başka yerlerden bir şeyler çalar.
0 1 2 83. İhtiyacı olmadığı halde birçok şey 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. Küfürlü 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: Doğru değil (Bildiğiniz kadarıyla) 1: Bazen ya da biraz doğru 2: Çok ya da sıklıkla doğru

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_____

APPENDIX D: Me and My Feelings Questionnaire

	Asla	Bazen	Her Zaman
1. Yalnız hissederim.			
2. Çok ağlarım.			
3. Mutlu değilim.			
4. Beni kimse sevmez.			
5. Çok endişe duyarım.			
6. Uyku sorunlarım var.			
7. Geceleri uyanırım.			
8. Utangaç biriyim.			
9. Korkan birisiyim.			
10. Okuldayken kaygılı birisiyim.			
11. Çok sinirlenirim.			
12. Gözü kara birisiyim.			
13. Sinirliyken şiddete başvururum.			
14. İnsanları incitici şeyler yaparım.			
15. Sakin birisiyim.			
16. Amacıma ulaşmak için bir şeyleri kırabilirim.			

APPENDIX E: The Difficulties in Emotion Regulation Scale-Brief Form (DERS-16)

1. Duygularıma bir anlam vermekte zorlanırım.
2. Ne hissettiğim konusunda karmaşa yaşarım.
3. Kendimi kötü hissettiğimde işlerimi bitirmekte zorlanırım.
4. Kendimi kötü hissettiğimde kontrolden çıkarım.
5. Kendimi kötü hissettiğimde uzun süre böyle kalacağına inanırım.
6. Kendimi kötü hissetmenin yoğun depresif duyguyla sonuçlanacağına inanırım...
7. Kendimi kötü hissederken başka şeylere odaklanmakta zorlanırım.
8. Kendimi kötü hissederken kontrolden çıktığım korkusu yaşarım.
9. Kendimi kötü hissettiğimde bu duygumdan dolayı kendimden utanırım.
10. Kendimi kötü hissettiğimde zayıf biri olduğum duygusuna kapılırım.
11. Kendimi kötü hissettiğimde davranışlarımı kontrol etmekte zorlanırım.
12. Kendimi kötü hissettiğimde daha iyi hissetmem için yapabileceğim hiçbir şey olmadığına inanırım.
13. Kendimi kötü hissettiğimde böyle hissettiğim için kendimden rahatsız olurum.
14. Kendimi kötü hissettiğimde kendimle ilgili olarak çok fazla endişelenmem.
15. Kendimi kötü hissettiğimde başka bir şey düşünmekte zorlanırım.
16. Kendimi kötü hissettiğimde duygularım dayanılmaz olur.

APPENDIX F: Parental Stress Index (PSI) – Short-Form

1. Çoğunlukla sorunlarla iyi baş edemediğimi düşünüyorum.
2. Çocuklarımın ihtiyaçlarını karşılamak için hayatımda beklediğimden çok daha fazla fedakârlık yapıyorum.
3. Bir anne/baba olarak kendimi sorumluluklarımdan dolayı kısıtlanmış ve mecbur hissediyorum.
4. Bu çocuk dünyaya geldiğinden beri yeni ve farklı şeyler yapamıyorum.
5. Çocuk sahibi olduğumdan beri istediğim şeyleri hiçbir zaman yapamayacağımı düşünüyorum.
6. En son kendim için bir şeyler aldığımda kendimi mutsuz hissettim.
7. Hayatımla ilgili pek çok şey beni rahatsız eder.
8. Çocuk sahibi olmak eşimle olan ilişkimde beklediğimden daha fazla soruna yol açtı.
9. Kendimi yalnız hissediyorum ve hiç arkadaşım yok.
10. Bir eğlenceye gittiğimde eğlenemeyeceğimi düşünüyorum.
11. İnsanlarla eskisi kadar ilgilenmiyorum.
12. Eskisi kadar bazı şeylerden zevk almıyorum.
13. Çocuğum nadiren beni iyi hissettirecek şeyler yapar.
14. Çocuğum için bir şeyler yaptığımda çabalarıma yeterince değer verilmediğini hissederim.
15. Çocuğum bana beklediğimden daha az gülümser.
16. Bazen, çocuğumun beni sevmediğini ve bana yakın olmak istemediğini hissederim.
17. Çocuğum çok duygusaldır ve kolaylıkla üzülür.
18. Çocuğum diğer çocuklar kadar hızlı öğrenemiyor.
19. Çocuğum diğer çocuklar kadar gülmüyor.
20. Çocuğum beklediğim kadarını yapamıyor.
21. Çocuğumun yeni şeylere alışması çok zaman alır ve oldukça zor olur.
22. Kendimi iyi bir anne baba gibi hissetmiyorum.
23. Çocuğuma duyduğum yakın ve sıcak duygulardan daha fazlasına sahip olmak isterdim. Bu durum beni rahatsız ediyor.
24. Bazen çocuğum kasıtlı olarak beni üzecek şeyler yapar.
25. Çocuğum diğer çocuklardan daha fazla ağlar ve yaygara çıkarır.
26. Çocuğum genellikle kötü bir ruh hali ile uyanır.
27. Çocuğumun olumlu ve olumsuz duygu değişiklikleri yaşadığını ve kolayca üzüldüğünü hissediyorum.
28. Ortalama bir çocuğa göre çocuğum evdeki planlanmış değişikliklere daha zor alışıyor.
29. Çocuğum hoşlanmadığı bir şey olduğu zaman oldukça büyük bir tepki verir.
30. Çocuğum oyun oynarken genelde kıkırdamaz ya da gülmez.

31 Çocuğumun uyku ve yeme düzenini ayarlamak tahmin ettiğimden zor oldu.

32 Çocuğuma bir şey yaptırmak ya da yaptığı bir şeyi bıraktırmak: (aşağıdaki seçeneklerden birine karşılık gelen sayıyı yan taraftan seçiniz)

Beklediğimden çok daha zordur.

Beklediğimden biraz daha zordur.

Hemen hemen beklediğim kadar zordur.

Beklediğimden biraz daha kolaydır.

Beklediğimden çok daha kolaydır.

33 Çocuğunuzun yaptığı şeylerden sizi rahatsız edenleri dikkatlice düşünün ve sayın. Örneğin; oyalanmak, dinlememek, hareketli olmak, ağlamak, konuşmayı bölmek, kavga etmek, sızlanmak vb. (Yukarıdaki seçeneklerden birini seçip, sağ taraftaki kutucuğa çocuğunuzun sizi rahatsız eden davranışlarının sayısını yansıtacak şekilde işaretleyin)

34 Çocuğumun yaptığı bazı şeyler beni çok rahatsız ediyor.

35 Çocuğumun davranışları beklediğimden daha fazla sorunludur.

36 Çocuğum benden birçok çocuğun istediğinden daha fazla şey talep eder.

APPENDIX G: Ethical Approval

ETHICS BOARD APPROVAL

Ethics Board Approval is available in the printed version of this dissertation.