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ASSOCIATION OF NONVERBAL COORDINATION QUALITY AND
THERAPEUTIC ALLIANCE IN MENTALIZATION-BASED TREATMENT FOR
CHILDREN (MBT-C)

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**Association of Nonverbal Coordination Quality and Therapeutic Alliance in
Mentalization-Based Treatment for Children (MBT-C)**

Çocuklar için Zihinselleştirme Temelli Terapi’de Sözdışı Koordinasyon ve Terapi
İttifakı İlişkisi

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ABSTRACT

Therapeutic alliance is an important element for therapy's effectiveness. The concept of alliance includes agreement on therapy tasks and creating a secure bond. The nonverbal aspects of the therapy relationship, such as bodily coordination of the therapeutic dyad is a predictor of therapeutic alliance in adult psychotherapy; however, this has not been studied in child therapies. Current research will be the first to analyze the nonverbal coordination of therapists with children and assess its impact on ruptures, which are moments in the therapy relationship when there is a weakening of the therapeutic bond. This can manifest itself in terms of the patient's confrontative or withdrawing attitudes. It was hypothesized that the therapists' nonverbal coordination quality will predict a decrease of children's rupture salience when the global alliance of the sessions was low. The sample consisted of 28 children between 5-12 years old who have internalizing, externalizing or comorbid problems. These children received Mentalization-Based Treatment for Children (MBT-C), in the context of a randomized controlled trial (RCT) conducted at Istanbul Bilgi University. Three sessions from each child's treatment were coded with Therapy Process Observational Coding System-Alliance Scale (TPOCS-A), Rupture Resolution Rating System (3RS), and Therapist's Body Coordination in Child Psychotherapy Coding System. Hierarchical Linear Modeling analyses were carried out. The results demonstrated that nonverbal coordination quality of therapists have different associations with the salience of different rupture types. There was a positive relationship between therapist's nonverbal coordination quality and child's moving against rupture salience. There was no significant relationship between therapist's nonverbal coordination quality and moving away rupture salience. These findings suggest that therapists' nonverbal coordination may provide children to be more expressive about their confrontative attitude. Possible explanations regarding these associations were discussed.

Keywords: Nonverbal Coordination, Therapeutic Alliance, Rupture, Mentalization Based Therapy for Children, Child Psychotherapy

ÖZET

Çocuklar ve terapistler arasındaki terapötik ittifak, terapinin etkililiği açısından önemli bir unsurdur. İttifak kavramı, terapi görevlerini yerine getirmek için işbirliği kurmayı, terapist ile bağ kurmaya ilişkin duygusal yönleri içerir. Bu çalışma terapistin sözdışı koordinasyon kalitesi ile çocuğun ittifak kopukluğu anları arasındaki ilişkiyi incelemektedir. İttifak kopuklukları çocuğun çatışmaya yönelik veya kendi içine çekildiği davranışlar üzerinden kendini gösterir. Bu çalışma, klinik problemleri olan okul çağındaki çocukların ittifakı ile terapistlerin sözdışı koordinasyonunun ilişkisini anlamaya yönelik ilk araştırmalardan biri olacaktır. Bu çalışmanın bir diğer amacı da çocuk psikoterapisinde kırılma anlarını araştırmaktır. Düşük ittifaklı olarak gözlemlenmiş seanslarda terapistlerin sözdışı koordinasyon kalitesinin çocukların kopmalarının azalmasını yordayacağı varsayılmıştır. Bu nedenle betimsel analiz yapılmıştır. Tüm seans örnekleminde düşük ittifaklı olan seanslar belirlendi. Bu seanslar içe yönelim, dışa yönelim veya komorbid problemleri olan 5-12 yaş arası 28 çocuğun seanslarıydı. Belirlenen seanslar Therapy Process Observational Coding System-Alliance (TPOCS-A), Rupture Resolution Rating System (3RS) ve Therapist's Body Coordination in Child Psychotherapy Coding System ile kodlandı. Hiyerarşik Lineer Modelleme analizleri yapıldı. Analizler, terapistlerin sözdışı koordinasyon kalitesinin farklı kopma türleri ile farklı ilişkilere sahip olduğunu gösterdi. Terapistin sözdışı koordinasyon kalitesi ile çocuğun çatışmaya dayalı kopmaları arasında pozitif bir ilişki bulundu. Terapistin sözdışı koordinasyon kalitesi ile içe dönme kopmaları arasında anlamlı bir ilişki bulunmadı. Bu bulgular, terapistlerin sözdışı koordinasyonunun çocukların daha ilişkisel ve ifade edici olmalarını sağlayabileceğini düşündürdü. Bulgulara ilişkin olası açıklamalar tartışıldı.

Anahtar kelimeler: Sözdışı Koordinasyon, Terapötik İttifak, Kırılma, Çocuklara Yönelik Zihinselleştirme Temelli Terapi, Çocuk Psikoterapisi

INTRODUCTION

Alliance is one of the significant aspect of the therapy relationship. Bordin's conceptualization (1979) suggested three components of therapeutic alliance: agreement on therapy goals, agreement on therapy tasks and emotional bond between therapist and patients. First generation research approached and investigated alliance as a fixed construct on therapy. However, within second-generation research, the dynamic aspect of alliance including deteriorations and repair moments (Safran & Muran, 1996) were investigated during therapy process. It was found that unresolved rupture moments were leading to drop-outs and the resolution of them were providing positive therapy outcomes (Safran et al., 2011; O'Keeffe, 2020). Although alliance research started with adult psychotherapy, recent research began to address the rupture-repair processes in child psychotherapy. Ruptures are divided into two different types: withdrawal (moving away) and confrontational (moving against).

When withdrawal ruptures are defined as patients' moving away from therapy work or therapist by nonverbal or verbal attitudes, confrontational ruptures are defined as patients' moving against therapist, therapy work or room to exhibit the dissatisfaction and anger in noncooperative ways (Eubanks et al., 2015). Rupture and repair moments and their relationship with children's pretreatment characteristics (Topkaya, 2022), different therapy modalities (Açıkgozler, 2022), and mentalization interventions (Güvenç & Halfon, 2023) were already examined in psychodynamic child psychotherapy. Also, there is a manual introduced for therapists regarding how to approach ruptures can be identified when working with children (Nof et al., 2019).

The centrality of nonverbal elements in constructing alliance is more emphasized with children than adults. Children exhibit their internal world through play and use nonverbal communication. Closer attention might be given to nonverbal cues of misattunement moments because children might be less verbal than adults about ruptures. In this case, it is also important to detect these misattunements and repair them with the help of nonverbal cues for therapists.

Developmental research regarding parent-infant relationship has shown that the timing and coordination of turn-taking in early years provide responsiveness and self-regulation in infants (Beebe & Lachmann, 2002). Also, rhythm and synchrony were influential elements for conveying messages of relatedness and attachment security (Beebe & Steele, 2013). Hence nonverbal coordination is important developmental aspect for children to promote regulation and relationship formation starting from early years. In therapy, therapists might provide responsiveness and regulation to children by using body movement, facial and vocal coordination elements. Muran & Eubanks (2020) proposed one of the repair characteristics as being reattunement to feelings and intentions of the patients. The attunement of therapist might include not only verbal but also nonverbal aspects. Mentalization Based Treatment for Children (MBT-C) therapy protocol perceives ruptures as opportunities for working on the unmentalized mental states (Fonagy et al., 2023) and emphasize the attention control interventions such as joint attention, mirroring, slowing down which are overlapping features of therapist's nonverbal coordination quality.

There are studies that examine nonverbal coordination and alliance relationship in adult psychotherapy regarding facial expressions (Ramseyer & Tschacher, 2011), vocal synchrony (Reich, 2014), physiological synchrony (Avdi & Seikkula, 2019) or gaze movements (Altimir & Valdés-Sánchez, 2020). However, these studies do not explore the relation between therapist's nonverbal qualities and rupture events in child psychotherapy. This study contributes to the child psychotherapy literature to better apprehend the relationship between therapeutic alliance and nonverbal coordination elements. Besides, it will be one of the first studies to measure nonverbal coordination of therapists as multidimensional construct regarding the components of body movement dynamics, vocal and facial coordination during interaction with the child. In addition, the therapeutic alliance will also be examined in detail, looking closely at rupture moments when the alliance between the patient and the therapist is weak. The following chapter will present a literature review on therapeutic alliance, nonverbal coordination, and MBT-C child psychotherapy.

CHAPTER 1

LITERATURE REVIEW

1.1. Background and Alliance in Child Psychotherapy

Building and maintaining relationships is an important aspect of our lives as social beings. Especially in psychotherapy setting, in-depth understanding of alliance is required because it may become part of the healing process.

Sigmund Freud explained the two distinct features of alliance. When therapists have genuine relationships with patients (rapport), they also have a transference relationship in which patients attribute some features from their important caregivers toward the therapist (Freud, 1912; Diguiseppe et al., 1996). If transference would be worked in therapy, the patients' adverse early experiences might be less influential and painful in their current life. Hence, Freud emphasized this phenomenon as positive transference and assumed the therapist-patient relationship itself a work of therapy (Horvath, 2001).

Despite Freud emphasizing the transference relationship as an essential part of the therapy, the therapist's stance in the early psychoanalytical perspective was more neutral and objective (Muran, 2022). Greenson proposed the term 'working alliance' (1960) and emphasized that there should be a collaboration between patient and therapist to pursue therapy work. After Greenson, Bordin (1979) conceptualized alliance in therapy with three different subcategories. For him, these defining subcategories were agreement on therapeutic goals, therapy tasks, and 'bond' between the patient and the therapist (Horvath, 2001). The definition of Bordin's therapeutic alliance (1979) was regarded as pan-theoretical because the definition was applicable to all therapy approaches (Horvath & Luborsky, 1993).

The therapeutic alliance definitions were regarding adult psychotherapy perspectives. While the notion of therapeutic alliance has been understood in adult

psychotherapy, it was equally important to explore how alliance conceptualized in child psychotherapy. Anna Freud and John Meeks conceptualized two different but core aspects of alliance in child psychotherapy. Freud (1946) proposed that therapist and child should have a positive emotional connection to provide a trusting relationship, which she called 'affectionate attachment'. Conversely, Meeks (1971) emphasized the significance of collaborative work between therapist and child in therapy. In therapy, alliance with children might be more complex than with adults for essential reasons. One of the reasons is that children may not have an insight into their own problems (Diguiseppe et al., 1996). They might be referred to therapy by an adult who thinks they need help (Norcross & Lambert, 2019). Also, they may be resistant to forming an agreement about the goals of therapy (Diguiseppe et al., 1996). The trusting and positive relationship may influence a child to be more collaborative about the work of therapy. However, a friendly and warm relationship were not regarded as sufficient for defining the relationship as a 'positive alliance' in therapy (Norcross & Lambert, 2019). The importance of the positive relationship and working alliance might change due to children's developmental level and age. For example, preschoolers' therapeutic alliance may rely solely on the bond when adolescents may be concerned about the agreement on therapy goals due to dependence and independence issues (Diguiseppe et al., 1996). In child psychotherapy, the concept of therapist-patient relationship usually relies on the affective and collaborative aspects (Shirk et al., 2011). These topics emphasized the alliance concept's relational aspects and they are essential to discover in child psychotherapy because children are relying more on emotional bond. Unlike adult psychotherapy, the third aspect of the alliance, which is collaboration on therapy goals and tasks, is considered to be less essential due to the involvement of parents and the developmental limitations of children. Therefore, it is necessary to explore how the therapist's approach is influential in alliance pressures in the therapeutic relationship.

Mahler (1974) emphasized the significance of therapy relationship to balance the opposing demands of being separate and connected individuals. She proposed that infants desire to be united with their mothers when also desire to be autonomous agents.

A mother's emotional availability, capacity to provide emotional aid, and encouragement for autonomy are essential for a healthy mother-infant relationship. The term 'emotional availability' was also emphasized by attachment theorists (Ainsworth, 1978 & Bowlby, 1975) in terms of generating a secure base for infants. Unresponsiveness and excessive misattunement might cause a child to feel stressed and insecure about the world when also they may have problems forming new relationships. Together with these, lack of attunement in early years may cause infants to internalize problematic interpersonal schemas (Tronick, 1989). Psychotherapy is where these miscommunications are expected and becoming opportunities to work on. In dyadic relationships, attunement and providing a supportive place from the therapist might aid patients' separation/individuation needs. This might be done by being both an internal representation of the child's primary caregiver and an external person (Bowlby, 1975) as Freud also proposed earlier. Also, the therapist's empathy, attunement and reliability might provide to repair misattunement, miscommunication moments and help children internalize these qualities (Halfon et al., 2019).

1.1.1. Alliance Rupture and Resolution

From 1990s and onward, the notion that alliance is an influential aspect for therapeutic change was accepted and 'second generation' research has started (Safran, 2001). It was argued that alliance is not established all at once but is an ongoing negotiation process between therapist and patients (Safran & Muran, 1996). Hence, rupture moments are regarded as inevitable moments. Second generation alliance research focused on understanding which factors provide development of alliance (Safran, 2001), how to detect alliance rupture moments and how to repair them in a persisting process of therapy relationship (Cirasola & Midgley, 2023). Also, research aimed to clarify which factors are influential in rupture and negotiation processes between patients and therapists during therapy (Eubanks et al., 2015).

Eubanks, Safran & Muran (2015) used Bordin's (1979) conceptualization about therapeutic alliance in adult psychotherapy and they defined rupture and repair sequences between therapist and patients. Ruptures are 'deterioration in the alliance, manifested by a lack of collaboration between therapist and patient on tasks or goals, or strain in emotional bond' (Eubanks et al., 2018, p.509). Also, they considered rupture moments as an integral part of the human experience because human interactions are open to misunderstandings and misattributions (Fonagy et al., 2023). Eubanks and colleagues (2015) divided rupture concept into two main categories: withdrawal (moving away) and confrontational (moving against) ruptures. In withdrawal ruptures or moving away ruptures, the patient may avoid therapist or therapy work by her nonverbal or verbal attitudes. In confrontation ruptures or moving against ruptures, the patient may move against therapist, therapy task or therapy room by stating her anger and dissatisfaction in a 'noncooperative' manner (Eubanks et al., 2015). Safran and Muran (2000) indicated that patients who make moving away ruptures may have desire to feel connected more than patients who prone to make moving against ruptures. They might prioritize to conform to the therapy task or therapist's desires even they do not feel comfort at that moment. On the other hand, confrontational ruptures may imply patients' prioritizing self-agency over the connectedness (Levy Chajmovic & Tishby, 2024). Even ruptures are common in therapy sessions, the significance of ruptures may vary. They might emerge such as remarkable breakdowns, subtle tensions or misunderstandings (Safran et al., 1990). Resolutions are related with detection of these rupture moments and renewing the emotional bond between therapist and patients. Repair moments are considered as essential to growth and creativity in therapy (Eubanks, 2022). Three pathways were proposed about repair moments which are reattunement to feelings/intentions of patients, renegotiating of tasks/goals and exploration of rupture (Muran & Eubanks, 2020). Therapists might reflect about the rupture moment, change the task or disclose internal experience about the ruptures.

Eubanks and colleagues (2015) proposed an observer-based measurement tool called the Rupture Resolution Rating System (3RS). It provided to micro-analyze

therapy alliance deteriorations in psychotherapy sessions and was originally developed for adult psychotherapy sessions. Specific confrontational (moving against) and withdrawal (moving away) rupture markers are defined in the manual. The frequency and significance of the rupture markers are determined separately by the measurement tool. The frequency of rupture markers indicates how many rupture markers exist in specific session minute intervals. On the other hand, the significance of rupture markers indicates how intense the rupture markers occur. In 2023, the coding system was revised by authors (Eubanks & Muran, 2023). Instead of coding frequency and significance of ruptures separately in the revised version, rupture salience is coded to involve both dimensions. If the frequency or significance of rupture markers increases in the session units, the rupture salience score increases (Eubanks & Muran, 2023).

1.1.2. Empirical Literature

While alliance research has historically focused on adult psychotherapy, recent studies started to explore the significance of alliance in children and adolescents' psychotherapy process (Labouliere et al., 2017; Halfon et al., 2019; Güvenç & Halfon, 2023). Recent research explored the influence of therapeutic alliance on treatment outcomes across distinct clinical problems and analyzed its significance in improving outcomes. Labouliere and colleagues (2017) investigated the therapy outcome and alliance with 34 adolescents who have depression symptoms in Cognitive Behavioral Therapy. Alliance and depression levels were measured with the Alliance Observation Coding System (Karver, 2018) and Beck Depression Inventory (Beck et al., 1961). They found the association that alliance in the first session between therapist and adolescent predicts the symptom severity negatively in the fourth session. Also, symptom severity in adolescents before treatment was not predictive of the alliance in both the first and fourth sessions. Zorzella and colleagues (2015) conducted a study with 95 children aged 7-12, who had gone through different traumatic experiences and

received Cognitive Behavioral Therapy. Children and therapists evaluated the strength of their alliance at different stages of the treatment. The study found that a strong alliance early in the treatment associated with a recovery in internalizing behaviors at the end of the therapy. However, research found that externalizing behaviors were not affected from the alliance factor (Zorzella et al., 2015). For children who exhibit clinical profile, the link of therapy outcome and therapeutic alliance was not only investigated in Cognitive Behavioral Therapy process but also in Psychodynamic Psychotherapy. In a study conducted by Halfon and colleagues in 2019, the center attention was on exploring the development and features of the therapeutic alliance and its association with treatment outcomes in psychodynamic child therapy. The study was conducted with 89 children between 4 to 10 years old. The results illustrated that the level of therapeutic alliance and its developing pattern across sessions influenced the treatment outcomes. This finding was independent of pretreatment factors such as age, gender, and problem type. Specifically, the study found that children who had an average level of alliance and experienced faster changes from downward to upward trends during the treatment showed more symptom recovery. This finding concludes the fact that significant ruptures may appear in the middle phase of the therapy when disruptive feelings of children come out (Halfon et al., 2019). The researchers highlighted the importance of quickly resolving any ruptures in the therapeutic alliance and explained that the U-shaped line is a characteristic of a psychodynamic treatment alliance. Furthermore, the study suggested that the quadratic trajectory could be due to changes in children's emotion regulation capacity throughout treatment, as the therapist becomes more dependable in the middle phases. This finding suggested that there is more need to understand rupture significances and how they are resolved in this age group.

In adolescent and child psychotherapy research, the key role of therapeutic alliance in symptom decline became evident. Together with these findings, it was examined whether pretreatment characteristics of patients are influential in alliance relationships. Even though there are mixed findings, it is visible that there are more

strong relationship between therapy outcome and alliance in some youth (Cirasola & Midgley, 2023). In the meta-analysis, the results of 16 studies (208 children and 395 adolescents) exhibited that for younger girls and patients with externalizing problems in both child and adolescent category, the alliance has a stronger relationship with outcome (Shirk et al., 2011). On the other hand, when controlling prior symptoms; age, sex, and conduct problems did not have a significant impact on the alliance-outcome relationship in 224 adolescents (Cirasola et al., 2021). Topkaya (2022) investigated rupture resolution processes in psychodynamic child psychotherapy with 42 children aged between 4-10 years old. It was investigated whether problem types such as internalizing and externalizing behaviors; sex, and age factors are influential in rupture repair processes. Low alliance sessions were identified by the therapist and patient alliance self-reports via Therapeutic Alliance Scale (TASC; Creed & Kendall, 2005). Afterwards, these sessions were coded with an observer-based measure Rupture Resolution Rating System (3RS; Eubanks et al., 2015). Regarding rupture resolution trends, there were no significant differences between children with internalizing and externalizing problems. However, in sessions of children with internalizing problems, there were fewer rupture markers and more effective resolution strategies. On the other hand, children with externalizing problems tend to have more significant rupture markers which result in challenges of forming and maintaining alliances (Topkaya, 2022). There were more frequent and significant ruptures in boys compared to girls. When boys had more moving against ruptures, girls had more moving away ruptures. Also, younger children tend to have more significant ruptures. These findings suggest that pretreatment characteristics might be influential in alliance.

Research aimed to shed light on the interplay between patient characteristics and their tendency to benefit from therapeutic alliance, as well as identify which patient demographics are more prone to encounter alliance-related challenges. Further, some studies identified therapist approaches that facilitate the alliance with patients. Patients' perspectives on the contribution of therapists to the alliance were investigated through qualitative and quantitative studies. Wilmots and colleagues (2020) interviewed 77

adolescents between 14 -18 years who had depression symptoms and good outcomes at the end of Cognitive Behavioral Therapy. Adolescents described features of therapists who enable positive therapy relationships. They emphasized the features regarding the respect for adolescent's autonomy, sustaining connection and emotional bond at the same time. They expect therapists to balancing the roles of being both professional and friendly. O'Keeffe and colleagues (2020) investigated research with 35 adolescents between 11-17 years old who have different satisfactions with therapy. The sessions of adolescents were coded with Rupture Resolution Rating System (Eubanks et al., 2015) and the Working Alliance Inventory-Observer Version (Tracy & Kokotovic, 1989). It was found that the group who were dropped out and dissatisfied with therapy had more unresolved ruptures than the group who completed their treatment and the group who dropped out but got what they needed. Also, adolescents explained therapist contributes to ruptures in three aspects: giving a minimal response, persisting the therapeutic activity that adolescents rejected and focusing on the risk issues of adolescents' overt wishes (O'Keeffe et al., 2020).

In adult psychotherapy research, the connection between the therapist contribution to rupture is more broadly examined. Levy Chajmovic and Tishby (2024) specifically investigated the intensity of ruptures, the therapist's contribution to rupture and how ruptures were resolved together with the patient and therapist's responsiveness. They investigated 35 patients between 22-40 years in short-term psychodynamic psychotherapy for 16 weeks. The therapist responsiveness was measured with PEAR scale (Snyder & Silberschatz, 2017) which evaluates the patient's perception about therapist's helpfulness, empathy and accomplishment (Levy Chajmovic & Tishby, 2024). There is a significant negative association between patients' perception of the therapist's responsiveness and confrontational ruptures. This significant association is only consistent when resolution is low. Hence, resolution has the role of transforming negative effects of rupture on patient's perception of responsiveness of the therapist. For withdrawal ruptures, no significant association was found. Also, there are significant negative association between the therapist's

contribution to rupture and patients' perception of therapist's responsiveness (Levy Chajmovic & Tishby, 2024). In sessions where there is high resolution, therapist's contribution to rupture is not associated with the therapist's responsiveness. Hence, resolutions are becoming an influential effect on the relationship. This research is one of the first research to investigate relationship between rupture repair and therapist's responsiveness. It still needs to be investigated more.

Therapists are suggested that instead of interpreting their patients' confrontational or withdrawal behavior as a sign of resistance or defensiveness, they should view it as an opportunity to address the issues and repair the rupture (Levy Chajmovic & Tishby, 2024). This approach is crucial in achieving successful therapeutic outcomes (Safran & Muran, 2000; Nof et al., 2019).

After the existence of downward of alliance relationship detected in process research (Halfon et al., 2019), there became more need to shed light on rupture moments in child psychotherapy. Further research examined different types of ruptures that happen within the therapeutic alliance. By examining the different forms of ruptures, studies seek to understand their frequency and impacts on the therapy process. Adolescents between 10-14 years old have been in psychodynamic psychotherapy (Açıkgözler, 2022). 37 of them in face-to-face therapy and 20 of them in online therapy. Research focused on how alliance evolve in two modalities. It was found that the mean alliance didn't significantly differ between the two therapies. However, face-to-face therapy depicted an alliance increase while online therapy showed a decrease over time. It suggested that the deepening of the therapy relationship in two modalities may be different (Açıkgözler, 2022). Together with these findings, it was found that face-to-face therapy had more frequent confrontational ruptures and more resolution attempts than online therapy. Withdrawal ruptures were common in two therapy settings. This finding was interpreted as face-to-face therapy might provide a secure enough relationship for confrontational ruptures to happen and opportunities for young patients to work on aggressive materials (Açıkgözler, 2022). The research about rupture repair in youth therapy also found that there are more withdrawal ruptures in quantity than

confrontational ruptures (Cirasola & Midgley, 2023) in adolescent samples. This finding was supported by the fact that there might be different power dynamics between children/adolescents and adult therapists. Also, identifying withdrawal ruptures has much importance for therapists because as Eubanks and Muran (2020) proposed, their content (being deferential, minimal response) might seem like pseudoalliance (Cirasola & Midgley, 2023). Schenk and colleagues (2019) assessed 10 adolescents between 14-18 and they treated them in the range of 5 to 25 sessions. Alliance rupture repair markers were coded for 187 sessions by independent coders. Confrontational markers such as efforts to control and pressure the therapist, complaints and concerns about therapy activity demonstrated a higher influence on therapeutic alliance throughout the psychotherapy process (Schenk et al., 2019). This research is also supported by the finding that the frequency of confrontational ruptures is associated with low therapist and patient ratings of working alliance (Eubanks et al., 2018). Based upon the mentioned research, even withdrawal ruptures are seen as much as quantity, confrontational ruptures are associated with serious alliance problems on therapy with adolescents when they are not resolved. Research has extensively explored withdrawal and confrontational rupture quantities in child psychotherapy, yet further investigation is necessary to elucidate which elements contribute to them, as well as factors that contribute to their resolution

1.2. Nonverbal Coordination in Psychotherapy

1.2.1. Background

As Watzlawick and colleagues (1967) emphasized, we cannot think about an individual who is 'non-behaving'. Body language, tone of voice, facial expression are cues that we infer from and explain ourselves during communication. Mirroring of gestures, facial expressions are important part of the nonverbal coordination that contributes communication (Tickle-Degnen, 2006).

Kestenberg (1975) proposed that language and movement are complementary means of self-expression. Following Kestenberg's idea, Jensen and colleagues (2021) explained that psychological concepts such as memory, perception, and language comprehension cannot be understood solely mental, and the understanding process cannot be separated from the body. These components are rooted in bodily experiences and sensory processes. This perspective is called embodiment (Gibbs, 2005; Johnson, 2007). The concept of embodiment conceptualized the body not only as a physical entity but also potential or capacity for doing things or responding via movement (Payne, 2017). Also, Kestenberg (1973) associated the alignment of body posture and the regulation of body tension in parent-infant interactions with the emergence of trust, affective resonance, and empathy.

Body movement and nonverbal elements are conceptualized in different terms. Nonverbal coordination was referred to two components: behavior matching and synchrony (Burgoon et al., 1995; Condon & Ogston, 1966). Synchrony conceptualized with denoting terms such as reciprocity, harmonic interaction, rhythmicity and shared affect (Leclère et al., 2014) which start from parent-infant interaction. Synchrony is also defined as the interaction of dyads with a certain rhythm (Bernieri & Rosenthal, 1991). The timing and coordination in the mother-infant relationship acknowledged as a marker of attunement because it conveys messages to infant about relatedness (Beebe & Lachmann, 2002).

Feldman (2007) proposed interpersonal coordination by behavioral matching and synchrony. Behavioral matching was conceptualized as doing what others are doing (Feldman, 2007). He emphasized the parent-infant synchrony as a developing concept from biological rhythm to symbolic exchange. He proposed that synchrony provides a bond formation, self-regulation and capacity for empathy for infants (Feldman, 2007). Around 3rd month, babies start to socially interact. They experience mismatches with their caregivers by gaze shift, vocalizing and arousal level in some of these social interactions. Eventually, these mismatches turn to matching and coordination again (Tronick, 1989). Hence, mismatch and rematch processes

considered as the basis of human interaction (Feldman, 2007). Stern (1985) proposed the term ‘vitality’ in his works about mother-infant nonverbal communication. He explained that it is possible to understand vitality with physical operations like force, time and movement. Orange (1995) explained that empathic response comes from attunement, and it emerges through glances, posture and vocal rhythms. Also, through matching, it might be possible to validate the child’s situation and showing that feelings and thinkings are understandable by therapist.

While synchrony and matching offer aligned movements, nonverbal coordination can also regulate other's actions (Harrison & Tronick, 2011). For instance, individuals may downregulate or attenuate their movements to facilitate a calming effect on a distressed counterpart. Conversely, they might upregulate or intensify their expressions to foster engagement and connection with the other person. Above mirroring, nonverbal coordination includes the complex interplay of movement dynamics adjustments that increase alliance, emotional attunement, and mutual understanding in interpersonal interactions.

Understanding nonverbal coordination in daily interactions is essential for effective communication. Besides, exploring its nuances in therapeutic settings can deepen insight into relational dynamics. The relationship between alliance and nonverbal coordination is complex to measure for some reasons. Nonverbal elements are regarded as various and context dependent. Interaction between two people might happen in earlier phase of communication or later (Tickle-Degnen & Rosenthal, 1990). Tickle-Degnen and Rosenthal (1990) stated three nonverbal components to build rapport: attentiveness, positivity-negativity and coordination. In this conceptualization, coordination is related with balance, harmony and being ‘in sync’. Various measures, including Motion Energy Analysis (MEA) (Ramseyer, 2008), software design to understand vocal synchrony (PRAAT; Boersma & Weenink, 2024) or physiological measures give insights about the nonverbal dynamics of interaction. These tools provide to quantify and analyze the slight nuances of nonverbal coordination between dyads. Also, manual coding systems, like the one established for assessing mother-

infant relationships (PEM; Shai & Belsky, 2017), are substantial resources. Through detailed observation and categorization of behaviors, these manual systems provide deeper understanding of the complexities in interpersonal coordination.

1.2.2. Empirical Literature

1.2.2.1. Adult Studies

Studies have demonstrated interaction between alliance and nonverbal coordination across diverse population such as clinical and nonclinical samples. Csikszentmihalyi (1990) proposed that rapport progresses by behavior characteristics and not only by the presence of behaviors (Nelson et al., 2016). Hence, some research focused on the behavior qualities and rapport. In research, the movement synchrony and rapport between 50 undergraduate student dyads investigated (Nelson et al., 2016). The rapport and movement qualities measured with self-report and objective measures such as Motion Energy Analysis. Motion Energy Analysis is a movement image method to measure movement synchrony between dyad (Nelson et al., 2016). Self-report measures were used for coordination expressivity. It was found that overactive (too expressive) or underactive (blunt) actions predicting the lower rapport in dyad. Besides, Motion Energy Analysis results of synchrony demonstrated that both tendencies (too expressive and blunt) disrupt the responsiveness of interactions (Nelson et al., 2016). In the relationship between rapport and nonverbal coordination research, there are favorable evidence about the moderate level of expressivity, positivity and attentiveness (Tickle-Degnen, 2006). Use of smile in synchrony as a pattern considered the assurance of a good therapeutic relationship and reciprocity. However, when it is excessive, it might serve as a defense mechanism and denial of negative affect (Bänninger-Huber & Widmer, 1999). Together with the movement qualities and expressivity, it was investigated whether there is nonverbal evidence of rapport regarding posture movements (Trout & Rosenfeld, 1980). 60 undergraduate students

watched video segments of differently demonstrated body posture and leaning positions of dyads and they rated the rapport. It was shown that the congruent body posture and forward-leaning significantly perceived as rapport between the dyads (Trout & Rosenfeld, 1980).

When there is negative relation between vocal synchrony and alliance in the research, synchrony regarding body coordination findings has mixed findings with alliance. In a study with 52 patients older than 18 years old who had been in individual therapy by therapists with different orientations, the video recordings of sessions investigated (Reich, 2014). Specialized software called PRAAT (Boersma & Weenink, 2012) is used to analyze pitch synchrony. Besides, self-report measures for working alliance (Working Alliance Inventory WAI; Tracey & Kokotovic, 1989) and symptom reduction were filled after the sessions by patients and therapists. It was found that higher levels of pitch synchrony had association with poor therapy relationship and higher stress. Descriptively in the sessions, there are more therapist leading pitch shifts than patient-leading pitch shifts. Also, it was found that higher therapist-leading pitch shifts were related with low ratings of alliance. Therapist's mirroring of patient pitch positively correlated with greater depressive symptoms in patients (Reich, 2014). This finding was interpreted as when matching with patient's pitch connotes empathy, it might also amplify the patients' distress (Reich, 2014).

37 women and 33 men from outpatient psychotherapy clinic who have diverse clinical problems such as anxiety disorder, affective disorder and personality disorders investigated (Ramseyer & Tschacher, 2011). Sessions were recorded to video tape and motion energy analysis technique used to assess nonverbal qualities. Also, self-reports are used for alliance and self-efficacy measures of patients. In the study, nonverbal elements involved gestures, facial expression and body language. It was found the existence of synchrony between patient and therapist, and it does not differ by gender, diagnosis and therapy process (Ramseyer & Tschacher, 2011). They distinguished synchrony and pseudosynchrony moments which are not interaction on purpose even it seems like synchrony. It was found that synchrony was significantly higher in initial

phase of therapy. Also, higher ratings of relationship quality and self-efficacy for patients were related with higher nonverbal synchrony.

Recent research especially focused on rupture and repair moments and nonverbal coordination of dyads. These research used observer-based measures and movement image techniques. Deres-Cohen and colleagues (2021) investigated 418 sessions of 75 adult patient-therapist dyads. They investigated body movement synchrony with motion energy analysis when they investigated rupture moments with 3RS (Eubanks et al., 2015). It was found that nonverbal synchrony is associated with confrontational ruptures but not with withdrawal ruptures. Hence, they considered synchrony as the marker of rupture moments. Høgenhaug and colleagues (2024) systematically reviewed 17 studies and found significant association between the synchrony of facial expression-vocalization and rupture moments in sessions. Especially one research demonstrated the fact that synchrony exists in rupture moments highest than no-rupture moments (Avdi & Seikkula, 2019). Avdi and Seikkula (2019) analyzed relationship between rupture moments and nonverbal elements in sessions of 26 years old man who had suicidal ideations and lost interest things he enjoyed earlier. Patient and therapist wore heart rate monitors to track their physiological changes. When rupture moments occur, the synchrony between heart rates and postural congruence between therapist and client existed. The authors interpreted this congruence to provide holding environment to get back to verbal communication and alliance (Avdi & Seikkula, 2019). In another study, the goal was to investigate the facial and verbal behavior of both the patient and therapist during moments of rupture and resolution in a brief psychodynamic therapy (Altimir & Valdés-Sánchez, 2020). It was hypothesized that there will be facial characteristic of therapist and patients during rupture and resolution moments and these facial expressions might be connotations of emotion dysregulation. The patient in this study was a 33-year-old woman seeking help for mild depressive symptoms and interpersonal issues. The analysis revealed that the patient displayed anger in her face during moments of conflict and exhibited fear and indicators of self-soothing behavior such as gaze away and self-touching when the

therapist offered new explanations or formulations. There are differences in the therapists' nonverbal characteristics during rupture and resolution moments. During rupture events, the therapist maintained eye contact with the patient, displaying emotional engagement and a willingness to address the issues. However, during resolution phases, the therapist emphasized interventions, using gestures to emphasize the importance of addressing previous conflicts. Contrary of the study hypothesis, therapist did not display excessive positive emotions in face during resolution strategies. Together with these findings, despite patient maintained functional level of well-being in therapy process, symptom measures at the end of treatment did not demonstrate significant change.

It can be concluded that there might be specific nonverbal markers of rupture and resolution moments for therapist and patients. Therapist's nonverbal behaviors such as gazing at patients during rupture moments may provide emotional engagement and comfort to patients. Some of the research demonstrated that nonverbal synchrony might be the marker of ruptures and attempt to repair the rupture moments especially in confrontational ruptures which is more apparent alliance deterioration than withdrawal ruptures (Cirasola & Midgley, 2023).

1.2.2.2. Parent-Infant Studies

61 studies about synchrony sampled children between 2-5 years old (Lèclere et al., 2014). It was explored that in normal population samples, synchrony was conceptualized as mirroring infant's interactions to provide infants being more engaged and it varies developmentally (Leclère et al., 2014). When first year interactions were related with mother's voice and infant's movement, later synchrony characterized with child initiation and turn taking (Leclère et al., 2014). Findings claimed that synchrony is not a perfect symmetrical timing but includes breaks or variance. These breaks might give space to improve creativity and adaptation in infants. Also, in some studies, synchrony was a distinguishing factor of maternal pathologies such as depression.

Depression level of mothers was associated with low levels of synchrony (Lèclere et al., 2014) in the mother-infant interaction.

Beebe and Steele (2013) investigated moment-to-moment mother-infant communication with 4-months old infants. They emphasized the fact that communication is reciprocal, and infants have effect on mother's behavior as much as mother's effect on them (Beebe & Steele, 2013). Maternal overstimulation, low maternal responsiveness and inconsistency in mother's behavior predicted insecure attachment in infants between 3-9 months old (Hane et al., 2003; Isabella & Belsky, 1991). Another study, mothers and infants' gaze, facial affect, spatial-head orientation are coded (Beebe & Steele, 2013). It was hypothesized that mothers of infants who might have risk of disorganized attachment at 12th months will not follow directions of their infants. Also, they will use more discrete facial and vocal affect. It was found that they tend to look away from their infants and having fewer facial expressions which interpreted as turning themselves off from infants (Beebe & Steele, 2013). In these circumstances, infants may start to expect that their mothers will not share their stress (Beebe & Steele, 2013)

In another study, it was found that vocal rhythmic overly coordination and undercoordination between partners in the context of switching vocal and rhythms of turn taking predicted insecure attachments at 12th months in infants (Jaffe et al., 2001). Hence, midrange of coordination is interpreted as giving space to 'unknown' and flexibility in communication. Too much coordination interpreted as too much monitoring and coping strategy for threat when low coordination interpreted as withdrawal from relationship, restrain of monitoring (Jaffe et al., 2001).

Even nonverbal interaction investigated in infant-mother dyad and adult psychotherapy, little research investigated nonverbal elements in child psychotherapy process. Harrison and Tronick (2011) gave insights about the case study of 5 years old boy patient who came therapy for disruptive behaviors and separation anxiety. Patient were dysregulated and not settle down in plays. Therapist admitted that his pauses

created rhythmic, turn-taking pattern that deliver child the information as ‘small bits to take in’ (Harrison & Tronick, 2011, p.970). Also, it was mentioned that pauses gave child the message that he is agentic, and he has space to interrupt therapist during conversation. Therapist explained that he has a purpose by slowly moving in the room and making small gestures which is designed to minimize confrontational nature of child’s behaviors and regulating the child (Harrison & Tronick, 2011).

Although there are relatively more nonverbal coordination and alliance studies in literature, these concepts have not been conducted systematically in child psychotherapy. Besides, these studies investigate nonverbal coordination in partly ways such as examining facial expressions, body position matching, or vocal synchrony between dyads (Reich, 2014; Trout & Rosenfeld, 1980; Ramseyer & Tschacher, 2011). There is a great need to study nonverbal coordination in child psychotherapy regarding its relationship with alliance. To our knowledge, no nonverbal coordination study has been conducted to date examining the alliance in children depending on their different rupture types.

1.3. Mentalization Based Treatment for Children (MBT-C)

Mentalization is the 'awareness of mental states in oneself and in other people, particularly in explaining their actions' (Bateman & Fonagy, 2019, p.28). The mentalization theory is based on attachment and developmental research (Byrne et al., 2020). Caregiver's interest in the child's mind and the child's feeling safe about exploring the mind of the caregiver can be provided in a secure attachment relationship (Fonagy et al., 2014). A child's ability to trust and receive new information from the social world is called epistemic trust (Fonagy, 2017). Epistemic mistrust is related to psychopathology, and people who has low epistemic trust don't find a reason to trust others and reject the information that does not support their earlier beliefs (Fonagy, 2017). In this respect, the child's experience of the therapist as supportive, attuned, and

nonjudgmental is considered one of the important aspects for therapeutic change (Shirk & Russell, 1996).

Mentalization has several dimensions. Explicit (controlled) and implicit (automatic) mentalizations are some dimensions that need to be distinguished. Evolutionarily, we infer others' mental states automatically and without using words (Midgley et al., 2017). Although our implicit mentalizing may be quick, it may not be accurate. Other times, we may use explicit mentalization, which is more conscious and involves the reflections on the emotions, thoughts and intentions.

When a child has emotional reactions, it is essential to reflect with the reaction that is not completely same but slightly different than the child's. This process is called marked mirroring, which demonstrates to children the representation of their subjective experience. Also, this process provides self-regulation and self-control capacities (Fonagy & Target, 1997). Fonagy and Luyten (2009) proposed the necessity of embodied features in mentalizing. They opposed the fact that mentalizing means to verbalize parental representations of the child but also requires expressing it in an embodied way. Slade (2005) defined mentalizing as the capacity to represent the link between affect, behavior, the body and self-experience. Parents' markedly mirroring facial expressions of infants gives the sense on the infant that there is a representation of inner states on the outside (Jensen et al., 2021). This situation provides self-regulation.

Mentalization Based Treatment is first developed for the treatment of adults with borderline personality disorder (Byrne et al., 2020). Then, its manual was modified to address the treatment of children and parents (Midgley et al., 2017). The aim of the treatment is explained as freeing parents from situations in which they are unable to mentalize their children and provide children to mentalize themselves and others as suitable for their developmental level. It is a time-limited therapy that persists of 12 sessions. Both children and parents have therapists (Midgley et al., 2017).

Enhancing epistemic trust is one of the goals of the MBT-C. Epistemic trust is defined as considering new information from someone as reliable, generalizable and

appropriate (Fonagy & Allison, 2014). By establishing epistemic trust, children and their parents can trust the information from each other and from their therapists. In the manual, the therapeutic stance of the therapist is explained with different elements. Therapists' presence should require 'helping, authentic, nonjudgmental, accepting and responsive' (Midgley et al., 2017, p.167). Therapists should be interested not only in the child's behavior but also in the mind of oneself. Therapists should have a curiosity about the child, and even though they know something as an adult, it might be helpful to take a 'not-knowing' stance for the child (Midgley et al., 2017). Also, they should monitor misunderstandings (alliance ruptures) during sessions (Midgley et al., 2017). Therapist stance is core in the MBT-C because therapists' curious stance, exploration of different perspectives, and humor provide a model to enhance a child's mentalization capacity.

Because internal states are opaque and open to change, there might always be an error in mentalizing someone or ourselves, which provides misunderstanding in a relationship. It is impossible to mentalize every mental state of the other correctly; unmentalized mental states or misattunements in marked mirroring are inevitable (Fonagy & Bateman, 2019). Momentary miscoordination and interactive repair are mentioned as the essence of human dialogue in infant-parent relationships (Tronick, 1989). Misunderstandings when mentalizing others and ourselves might lead to rupture moments (Fonagy et al., 2023). From the MBT-C perspective, ruptures can be used to understand a child's insight and enhancing the skills to take the other person's perspectives. Also, repair moments are challenging the earlier maladaptive patterns and becoming crucial for enhancing epistemic trust in children (Folmo et al., 2019; Miller-Bottome et al., 2018; Fonagy et al., 2023). Rupture moments are defined as loss of wellness and joint intentionality in mentalization based treatment (Fonagy et al., 2023). Hence, Mentalization Treatment therapists are encouraged to find rupture moments and try to find the ways of successful resolutions. Alliance is considered an important element in MBT-C, especially to enhance both the child's and parents' reflective functioning (Midgley et al., 2017). In the initial sessions, the therapist's stance to

understand the child's perspective and empathically attune with them may provide a model for children as a reflective person who tries to understand herself and the other. Forming an alliance requires empathically attuning to patients and parents and maintaining a mentalizing stance (Fonagy et al., 2019).

Mentalization Based Treatment interventions are divided into three categories: Attention Control, Emotion Regulation and Explicit Mentalization. Attention control skills are perceived as the backbone of mentalization (Midgley et al., 2017). Attention control is defined as a child's capacity to regulate himself, focusing something, and inhibit responses that are not proper in social interactions (Midgley et al., 2017). These skills are associated with perspective-taking and empathy in later years. When infants get emotionally dysregulated in parent-infant relationships, their mothers attempt to shift the infant's attention to regulate their emotions. By responsiveness of the mother, they start to defocus from undesired objects. Mother's responsiveness may be provided by nonverbal qualities such as joint attention, mirroring and slowing down. These processes develop in the preverbal period, and they are regarded as essential for the mentalization capacity (Midgley et al., 2017). It is necessary to be emotionally regulated at some level to mentalize (Bate & Malberg, 2020). In MBT-C, attention control interventions are joint attention, matching with nonverbal or verbal rhythm, mirroring, slowing down, stop and stand, noticing what is happening in the here and now (Bate & Malberg, 2020; Bate & Midgley, 2020).

For instance, when a child throws the ball so fast and uncontrolled in the room, he might hurt himself or the therapist. In this case, the therapist might stop the play and keep eye contact with the child. Through this intervention, the therapist stands with the child while creating a safe room. A therapist might admit that the child hit the ball so hard that it sounded loud. This comment links the child's action and consequences to the external world. In another instance, a child who has withdrawal problems might maintain little eye contact and limited interaction during play. When the child whispers and slowly vocalizes a character, the therapist might speed up and increase the voice volume by repeating what the child says. Through this intervention, the therapist may

upregulate the child's arousal. Also, when a child says that he is bored from the play, the therapist might mirror the child's facial affect to match the child and validate her emotional state.

In mentalization based treatment, there are interventions to provide for children who are dysregulated and have difficulties controlling their impulses. Nonverbal coordination of therapists, such as matching with the patient's body shape, synchrony with movement, and body posture (Deres-Cohen et al., 2021), provides relatedness and a secure environment in therapy. Also, the therapist's nonverbal coordination sometimes provides being in the same rhythm with the patients to convey alliance (Avdi & Seikkula, 2019) and empathy. The objectives of nonverbal coordination might include enhancing emotional connection and interaction, supporting regulation, promoting affective expressiveness, and developing reflective functioning (Çatay et al., 2023). These objectives overlap with attention control interventions.

1.3.1. Empirical Literature

One of the research studies focused on rupture repair moments in Mentalization Based Group Treatment (Bateman et al., 2021). The resolution strategies by therapists are explained as accepting the therapist's contribution to rupture, empathically validating the situation's impact on group members' inner states and making the group members think about the repair processes. This study suggests that some repair techniques differ by the therapy approach or patients' characteristics. Hence, child psychotherapy, which is more related to nonverbal communication and playful elements, might need more nonverbal repair techniques. Nof and colleagues (2019) proposed a method for managing ruptures in child psychotherapy. Their approach consisted of four phases. The first two phases involved identifying and acknowledging the rupture. In contrast, the third phase focused on taking responsibility without blaming and reframing the rupture as an active effort by the child to express their distress. Finally, in the fourth phase, therapists use a change strategy and meta-

communication story intervention to resolve the rupture. This model was seen as suitable for children aged 6-17 with a range of clinical issues. They gave the example of the 'pausing' of the therapist, which might be the punctuation moment of rupture moments (Nof et al., 2019).

Shai and Belsky (2017) emphasized that mentalization assessments only deal with semantic knowledge, and they wanted to understand how mothers and infants bodily communicate. They proposed a coding system that assesses parents' ability to understand and respond to their infant's mental states by bodily movement. This system codes dyad's movements in relation to one another considering tension, flow, tempo, space, directionality (Shai & Belsky, 2017). This system aimed to code the infant's behavior and parents' response to the infant's movement and modify toward them. They hypothesized that higher-rating mothers on PEM will have more competent children in childhood (Shai & Belsky, 2017). Two hundred mother-infant dyads were randomly selected and classified as secure, avoidant, anxious and disorganized attachments. It was found that PEM scores of parents when infants are 6 months old predicted a reduction of insecure attachment styles in 36th months. Also, high PEM ratings predicted less internalizing and externalizing problems and the development of social skills at 54th months.

Güvenç and Halfon (2023) examined mentalization techniques and therapeutic alliance in two cases of psychodynamic psychotherapy with children 9 and 10 years old who were referred for social withdrawal problems. One has more clinical improvement than the other at the end of therapy. It was hypothesized that therapists' mentalization interventions would predict higher levels of the therapeutic alliance when this, in turn, provides more use of mentalization interventions in the next sessions. Observer-based ratings coded for mentalization techniques and alliance. It was found that this relationship occurred in the case of clinical improvement at the end of therapy. It was suggested that when mentalization intervention techniques are not used in a strong alliance context, they may cause ruptures (Halfon, 2021).

1.4. Current Study

Although there is ample research about alliance in child psychotherapy, there still exists some gaps in the literature. In youth literature, therapist's features such as responsiveness, giving autonomy, and being friendly were related to positive alliance (O'Keeffe et al., 2020; Levy Chajmovic & Tishby, 2024). Also, therapists use specific nonverbal expressions during rupture and repair moments, which were found to be reparative (Altimir & Valdés-Sánchez, 2020). However, a research gap exists about therapists' body coordination and how it affects a child's alliance. Parent-infant literature showed that infants' attachment security and self-regulation capacity were predicted by synchrony body movements and responsiveness of mothers (Beebe & Steele, 2013; Jaffe et al., 2001). In child psychotherapy, being attuned and responsive toward a child could relate to nonverbal coordination. The therapist's capacity for nonverbal attunement, the ability to hear, sense, and respond to the child's nonverbal cues, may provide the feeling of safety and understanding in the therapy relationship and strengthen the therapeutic bond, especially in times of deterioration in the therapy relationship.

The current study aims to investigate sessions in Mentalization Based Treatment for Children (MBT-C) where the alliance between child-therapist dyads was low. The sessions were conducted with 5-11 years old children. The manual of the MBT-C emphasized that the interventions are modifiable to wide range of age and sensitive to developmental levels. We define weak alliance as sessions with at least one standard deviation below the overall treatment alliance means of the sample. Drawing from the findings of Deres-Cohen et al. (2021) and Levy Chajmovic & Tishby (2024), we specifically examine the relationship between therapists' nonverbal coordination and moving away and moving against ruptures. Our hypothesis is that the nonverbal coordination of the therapists will predict a decrease in both children's moving away and moving against rupture salience. In therapy process research, it was found that the ruptures are more observed in middle sessions than first and last sessions of treatment

(Halfon et al., 2019). However, this situation is observed in long term treatment which is psychodynamic child psychotherapy. Eubanks and Muran (2023) emphasized that ruptures are inevitable moments that may occur in any therapy sessions. Hence, for our hypothesis, we will investigate rupture moments in the sessions of children from every phase which are first, middle and end.



CHAPTER 2

METHOD

2.1. DATA COLLECTION

Current thesis collected data from the ‘Effectiveness and Change Mechanism of Mentalization Based Therapy for Children (MBT-C)’ randomized controlled trial (RCT). The RCT aimed to compare the effectiveness of two interventions for 5-12 aged children who have clinical problems. The patients in the RCT were randomly assigned to two interventions. There were two inclusion criteria in the randomized controlled procedure for children; (1) being in the age range of 5 to 12 years old and (2) having clinical problems identified by Child Behavior Checklist (ÇDDÖ; Erol & Şimşek, 1995). The exclusion criteria were as follows: (1) parents’ risk of harm to self and others, level of psychosis, alcohol-substance problem. These criteria were assessed by using Brief Symptom Inventory (KSE; Şahin & Durak, 1994) and BAPIRT Alcohol and Drug Scale (Ögel et al., 2017). (2) Children’s having Autism Spectrum Disorder, Psychosis, Eating Disorder, Conduct Disorder, Alcohol/Substance Use. These criteria were assessed by Affective Disorder and Schizophrenia Interview Schedule for School-Age Children (K-SADS; Gökler et al., 2004). (3) Ongoing physical and sexual abuse in family, (4) mental retardation of children and parents assessed by Kaufman Brief Intelligence Test (KBIT-2; Kaufman & Kaufman, 1990). 222 children who meet the mentioned criteria were randomly assigned to the active treatment group (MBT-C) and control group (Parenting and Social Skills Group). 111 children were in MBT-C and 111 children were in group treatment. 5 children from MBT-C and 6 children from social skills group were never treated. In conclusion, 106 children received MBT-C intervention and 105 children received Parenting and Social Skills Group intervention. For further information, please see the trial protocol and consort flow that details the patient inclusion (Appendix A and B).

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) (Appendix I). Parents that participated in the study gave written consent and children in the study gave verbal consent. The clinical study protocol can be found in Appendix A (Protocol No: NCT05290714).

In this thesis, only patients who were randomly assigned to the MBT-C treatment were included. Even though 106 children were randomized to treatment in MBT-C, 28 children whose sessions had low alliance quality were selected and their sessions were included in further analyses.

2.2. PARTICIPANTS

Participants of the current study were 28 children (71.4 % male and 28.6 % female) who received Mentalization Based Treatment for Children. Participants' ages varied between 5 to 11 ($M = 7.49$, $SD = 1.73$). 46.5% of the children were between ages 5 and 6; 35.7% of children were between 7-8 years old and 17.8% of children were between 9-11 years old. The socioeconomic status of families was evaluated based on their economic income compared to the minimum wage at the time they started therapy. The demographic characteristics of the participants were shown in Table 2.1.

Table 2.1. Demographic Characteristics of the Child Participants (N=28)

Categories		Frequency (N)	Valid Percent (%)
Sex	Female	8	28.6
	Male	20	71.4
Socioeconomic Status	Low	4	14.3
	Middle-Low	7	25.0
	Middle	3	10.7
	Middle-High	8	28.6
	High	6	21.4
CBCL*	Internalizing	12	42.9
	Externalizing	6	21.4
	Comorbid	10	35.7

**Child Behavior Checklist (Achenbach, 1991)*

2.3. THERAPISTS

There were 15 (13.3% male, 86.7% female) clinicians whose ages ranged from 21 to 37 ($M = 26.76$, $SD = 3.4$). 46.6% of the therapists were between ages 25-27; 40% of therapists were between 28-32 years old and 13.4% of therapists were between 33-41 years old. Therapists conducted psychotherapies with children and their parents. They had taken MBT-C training from Anna Freud Center instructors Dr. Emma Morris and Dr. Holly Dwyer Hall. The standard training lasted for 18 hours and were completed in the 6 sessions. Also, therapists received supervision from the same experts while conducting the therapies. 46.7% of therapists had 1–2-years of experience. 33.3% of the therapists had 3-4 years of experience and 20% of therapists had 5-6 years of experience.

2.4. SAMPLING OF THERAPY SESSIONS

In the current study the sessions which were at least one standard deviation below the mean were selected ($N = 42$). In these 42 sessions, some of the sessions belonged to the same child. Hence, to eliminate confounding, one session from each child was selected from 42 sessions. As a result, 28 sessions from 28 children were analyzed for the research purposes. The mean score of the selected sessions was 17.42 ($SD = 3.91$); whereas the overall mean of the whole sample from 106 children was 27.46 ($SD = 5.78$) in Therapy Process Observational Coding System-Alliance (TPOCS-A) measure. Below, the measurement will be described in detail.

8 of these sessions (28.6%) were the 2nd session of the therapy which corresponded to the first session the child was seen individually by the clinician. 7 (25%) of the 28 sessions were 9 and 10th session of the therapy. These sessions were regarded as the middle phase of therapy. 3 (10.7%) of the sessions were 12 and 13th sessions of the therapy and 10 (35.7%) of the therapies were 14th and 15th sessions which were the end phase of the therapy. From these session videos as per the coding manuals for alliance and nonverbal coordination, 3 minutes from beginning and 3 minutes from middle phase were selected. 6 different one-minute intervals were coded from 28 sessions. In sum, 168 one-minute intervals were subjected for further analysis in the current study.

2.5. MEASURES

2.5.1. ASSESSMENT MEASURES

2.5.1.1. Demographic Information

Sociodemographic forms were taken from families participating in the randomized controlled study. The forms involve the age, sex and history of the psychological help information for children and parents. Also, they involve information about educational status, socio-economic and marital status. Moreover, therapists fill

demographic forms before starting the therapy procedure. The information of age, sex, years of experience and therapy orientation are collected.

2.5.1.2. The Child Behavior Checklist (CBCL)

The objective of the Child Behavior Checklist (Achenbach, 1991) is to identify the children's behavioral problems. The parent report questionnaire known as CBCL appears in a variety of formats and exhibit variance regarding age differences. For children 1.5–5 and for children ages 6–18, there are two distinct scales (See Appendix C and D). The questions are evaluated by using a 3-point Likert scale (0 = ‘not true’ 1 = ‘somewhat or occasionally true’ and 2 = ‘very true or often true’). Parent responses provide ratings for internalizing, externalizing, and comorbid problems of children. The clinical severity of children can be measured with the use of the ASEBA software program. A score greater than 65 denotes the clinical range. The scores between 60-65 indicates borderline level when scores less than 60 indicates non-clinical level.

The internal consistency of the CBCL for internalizing symptoms scales have good results for children aged 1.5 to 5 years ($\alpha = 0.89$) and for 6 to 18 years ($\alpha = 0.90$). Furthermore, the internal consistency results for the externalizing symptoms scale are high ($\alpha = 0.94$ for CBCL 6-18 and $\alpha = 0.93$ for CBCL 1.5-5) (Achenbach & Rescorla, 2000). Erol and Şimşek (1995) adapted the CBCL to Turkish. The adapted version had strong internal consistency ($\alpha = 0.87$ and 0.90) for the internalizing and externalizing symptom scales.

2.5.2. PROCESS MEASURES

2.5.2.1. Therapy Process Observational Coding System-Alliance Scale (TPOCS-A)

The therapeutic alliance is evaluated by using the observer-based scale Therapy Process Observational Coding System-Alliance (TPOCS-A; McLeod & Weisz, 2005).

The scale consists of nine items divided into two subscales that evaluate the working alliance and bond characteristics. Coders observe the entire therapeutic session and assign a frequency and intensity rating to each item. A child may: (1) state that the therapist is understanding and supportive; (2) act in a hostile, critical, or defensive manner toward the therapist; (3) show positive affect toward the therapist; (4) share an experience with the therapist; (5) appear nervous or uncomfortable when interacting with the therapist; (6) appear nervous or uncomfortable when interacting with the therapist together; (7) uses therapeutic tasks to create changes outside of the session; (8) disobeys therapeutic tasks; and (9) collaborates equally with the therapist on therapeutic works (McLeod & Weisz, 2005). A 5-point Likert scale is used to score the items ('0' denotes not at all and '5' denotes a great lot). Good internal consistency, convergent validity, and inter-rater reliability of TPOCS-A have been demonstrated (Fjermestad et al., 2012; McLeod & Weisz, 2005). TPOCS-A measurement scale was adapted to the Turkish child population between 4-10 years old by Halfon and colleagues (2021) with the consultation of Bryce D. McLeod (Açıkgözler, 2022). In this adaptation study, there is a good internal consistency ($\alpha = 0.73$) apart from the item 7 (i.e., "Child uses therapeutic tasks to make changes outside the session"). The reason for this is psychodynamic psychotherapy does not provide assignments compared to behavioral treatments (Halfon et al., 2021). Adaptation of the measurement to adolescents who are older than ten years old has not been made yet in the Turkish population; nevertheless, the measurement tool has been developed for the age group (8 to 14 years old) in the original study, and this population is in line with the current study population (McLeod & Weisz, 2005). Additionally, it has proven to be predictive of therapy outcome (Halfon et al., 2019; Liber et al., 2010). Six graduate students who were study coders had completed theoretical and practical training from educators. The training lasted for six hours. The coders were randomly assigned to each of the child sessions used in this investigation. The mean scores of the coders who worked in pairs were employed for the analysis. The coders' inter-rater reliability coefficients (ICCs) ranged from 0.80 to 1 ($M = 0.87$, $SD = 0.05$), indicating good to exceptional

performance. The coding procedure was started at September 2023 and ended at March 2024 (See Appendix E).

2.5.2.2. Rupture Resolution Rating System (3RS)

Rupture Resolution Rating System (3RS; Eubanks & Muran, 2023) is an observer-based coding system. It is used to identify alliance ruptures and how they are resolved during psychotherapy sessions. Ruptures manifested as a deterioration in collaboration toward tasks or tensions in the emotional relationship between patient and therapists (Eubanks et al., 2015). Researchers code the five-minute intervals of the video recordings of the sessions to identify signals of alliance rupture and resolution. The rating system was created in 2015 and revised in 2022 by Eubanks and colleagues (Eubanks & Muran, 2023).

Ruptures are coded in two different subscales: Withdrawal (moving away) and confrontational (moving against). In the revised version of the coding system, these subscales are coded by examining the salience of defined markers and coded for therapist and patients separately (Eubanks & Muran, 2023). There are two items in moving away subscale: (1) Patient moves away, (2) Therapist moves away. Also, there are two items in moving against subscale: (3) Patient moves against (4) Therapist moves against. Patient's moving away are evaluated by assessing significance and frequency of the moving away behaviors in the minute segment such as: shut down (avoidant denial, minimal response, give up), abstract communication, avoidant storytelling, topic shift, deferential/appeasing, content/affect split.

Avoidant denial happens when the patient denies evident feelings or the importance of interpersonal relationships relevant to the work of therapy. Even difficult topics were discussed, patient might refuse that the topic has no influence on them. Minimal response is characterized by patient's becoming silent or when patient refuses to participate in conversations with the therapist. On the other hand, patient might show signs of giving up by expressing hopelessness about therapy or the therapist's

effectiveness. This expression is not collaborative or focusing on solving the current problem. Abstract communication involves using vague language to avoid directly addressing emotions or issues, while avoidant storytelling and topic shift serve to deflect attention from the work of therapy. Additionally, patient may exhibit deferential/appeasing behavior that conceals underlying dissatisfaction about therapy work. Also, patient may be overly conforming and not express underlying dissatisfaction about therapy. In the content/affect split, emotions do not align with the narrative (Eubanks et al., 2022). For example, the patient might explain difficult situation in her life by smiling (See Appendix G). The salience of the patient moves away can be coded from '1' = not salient to '5' = very salient. If at least one clear moving away marker mentioned above exists, this might be adequate to code the minute as '3' (Eubanks & Muran, 2023). If moving away markers are relevant, intense and much as quantity in the minute, the coding score increases (See Appendix H).

Patients' moving against categories are evaluated by looking at the markers such as: complain about/criticize (activity, intervention, progress), push back (reject other's idea, defends self, hostile denial), control/pressure (See Appendix F). In detail, complain about/criticize markers involve expressing dissatisfaction about the therapist, criticizing therapy activities and interventions, raising concerns about treatment parameters such as the therapy schedule, appointment times, session length, number of sessions or research requirements. In push back markers, patient may express skepticism or doubts about the progress achieved or achievable in therapy, demonstrates rejection of the therapist's ideas or defends self against perceived criticism or judgment from therapist. Hostile denial may also be present, when denying prominent emotional states or the significance of interpersonal relationships in an hostile manner. Lastly, patient might attempt to exert control or pressure on the therapist, seeking quick solutions to current problems. The salience of the patient moving against can be coded from '1' = not salient to '5' = very salient. In the manual, it was mentioned that at least one clear moving against marker is adequate for coding

the minute as '3'. If moving against rupture markers mentioned above are relevant, intense and much as quantity in the minute, the coding score increases.

In earlier research (Açıkgözler, 2022), different rupture occasions happened only in child psychotherapy but not in adult psychotherapy are emphasized. In this study, the author and coders were loyal to earlier observations. Patients' shifts in the play were perceived as avoidant storytelling and/or topic shift in the case of showing moving away from the therapist and/or therapy work. Additionally, complaints about toys, board games were perceived as complaints and/or concerns about the parameters of the therapy.

Eubanks and colleagues (2019) have achieved a remarkable level of reliability and validity for the 3RS assessment tool, particularly for the population aged between 21-78 ($M = 39.48$, $SD = 16.06$). 3RS has demonstrated strong predictive validity and good inter-rater reliability (ICCs = .81 - .98) when considering psychometric features (Eubanks et al., 2019). This assessment was developed for adult patients, but it has been used in several studies on adolescent populations (O'Keeffe et al., 2020; Gersh et al., 2017). Also, it is used in psychodynamic child psychotherapy sessions (Güvenç & Halfon, 2023; Topkaya, 2022; Açıkgözler, 2022). This scale was initially developed for adult patients (Eubanks et al., 2015).

First, the author of the current study conferred Sibel Halfon, PhD, and Catherine F. Eubanks, PhD, to obtain the 3RS-Revised manual and learning materials. The author began training by coding the seven sessions of adult patients that Catherine F. Eubanks and her team had previously coded. Two coders other than the author were previously trained to code 3RS. For current training, they coded two sessions of adult patients. The inter-rater reliability of the coders for adult psychotherapy sessions was moderate to excellent ICC's ranging from .71 to .93 ($M = .83$, $SD = 0.09$). Afterward, five child psychotherapy sessions with low alliance from data were selected and coded as pairs. The inter-rater reliability of the coders for child psychotherapy training sessions was moderate to good ICC's, ranging from .71 to .89 ($M=.82$, $SD=0.06$). Regular meetings were arranged to discuss the ruptures in the child sessions. The coders were randomly

assigned to each low alliance child session used in this investigation. Analyses were conducted using the mean scores of the coders, who worked in pairs. The coders' interrater reliability coefficients (ICCs) for coded data ranged from .70 to .99 ($M = .90$, $SD = 0.07$), indicating moderate to excellent performance. Sessions that were not adequate due to interrater reliability ($ICC < .70$) were resolved by pair discussions. The coding procedure was started in November 2023 and ended in March 2024.

2.5.2.3. Therapist's Body Coordination in Child Psychotherapy Coding System

This scale measures how much a psychotherapist uses their body, their dynamic movements, their facial and vocal expressions to support the goals of child psychotherapy. Also, it measures the bodily responsiveness of therapist toward child's nonverbal qualities. Primary objectives of psychodynamic child psychotherapy and MBT-C are the basis of the coding system. Some of these objectives are enhancing emotional connection and interaction, supporting regulation, promote affective expressiveness and develop reflective functioning (Çatay et al., 2023).

Nonverbal variables of therapists are distinguished as body location, body shape, movement dynamics (time, weight, gaze/space), facial and vocal coordination (Çatay et al., 2023). There are elements to consider in therapists when coding these variables. Firstly, location encompasses factors such as distance, level, and position regarding the child, reflecting the relational dynamics at play. Secondly, body shape nuances, including openness or closedness, length, advancement, or retreat, shaping around provide additional information about the therapist's engagement level. Movement dynamics have three subcategories. These are time, weight, and space/gaze. Time is indicated by the speed, sustainability, acceleration/deceleration, stillness, and rhythm of movements. Weight is indicated by being active or passive, and the intensity of it such as having strong or light weight. Gaze and space dynamics, encompassing direct or indirect focus, unifocal or multifocal attention, proximity or distance in space, offer insights into the individual's attentional and relational focus. Facial coordination

characterized by the content and intensity of facial expressions and eye contact. Vocal coordination, characterized by tempo, rhythm, pitch variations, volume intensity, use of melodicty, punctuation, quantity of vocalization, and appropriate use of silence (Çatay et al., 2023).

Using video recordings of psychotherapy sessions, coder ratings assessed the variables related with the therapist's nonverbal coordination. Trained coders watch one-minute from therapy sessions and assign a 3-point Likert scale rating for seven subcategories (location, body shape, time, weight, gaze/space, facial coordination, vocal coordination). Three combined scores are based on these subcategories (Combined Body Shape and Location, Combined Movement Dynamics, Combined Face and Vocal). Afterwards, three combined scores averaged to calculate Total Coordination Score (Çatay et al., 2023). A score of 3 denotes "Good coordination". "Satisfactory coordination" is defined as receiving a score of 2 and "Unsatisfactory coordination" is defined as receiving a score of 1. Therapist's coordination are also coded by referencing markers such as child's maintaining of play, engagement to therapist or engagement to play. Child's dysregulation (overly excited, freezing, risk of hurting himself or therapist), child's disengaging from play, avoiding therapist throughout the minute are interpreted as negative markers (Çatay et al., 2023).

The coders were randomly allocated to each of the child sessions used in this investigation. The intercoder reliability training took place from October 2022 through March 2023. 8 coders were trained through online training meetings that took place weekly for 1,5 hours. The training involved reviewing coding criteria, engaging in embodied exercises, viewing sample videos, coding them as a group and independent video coding assignments. The initial training phase took approximately 50 hours in total. During the coding process coders' meetings were held every other week to prevent rater drift and to discuss the coding for minutes that could not be resolved by the coder dyad. The coders' training inter-rater reliability coefficients (ICCs) were larger than .70 ($\alpha > .70$).

Analyses were conducted using the combined scores of the eight coders, six coders who worked in pairs. The coders' inter-rater reliability coefficients (ICCs) ranged from 0.77 to 1 ($M=0.95$, $SD = 0.08$), ($\alpha = 0.85$) indicating good to exceptional performance.

2.6. PROCEDURE

First, sessions that were lower than one standard deviation from the overall treatment mean as measured by TPOCS-A (McLeod & Weisz, 2005) alliance scores were selected. 6 separate one-minute intervals in the video recordings of the selected sessions from the 28 children were coded with Therapist's Body Movement Coordination Coding System (Çatay et al. 2023). Intervals longer than one minute may be challenging to code because many things may happen in nonverbally in little time interval (Çatay et al., 2023). Same one-minute intervals in the sessions were coded with 3RS-Revised Coding System (Eubanks & Muran, 2023). Although five-minute intervals are recommended to be coded in the manual, manual developers gave the flexibility to apply coding system to shorter or longer periods for researchers' need (Eubanks & Muran, 2023). Video recordings of the sessions were assigned randomly to the coders. Sessions were coded as pairs and their average scores were used in the analyses. For the hypotheses, patient moves away and patient moves against salience were used as dependent variables. Total nonverbal coordination score of therapists which is the combined scores of the nonverbal elements was used as the independent variable. Due to the past research showing a link between rupture types, child characteristics such as sex, age and problem type (Topkaya, 2022), these were controlled in the analyses.

CHAPTER 3

RESULTS

There were two hypotheses in the current study. First, therapist's total nonverbal coordination will negatively predict the salience of patient moving against. Second, therapist's total nonverbal coordination will negatively predict the salience of patient moving away. These hypotheses were investigated through multilevel modeling with the HLM Version 18 (Raudenbush & Congdon, 2021). In the model, effects of age, sex and problem type of children were controlled. Descriptive statistics were executed by using SPSS version 27.

3.1. DESCRIPTIVE STATISTICS

Descriptive analysis conducted for dependent, independent and age variables (See Table 3.1.).

Table 3.1. Descriptive Statistics for Age, Rupture Salience and Nonverbal Coordination (N=168)

Variable	<i>M</i>	<i>SD</i>	<i>Min</i>	<i>Max</i>	<i>Skewness</i>	<i>Kurtosis</i>
Age	6.89	1.50	5	11	.77	.16
Total Nonverbal	1.89	.42	1	3	-.37	-.40
Coordination						
Moving Against Salience	1.55	.79	1	4	1.52	1.54
Moving Away Salience	2.30	1.06	1	5	1.30	1.32

Inter-correlations among child age, rupture salience and therapist's nonverbal coordination were carried out. The results demonstrated that child age and therapist's nonverbal coordination have opposite associations with different type of rupture saliences. It was found that age had a negative correlation with moving against salience ($p = .04$) when it had a positive correlation with moving away salience ($p = .00$). Also, it was found that nonverbal coordination quality negatively correlated with moving away salience ($p = .02$) when it was positively correlated with moving against salience ($p = .03$). Lastly, there was a negative correlation between moving against salience and moving away salience ($p = .01$). No significant correlation between age and therapist's nonverbal coordination was found ($p = .44$) (See Table 3.2.).

Table 3.2. Bivariate Correlations Among Rupture Salience, Nonverbal Coordination and Age (N=168)

	(1)	(2)	(3)	(4)
(1) Age	-			
(2) Moving Against Salience	-.16*	-		
(3) Moving Away Salience	.25**	-.22**	-	
(4) Total Nonverbal Coordination	-.06	.17*	-.18*	-

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

To explore the relationship of rupture salience and nonverbal coordination with child sex, an Independent-Samples T-Test was conducted. Independent variable was sex with 2 levels while dependent variables were rupture salience and nonverbal coordination. Results indicated that moving away salience significantly differed between female and male patients. Male patients had significantly higher moving away

salience than female patients. Also, nonverbal coordination was significantly differed by child sex. Therapist's nonverbal coordination was significantly higher in sessions with female patients than male patients. Lastly, moving against rupture salience did not differ by child sex (See Table 3.3).

Table 3.3. Means, Standard Deviations and Independent Samples T-Test of Rupture Salience and Nonverbal Coordination (N=168)

Measure	Female		Male		t	p	Cohen's d
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>			
Moving away	1.94	.67	2.44	1.15	-3.55	.00	-.49
Moving against	1.58	.75	1.54	.80	.34	.74	.06
Nonverbal coordination	2.06	.33	1.81	.44	4.06	.00	.62

Further, One-Way Analysis of Variance (ANOVA) was conducted to investigate whether rupture salience and nonverbal coordination scores were different depending on children's baseline problem types. The baseline problems were internalizing, externalizing and comorbid problems. Independent variable was problem type with 3 levels, while rupture salience and nonverbal coordination was the dependent variable. (See Table 3.4.).

Table 3.4. Means, Standard Deviations and One-Way Analyses of Variance of Rupture Saliency and Nonverbal Coordination (N=168)

Measure	Internalizing		Externalizing		Comorbid		F	η^2	p
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>			
Moving away	2.46	1.28	1.97	.93	2.27	.77	2.36	2.59	.10
Moving against	1.38	.61	1.78	.81	1.63	.92	3.37	2.03	.04
Nonverbal coordination	1.81	.46	1.80	.39	2.01	.36	4.88	.83	.01

The results of One-Way ANOVA illustrated that moving against rupture saliency scores differed significantly depending on children's problem types, $F(2, 165) = 3.37, p < .05$. Together with rupture saliency, total nonverbal coordination scores also differed significantly determined by children's problem types, $F(2, 165) = 4.88, p < .05$. To examine which groups differ specifically, LSD post-hoc tests were conducted. Post-hoc comparisons using the LSD test demonstrated that the moving against saliency of children with externalizing problems ($M = 1.78, SD = .81$) was significantly higher than children with internalizing problems ($M = 1.38, SD = .61$) ($p < .05$). In other words, children with externalizing problems had more moving against rupture saliency than children with internalizing problems. Also, it was demonstrated that therapist's total nonverbal coordination was significantly higher in sessions with children who have comorbid problems ($M = 2.01, SD = .36$) than children who have internalizing problems ($M = 1.81, SD = .46$) and externalizing problems ($M = 1.80, SD = .39$) ($p < .05$). In simpler terms, therapists were more nonverbally coordinated while they work with children who have comorbid problems.

3.2. DATA ANALYSIS

For the first hypothesis, the degree of therapist-patient interdependency was checked since the same therapists have sessions with multiple patients. Patient moves against salience was the outcome variable with no predictor variables in two-level (sessions nested within patients) and three-level (sessions nested within patients nested within therapists) "empty" multilevel models. Session minutes (N=168) which were nested within patients (N=28) were nested within therapists (N=15) in the data. The intra-class correlation (ICC) at the therapist level was 0.00, ns., suggesting that the variation in the session measures is not attributable to variations between therapists and that therapists accounted for approximately 0% of the variance in therapeutic alliance. On the other hand, the 3RS measurements revealed that the patient level ICC ranged from 0.26 to 0.28 ($p < .01$), which accounted for an average of 27% of the variation in patient moves against salience. This suggested that a two-level model better fits the data and that not all variance is related to session level. Hence two-level model was used for the analysis.

In the first model (See Table 3.5.) combined total nonverbal coordination of therapist was added to the analysis as an independent variable. The patient moves against salience was the dependent variable. Age, sex and problem type of patients were control variables. The results demonstrated that nonverbal coordination significantly positively predicted patient moves against salience ($p = .01$).

Table 3.5. Summary of Multilevel Model in Prediction of Patient Moves Against Salience When Controlling for Child Age, Sex and Problem Type

Patient moves against salience			
Intercept and Predictors	β	SE	p
Intercept (β_{00})	1.405	0.404	0.002
Child Age (β_{01})	-0.059	0.068	0.390
Child Sex (β_{02})	-0.055	0.214	0.801
Problem Type (β_{03})	0.124	0.115	0.292
Nonverbal Coordination (β_{10})	0.577	0.200	.005

Note. Sex was dummy coded as 1=female, 2=male. Problem Type was dummy coded as 1=internalizing, 2=externalizing 3=comorbid problems

For the second hypothesis, the degree of therapist-patient interdependency was checked again since the same therapists have sessions with multiple patients. Patient moves away salience was the outcome variable with no predictor variables in two-level (sessions nested within patients) and three-level (sessions nested within patients nested within therapists) "empty" multilevel models. Session minutes (N=168) which were nested within patients (N=28) were nested within therapists (N=15) in the data. The inter-class correlation (ICC) at the therapist level was 0.00, ns., suggesting that the

variation in the session measures is not attributable to variations between therapists and that therapists accounted for approximately 0% of the variance in therapeutic alliance. On the other hand, the 3RS measurements revealed that the patient level ICC ranged from 0.66 to 0.68 ($p < 0.01$), which accounted for an average of 67% of the variation in patient moves away salience. This suggested that a two-level model better fits the data and that not all variance is related to session level. Hence two-level model was used for the analysis.

Combined total nonverbal coordination of therapist was added to the analysis as an independent variable. The patient moves away salience was the dependent variable. Control variables were the same as in earlier model (age, sex and problem type). The results demonstrated that nonverbal coordination is not significantly associated with patient moves away salience, however, it is near significant as being negatively associated ($p = .07$) (See Table 3.6.).

Table 3.6. Summary of Multilevel Model in Prediction of Patient Moves Away Salience When Controlling for Child Age, Sex and Problem Type

Patient moves away salience			
Intercept and Predictors	β	SE	p
Intercept (β_{00})	1.573	0.729	0.041
Child Age (β_{01})	0.151	0.122	0.227
Child Sex (β_{02})	0.455	0.385	0.249
Problem Type (β_{03})	-0.029	0.207	0.892
Nonverbal Coordination (β_{10})	-0.338	0.184	0.069

Note. Sex was dummy coded as 1=female, 2=male. Problem Type was dummy coded as 1=internalizing, 2=externalizing 3=comorbid problems

CHAPTER 4

DISCUSSION

The study aimed to examine therapists' nonverbal coordination quality and its relation to different rupture types in MBT-C sessions. The hypotheses were that the therapist's nonverbal coordination quality would predict a decrease in children's moving against and moving away salience. Different rupture types had different relations with the nonverbal coordination quality of therapists. The therapist's nonverbal coordination quality predicted an increase in the child's moving against salience. Moving away salience was not significantly associated with the therapist's nonverbal coordination. However, a marginally significant result about the therapist's nonverbal coordination quality predicted a decrease in moving away salience.

4.1. Discussion of the Current Study Findings

In child psychotherapy literature, to our knowledge, this research is the first to investigate rupture moments and nonverbal coordination of therapists in MBT-C. The findings supported earlier research (Açıkgözler, 2022; Topkaya, 2022) about the existence of different types of ruptures in child psychotherapy. This study was significant because it demonstrated how the therapist's body coordination quality in MBT-C affected children's rupture salience. Also, this research is one of the first studies in which the revised version of the Rupture Resolution Rating System (3RSRevised; Eubanks & Muran, 2023) was used in child psychotherapy.

It was found that there was a positive significant relation between the nonverbal coordination quality of the therapist and moving against salience of children. There might be some reasons behind this finding. Ruptures are inevitable interactions and may be an opportunity instead of an obstacle (Safran & Kraus, 2014; Halfon et al., 2019) in child therapy. Nonverbal coordination of therapists may provide a holding environment for children to display their confrontative feelings. Açıkgözler's research

(2022) found more significant confrontational ruptures in face-to-face therapy than online therapy sessions in psychodynamic psychotherapy. This finding suggested that adolescents might be feeling secure enough to express their intense feelings in face-to-face therapy. The current study finding might also be interpreted similarly that rupture moments are opportunities for children to express their confrontative feelings. These feelings are expressed in response to the therapist's bodily communications which provide space for the child's emotions. Moving against ruptures might be essential, especially for children with internalizing problems. Dwyer Hall (2021) found that adolescents with depressive symptoms exhibited moving against ruptures more over time in therapy, especially in the middle and later phases. This is crucial because children with internalizing problems are known to have rigid emotion regulation mechanisms and have difficulty expressing their feelings openly (Eisenberg et al., 2010). Halfon and colleagues (2019) found ruptures during the middle phases of therapy in which children become more open to their therapists. Hence, children might exhibit dissatisfaction about therapy and become more direct when they feel they are in a secure enough relationship (Dwyer Hall, 2021). However, moving against ruptures should be carefully handled and resolution strategies must be discovered because they impact alliance more than moving away ruptures (O'Keeffe et al., 2020). In earlier research, rupture moments are emphasized as necessary to be resolved and may function as opportunities for working on emotion regulation in children with different problem types (Halfon et al., 2019). In this study, the expression of intense feelings in the context of a therapist's nonverbal attunement can function as an opportunity for working on emotion regulation work in MBT-C (Midgley et al., 2017).

Our study supported prior findings from the synchrony literature and its relationship with rupture types. It was found that there is a positive association between body synchrony and moving against ruptures in adult patient-therapist dyads (Deres-Cohen et al., 2021). However, they did not find this relationship with moving away ruptures. Our study resulted in a similar pattern. They measured synchrony with the visual movement analysis technique called motion energy analysis. We conceptualized

nonverbal coordination as a more extensive construct that contains synchrony depending on the child's specific and moment-to-moment needs. Another research found that during the rupture moments, there was the highest physiological synchrony (Avdi & Seikkula, 2019). They conducted the study using 3RS coding systems, verbal discourse analysis, and physiological measures of heart rate in a case study. However, they did not divide rupture types in their study.

Ramseyer and Tschacher (2011) found a positive relationship between high ratings of relationship quality and higher nonverbal synchrony between adult patient therapist dyads. They investigated gestures, facial expressions, and body language and used motion energy analysis to measure synchrony. Deres-Cohen and colleagues (2021) conducted research with a specific sample of adult patients who have diagnostic criteria of Major Depression Disorder in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5; APA, 2013). Similarly, Avdi and Seikkula (2019) conducted a case study with a man who had suicidal ideations and had lost interest in his life. Ramseyer & Tschacher (2011) conducted research with patients who have diverse clinical problem characteristics such as Anxiety Disorder, Personality Disorder, and Affective Disorder. Hence, there might be different synchrony and alliance relationships with different sample characteristics. Our sample was limited to children who show common child mental health problems such as internalizing and externalizing difficulties; however, future research can investigate rupture patterns with children who suffer from more varied diagnoses.

Even though we do not know whether the moving against ruptures or the therapist's coordination came first, future research can assess the timing of these effects in a time-series model. Parent-infant research emphasizes that communication is reciprocal, and infants affect mothers' behavior as much as mothers affect them (Beebe & Steele, 2013). Parallel with this understanding, it is possible that the more children express themselves noncooperative, hostile, and conflictive manner, the more therapists try to coordinate nonverbally to repair alliance relationships implicitly.

In adult psychotherapy, it is demonstrated that moving against ruptures are addressed more effectively with explicit resolution strategies than moving away ruptures (Boritz et al., 2018). It is also possible that therapist's responsivity to moving against ruptures may be poor and hence their responses may be associated with an increase in child's moving against attitudes. In adult psychotherapy, it was qualitatively investigated that therapists feel confused and incompetent when they encounter moving against ruptures, but they are more empathic and understanding about the moving away ruptures (Cautinho et al., 2011; Hill et al., 2003). Even therapists perceive moving against ruptures less emphatically and are confused about them; current study suggests that they might implicitly take action to repair the alliance relationship in these moments.

It was found that there was a marginally significant association between moving away ruptures of children and the nonverbal coordination of therapists. As the nonverbal coordination of the therapists increased, the moving away rupture salience decreased. Despite not reaching significance, the nonverbal coordination of therapists might be a subtle and implicit way of handling moving away ruptures by synchronizing and attuning. By that, the nonverbal coordination quality of therapists might help children be more authentic (Midgley et al., 2017), more engaged, and more open. One reason for moving away ruptures not reaching salience may be that moving away ruptures may be subtle and masking themselves as compliance and pseudoalliance (Cirasola & Midgley, 2023).

In Topkaya's study (2022), the significance of rupture is considered as a severe threat to the therapeutic alliance between therapist and child. It was found that children with externalizing problems had more significant ruptures than internalizing problems. Together with this, they found that younger children tend to have more significant ruptures. Our study partially supported these findings. We found that children with externalizing problems had significantly higher moving against rupture salience than children with internalizing problems. Also, we found that younger children tend to have more moving against rupture salience. Açıkgözler (2022) found that youth between 10-

14 years old who were in psychodynamic psychotherapy had more moving away ruptures than moving against ruptures. Similarly in our study, the moving away rupture salience increased as children's age increased. As children go through adolescence, they might make more salient moving away ruptures.

Topkaya (2022) found that children had different rupture frequency and significance due to their sex in psychodynamic psychotherapy. Boys had more frequent and significant ruptures than girls. Also, when boys had more confrontational ruptures, girls had more withdrawal ruptures. In our study, boys had significantly more moving away rupture salience than girls. The different results might be related to the fact that in the current study, the child's frequency and significance scores are reduced to one score, which is salience. Hence, the measure we used might not clearly comparable. In earlier research, ruptures are investigated separately in terms of their quantity and significance. Also, the previous studies were conducted with children in psychodynamic psychotherapy, while this study was conducted in MBT-C therapy setting.

4.2. Clinical Implications

From the research results, it might be suggested that nonverbal coordination may provide a context where a deeper relation including strong feelings emerges in the child-therapist dyad. For this reason, it becomes essential for therapists to be trained about how to use their bodies considering different elements like body shape, location, movement dynamics (weight, gaze, time), and vocal facial areas. Also, the quality of nonverbal coordination has different relations with different rupture types. Hence, it becomes more important for therapists to be trained to detect different rupture types because the body coordination element has different influences on different rupture moments. It was found that the therapist's synchrony is associated with confrontational ruptures (Deres-Cohen et al., 2021). In other words, therapists may rely on more synchronous movements when they observe confrontative feelings in the patient,

possibly to repair a misattunement. The same link might apply to the therapists' using their bodies in a coordinated manner. In the therapy setting, therapists might think about why their body becomes more coordinated with the child. Thus, these moments may become opportunities for the child and therapist to reflect on possible misattunements verbally and nonverbally. In this study, identifying rupture moments gave insight into potential barriers to effective communication between therapist and child in the MBT-C structure. Rupture moments are perceived as opportunities to work on unmentalized states and misunderstandings (Fonagy et al., 2023). In this respect, it is crucial to understand the different kinds of ruptures and how therapists coordinate their bodies in these moments.

4.3. Limitations of the Present Study and Directions of Future Studies

The study has several limitations. One of these limitations is the small sample size. Moving away ruptures and nonverbal coordination variables have near significant associations. However, the associations did not reach significance. One of the reasons for this situation might be the small sample size of the data. 28 children and six time points from each of them might not be enough to achieve satisfactory power in multilevel models. Our sample were including children from 5 to 11 years old. This age range might be extensive and influential in findings. It might be predictable that children with lower ages have more moving against ruptures due to their self-regulation capacities developmentally instead of children who are in older ages.

In the current study, the measurement tool used for assessing rupture salience was a revised version of the Rupture Resolution Rating System (Eubanks & Muran, 2023). This measurement was initially developed for the adult psychotherapy setting. The validity and reliability research were conducted for adult psychotherapy sessions (Eubanks et al., 2019). Hence, the measurement has not adapted to the child psychotherapy setting yet. Nevertheless, the first version of the 3RS (Eubanks et al., 2015) was utilized for children and adolescents who had been in psychodynamic

psychotherapy (Açıkgözler, 2022; Topkaya, 2022; Güvenç & Halfon, 2023). Future studies might consider adaptation studies of the revised version of 3RS for child psychotherapy settings.

In this research, the nonverbal coordination of therapists is the total score of different nonverbal elements such as movement dynamics, face and vocal coordination, location, and body shape. Future studies might investigate which elements of nonverbal coordination were specifically more influential in therapy settings for children with different problem types, sex, and age.

In some prior research, nonverbal synchrony and rapport were conceptualized as dyadic constructs, and patients' nonverbal coordination was measured together with therapists (Nelson et al., 2016; Tickle-Degnen et al., 1990). Also, in developmental research, regulation is conceptualized as a dyadic process in which infants communicate their regulatory situation with the caregiver (Tronick, 2007). A measurement tool assessing dyadic embodiment between parents and infants (Shai & Belsky, 2017) investigates the action-reaction patterns of infants and mothers. In this study, only therapists' nonverbal coordination is measured. Hence, there might be scarce information regarding how dyad's body coordination is influencing each other. Future studies might investigate the complex relationship of nonverbal interaction between children and therapists by also including the child's coordination as a variable. The nonverbal coordination and rupture salience scores are coded from six minutes of each session. These minutes are selected from the first and middle parts of the sessions. Hence, we have limited momentary time sampling. There might be more significant ruptures in different minutes of the session. In the future, specific minutes from the session might be chosen to give a more varied sample of the ruptures and nonverbal coordination moments.

The therapists in the research were generally newly starting clinicians with limited experience. Future research can consider using a sample of therapists who are more advanced in their careers to assess whether clinical experience impacts nonverbal coordination and rupture salience variables.

The Revised version of Rupture Resolution Ratings Coding System (Eubanks & Muran, 2023) provides codes about patients' and therapists' rupture and repair processes as separate entities. While investigating a child's rupture moments, understanding the effects of therapists' ruptures on the alliance and nonverbal coordination might also be influential in understanding the complex relationship of alliance dyad. More research about the interaction between therapists' rupture and nonverbal coordination relationship might provide information about therapists' counter transferential attributions. Future studies may consider repair processes and how they are effective with the nonverbal coordination elements of therapists in sessions.

This research had observer-based measures for every variable. Together with observer-based measures (3RS, TPOCS-A), it would be preferable to have self-report measures such as Therapeutic Alliance Scale for Children-Patient Form and Therapeutic Alliance Scale for Children-Therapist form (TASC-C and TASCT; Creed & Kendall, 2005) to understand different perspectives. Future studies might replicate the hypothesis with the patient and therapist ratings for specific rupture moments. New scales and measurements might be improved for children which are suitable their developmental levels. Also, it might be elucidative to qualitatively explore that how therapists experience moving against and moving away ruptures in their bodies.

CONCLUSION

The present study is one of the first to investigate the relationship between a therapist's nonverbal coordination quality and child alliance in Mentalization Based Treatment for Children at micro levels by assessing observer-based measures. The study demonstrated different associations between different rupture types and the nonverbal bodily coordination of therapists. The therapist's nonverbal coordination quality positively associated with the child's moving against rupture salience. No significant relationship was found with moving away rupture salience. The present study highlighted the influences of nonverbal elements on the therapy relationship with children during the Mentalization Based Treatment for Children process.

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APPENDICES

APPENDIX A: Randomized Controlled Trial Protocol

ClinicalTrials.gov PRS
Protocol Registration and Results System

ClinicalTrials.gov Protocol Registration and Results System (PRS) Receipt
Release Date: September 23, 2023

ClinicalTrials.gov ID: NCT05290714

Study Identification

Unique Protocol ID: MBT-C Trial

Brief Title: The Effectiveness and Change Mechanisms of Mentalization Based Therapy for Children (MBT-C)

Official Title: The Effectiveness and Change Mechanisms of Mentalization Based Therapy for Children (MBT-C)

Secondary IDs:

Study Status

Record Verification: September 2023

Overall Status: Active, not recruiting

Study Start: March 15, 2022 [Actual]

Primary Completion: January 1, 2024 [Anticipated]

Study Completion: February 1, 2025 [Anticipated]

Sponsor/Collaborators

Sponsor: Istanbul Bilgi University

Responsible Party: Principal Investigator
Investigator: Sibel Halfon [shalfon]
Official Title: Assistant Professor
Affiliation: Istanbul Bilgi University

Collaborators: The Scientific and Technological Research Council of Turkey
Anna Freud National Centre for Children and Families

Oversight

U.S. FDA-regulated Drug: No

U.S. FDA-regulated Device: No

U.S. FDA IND/IDE: No

Human Subjects Review: Board Status: Approved

Approval Number: 2021-40024-48

Board Name: Istanbul Bilgi University Committee on Ethics in Research on Human

Board Affiliation: Istanbul Bilgi University

Phone: 902123117720

Email: ethics_committee@bilgi.edu.tr

Address:

Istanbul Bilgi University
Santralistanbul Eski Silahtarağa Elektrik Santrali Kazım Karabekir Cad. No:
2/13

Data Monitoring: No

FDA Regulated Intervention: No

Study Description

Brief Summary: The main aim of the project is to investigate the effectiveness and change mechanisms of Mentalization Based Therapy for Children (MBT-C; Midgley et al., 2017). MBT-C is a transdiagnostic treatment for children aged between 5 to 12 years old with the main aim of increasing mentalization and restoring epistemic trust. Parallel parental work takes place to increase parental mentalization. This project will test the effectiveness of MBT-C in a parallel group single blind pragmatic Randomized Controlled Trial (pRCT) conducted in Turkey in comparison to a parenting and social skills group. The sample will include 220 children between 5-12 years old with internalizing and externalizing and comorbid internalizing/externalizing problems and their parents. During the study, the patients will be randomized to two arms, and the treatment's effectiveness will be investigated both at short (8th and 12th weeks) and long terms (24th and 36th weeks) to also assess relapse prevention. The large sample size and the longitudinal evaluation of primary (decrease in problems), and secondary outcomes will enable the investigation of mediators and moderators.

This project will also undertake a rigorous psychotherapy process study within the RCT, examining for the first time, for which children and under what circumstances MBT-C may be most effective, meaningfully linking process with outcome. For this purpose, patients' baseline characteristics, especially attachment security and mentalization deficits that may interact with treatment outcome (moderators) and different dimensions of mentalization that develop over the course of the treatment (change mechanisms/mediators) will be assessed.

Detailed Description:

Conditions

Conditions: Mental Disorder, Child

Keywords: mentalization
internalizing problems
externalizing problems
comorbid internalizing/externalizing problems

Study Design

Study Type: Interventional

Primary Purpose: Treatment

Study Phase: N/A

Interventional Study Model: Parallel Assignment

Number of Arms: 2

Masking: Single (Outcomes Assessor)

Allocation: Randomized

Enrollment: 222 [Actual]

Arms and Interventions

Arms	Assigned Interventions
Experimental: Mentalization Based Treatment for Children (MBT-C) Mentalization Based Therapy for Children (MBT-C) is a transdiagnostic time-limited (12 weekly sessions) and manualized treatment for children aged between 5 to 12 years old with the main aim of increasing mentalization and restoring epistemic trust. Parallel parental work takes place to increase parental mentalization.	Behavioral: Mentalization-Based Treatment for Children (MBT-C) MBT-C will involve 12 parallel individual sessions with the parents and children separately conducted by two different therapists.
Active Comparator: Parenting and Social Skills Group Parenting groups will run for 12 weeks with 10 parents per group. They will involve activities to help parents develop effective parenting skills via working on a family genogram, providing information on child development, developing acceptance and empathy, setting boundaries and anger regulation. The social skills groups will run for 12 weeks and will be conducted with 10 children per group. They will involve activities on self-presentation, peer communication, play skills, empathy and anger management.	Behavioral: Parenting and Social Skills Group Parenting/social skills groups will be co-led by two therapists and involve 12 group therapy sessions with the parents and their children separately (10 parents and children per group).

Outcome Measures

Primary Outcome Measure:

1. Change from Baseline to 36th week on the Child Behavior Checklist (CBCL)
The Child Behavior Checklist (CBCL; Achenbach, 1991) is a widely used method of identifying problematic behaviors in children with two separate versions for ages 1.5–5 and 6–18. The CBCL asks the parents to indicate how true a series of 112 problem behavior items are for their child in the past two months on a 3-point likert scale (0 = "not true", 1 = "sometimes true", and 2 = "very true or often true"). Outcomes can be determined for significant problems for Internalizing (e.g., depression, anxiety), Externalizing (e.g., aggression, violence) or Total Problems. The scale has been adapted to Turkish with good reliability and validity (Erol et al., 1995).

[Time Frame: Baseline (T0), 8th week (T1), 12th week (T2), 24th week (T3), 36th week (T4)]

Secondary Outcome Measure:

2. Change from Baseline to 36th week on the Me and My Feelings Questionnaire (M&MF)
Me and My Feelings Questionnaire (M&MF; Deighton et al., 2013) is a child-report measure consisting of total short 16-items: 10-items of emotional difficulties scale and 6-items of behavioral difficulties scale. It is scored on a 3-point likert scale (0 = "never expressed", 1 = "sometimes expressed", 2 = "always expressed"). Total score of scales are calculated as the sum of item scores with threshold values 10 for the emotional difficulties and six for the behavioral difficulties. Higher scores of each set of difficulties indicate the probability of mental health problems. The scale has been adapted to Turkish with good reliability and validity (İlinem, 2020).

[Time Frame: Baseline (T0), 8th week (T1), 12th week (T2), 24th week (T3), 36th week (T4)]

3. Change from Baseline to 36th week on the Emotion Regulation Checklist (ERC)
Emotion Regulation Checklist (ERC; Shields & Cicchetti, 1997) is a parent-report measure of children's emotion regulation characteristics and involves 24-items rated on a 5-point likert scale (1 = "never" to 5 = "always"). It taps

into two factors one of which is emotional lability and negativity defined as arousal, anger dysregulation, and mood changes; and the second is emotion regulation defined as socially appropriate emotional displays, empathy, and emotional self-awareness. The scale has been adapted to Turkish with good reliability and validity (Batum & Yagmurlu, 2007).

[Time Frame: Baseline (T0), 8th week (T1), 12th week (T2), 24th week (T3), 36th week (T4)]

4. Change from Baseline to 12th week on the Children's Global Assessment Scale (CGAS)
The Children's Global Assessment Scale (CGAS; Schaffer et al., 1983) is a numeric scale (from 1 to 100) used by mental health clinicians to rate the global functioning of children under the age of 18 on a scale of 0 to 100. 90–81 range is scored when there is "good functioning in all areas; security in family, school, and with peers with only transient difficulties and everyday worries"; 50–41, when there is "moderate degree of interference in functioning in most social areas or severe impairment of functioning in one area"; and 20–11, when there is "need for considerable supervision to prevent hurting others or self or to maintain personal hygiene or gross impairment in all forms of communication". The scale has been adapted to Turkish with good reliability and validity (Gökler et al., 2004).

[Time Frame: Baseline (T0), 8th week (T1), 12th week (T2)]

5. Change from Baseline to 36th week on the Parental Stress Index - Short Form (PSI-SF)
Parental Stress Index - Short Form (PSI-SF; Abidin, 1983) is a 36-item parent-report scale. The PSI-SF contains 36 items divided into three subscales, each composed of 12 items: "Parental distress"; "Parent-child dysfunctional interaction"; "Difficult child". Each item is rated on a 5-point likert scale from 1 = "strongly disagree" to 5 = "strongly agree". The PSI-SF gives three subscores and a total distress score. The scale has been adapted to Turkish with good reliability and validity (Mert et al., 2008).

[Time Frame: Baseline (T0), 8th week (T1), 12th week (T2), 24th week (T3), 36th week (T4)]

6. Change from Baseline to 36th week on the Parent Reflective Functioning Questionnaire (PRF-Q)
Parental Reflective Functioning Questionnaire (PRFQ; Luyten et al. 2017) includes 18 items divided into three subscales that measure PRF. A 7-point likert scale from 1 (strongly disagree) to 7 (strongly agree) is used to score each item. The PRFQ gives three subscales pertaining to "curiosity and interest in mental states", "prementalizing modes" and "certainty about mental states". The scale is in the process of being adapted to Turkish by our research group.

[Time Frame: Baseline (T0), 8th week (T1), 12th week (T2), 24th week (T3), 36th week (T4)]

7. Change from Baseline to 36th week on the Difficulties in Emotion Regulation Scale (DERS)
Difficulties in Emotion Regulation Scale (DERS; Gratz & Roemer, 2004) is an instrument measuring emotion regulation problems in adults (to be used with parents in the current study). The scale comprises 36 items that are rated on a 5-point likert scale from 1 = "almost never" to 5 = "almost always", with higher scores indicating a difficulty of emotion regulation. The scale produces scores on the following subscales: (a) lack of awareness of emotional responses; (b) lack of clarity of emotional responses; (c) nonacceptance of emotional responses; (d) limited access to effective strategies; (e) difficulties in controlling impulsive behavior when experiencing negative affect; and (f) difficulties in engaging goal directed behavior when experiencing negative affect as well as a total dysregulation score. The scale has been adapted to Turkish with good reliability and validity (Yiğit & Güzey-Yiğit, 2017).

[Time Frame: Baseline (T0), 8th week (T1), 12th week (T2), 24th week (T3), 36th week (T4)]

Other Pre-specified Outcome Measures:

8. Screening: Brief Symptom Inventory (BSI)
Parents' initial psychopathology levels will be screened by the Brief Symptom Inventory (BSI; Derogatis, 1992). The BSI is an 53 item self-report scale and assesses three symptom scales, covering nine symptom dimensions: Somatization, Obsession-Compulsion, Interpersonal Sensitivity, Depression, Anxiety, Hostility, Phobic anxiety, Paranoid ideation and Psychoticism; and three global indices of distress: Global Severity Index, Positive Symptom Distress Index, and Positive Symptom Total. Items are rated on a 5-point likert scale from 1 = "never" to 5 = "a lot". The Turkish adaptation of the scale was conducted by Şahin and Durak (1994).

[Time Frame: Baseline (T0)]

9. Screening: Schedule for Affective Disorders and Schizophrenia for School Aged Children (6-18 Years) (K-SADS-PL DSM-5)
Schedule for Affective Disorders and Schizophrenia for School Aged Children (6-18 Years) (K-SADS-PL DSM 5; Kaufman et al., 2016) is a semi-structured interview that probes child psychiatric disorders according to DSM-5 criteria. If a primary symptom is endorsed, further questions are asked to determine whether diagnostic criteria are met. In

the study, specific components of the instrument will be selected to screen for psychosis, autistic spectrum disorders, substance abuse and dependence, acute risk of harm to self and others. It was adapted to Turkish by Ünal et al. (2019).

[Time Frame: Baseline (T0)]

10. Screening: Kaufman Brief Intelligence Test-Second Edition (KBIT-2)

Kaufman Brief Intelligence Test-Second Edition (KBIT-2, Kaufman & Kaufman, 1990) will be used to screen for general intelligence in children and their parents. The Verbal Scale contains two kinds of items—Verbal Knowledge and Riddles—both of which assess crystallized ability. The Nonverbal Scale includes a Matrices subtest that assesses fluid thinking—the ability to solve new problems by perceiving relationships and completing analogies. The KBIT-2 provides Verbal and Nonverbal Scores, plus a composite IQ. The scale was adapted to Turkish with good reliability and validity (Savasan, 2006).

[Time Frame: Baseline (T0)]

11. Screening: BAPIRT Alcohol and Drug Questionnaire

BAPIRT Alcohol and Drug Questionnaire (Ogel et al., 2017) is a risk-screening questionnaire appropriate for Turkish cultural characteristics in detection of alcohol- and drug-use level through utilization of Addiction Profile Index (API). BAPIRT-alcohol and BAPIRT-drug subscales each involve 6 questions rated on a 3 point likert scale (0 = "none", 1 = "often", 2 = "very frequently"). The scale was constructed for use in the Turkish culture by Ögel et al. (2017).

[Time Frame: Baseline (T0)]

12. Baseline Moderator: Adverse Childhood Experiences Scale (ACE)

In order to measure parents' and children's early trauma history, an adapted version of the Adverse Childhood Experiences (ACE) questionnaire (Dube et al., 2003; Murphy et al., 2007) will be used. ACE is a parent-report scale and assesses retrospectively forms of abuse, neglect, and household dysfunction (i.e., witnessing domestic violence, separation and mental illness in the family) both for the parent's and child's early history. Scores range from 0–10 on the ACE, with the latter representing full exposure at some point in the first 18 years of life, to all forms of household dysfunction and abuse detailed in the questionnaire. The scale has been adapted to Turkish by Gunduz et al. (2018).

[Time Frame: Baseline (T0)]

13. Baseline Moderator: Attachment Doll Story Completion Task (ASCT)

An adapted version of the Attachment Doll Story Completion Task (ASCT; Bretherton et al., 1990) will be used to assess the quality and the security of attachment-related representations of children's relationships with their caregivers. ASCT was originally designed for three-year-olds and later adapted to school age children by Granot and Mayseless (2001). ASCT comprises of five storysystems that aim to elicit stories from children on attachment-related day-to-day issues. A set of family figure dolls and related props are used to prime children and invite them to complete unfinished stories. Children are classified as secure, fairly secure or insecure based on their responses. The scale was adapted to Turkish by Uluç (2005).

[Time Frame: Baseline (T0)]

14. Baseline Moderator: Kerns Security Scale (KSS)

The Kerns Security Scale (KSS; Kerns et al., 1996) will be used to assess children's baseline attachment security. KSS is a child-report scale and comprises of 15 items measuring (a) the extent to which children believe that their attachment figures are sensitive and available; (b) their tendency to trust attachment figures under stress; and (c) their level of willingness to communicate with attachment figures. Children complete the form separately from both their mother and fathers. The items are rated on a 4-point likert scale "Some kids . . . Other kids . . ." format with higher scores indicating a more secure attachment. The scale was adapted to Turkish by Sümer and Anafarta-Şendağ (2009).

[Time Frame: Baseline (T0)]

15. Baseline Moderator: Experiences in Close Relationships Scale-II (ECR-II)

Experiences in Close Relationships Scale-II (ECR-II; Fraley et al., 2000) will be used to assess the attachment patterns of the parents at baseline. The ECR-II consists of a total of 36 items, 18 in the anxiety and 18 in the avoidance sub-dimensions. The items are answered on a 7-point likert scale (1 = "Never Agree", 7 = "Strongly Agree"). The scores for each attachment dimension are calculated by taking the average of the item total score. The increase in scores indicates an increase in the anxious or avoidant attachment patterns. The adaptation study of the ECR-II Turkish Form was conducted by Selcuk et al. (2005).

[Time Frame: Baseline (T0)]

16. Baseline Moderator: Child Attachment Interview (CAI)

The Child Attachment Interview (CAI; Target et al. 2003) is a 19-question, semi-structured interview for 8- to 12-year-olds that assesses children's attachment representations of their current relationships with their primary caregivers. CAI coders rate videotapes and verbatim transcripts on 11 9-point scales (e.g., idealization of attachment figures, balance of positive/negative references to attachment figures).

[Time Frame: Baseline (T0)]

17. Experience of Service Questionnaire (ESQ)

The Experience of Service Questionnaire (ESQ, Brown et al., 2014) consists of 12 items rated on a 3-point likert scale (1 = "not true"; 3 = "certainly true") and 3 free text sections looking at what the respondent liked about the service, what they felt needed improving, and any other comments.

[Time Frame: 12th week (T2)]

18. Therapeutic Alliance Scale for Children-revised (TASC-r, TASC-r-T, TASC-r-P)

The Therapeutic Alliance Scale for Children-revised (TASC-r, Shirk et al., 2011) will be used as a measure of therapeutic alliance across treatment. The TASC is a 12-item, 4-point Likert-type scale completed by the children and parents and there is a parallel version for the therapist to complete. Each item is rated on a 4 point scale ranging from 1 = "not at all" to 4 = "very much".

[Time Frame: 3rd week (T1) 8th week (T2) 12th week (T3)]

Eligibility

Minimum Age: 5 Years

Maximum Age: 12 Years

Sex: All

Gender Based: No

Accepts Healthy Volunteers: No

Criteria: Inclusion criteria

1. Child age 5 to 12 years old
2. Clinical levels of child internalizing, externalizing and comorbid internalizing/externalizing problems (clinical levels on CBCL)

Exclusion criteria Children

1. a clinical diagnosis of autistic spectrum disorders (ASD) (meets KSADS-PL threshold criteria)
2. severe intellectual impairment (below 5th percentile on KBIT-2)
3. a clinical diagnosis of psychosis (meets KSADS-PL threshold criteria)
4. severe conduct disorder (clinical range on CBCL DSM-Oriented Conduct Problems scale)
5. severe substance abuse and dependence (meets KSADS-PL threshold criteria)
6. acute risk of harm to self and others (KSADS-PL risk item scores = 3)
7. an emergency/crisis referral, where an immediate response to a significant risk is required

Parents

1. risk of psychotism (clinical on BSI psychotism scale)
2. severe intellectual impairment (below 5th percentile on KBIT-2)
3. severe substance abuse and dependence (positive case on BAPIRIT)
4. acute risk of harm to self and others (BSI item 9, 39 & 40 = 4)
5. an emergency/crisis referral, where an immediate response to a significant risk is required

Contacts/Locations

Central Contact Person: SIBEL HALFON, PhD

Telephone:

Email:

Central Contact Backup:

Study Officials: SIBEL HALFON, PhD

Study Principal Investigator

Istanbul Bilgi University

Locations: **Turkey**

Istanbul Bilgi University Psychological Counseling Center

Istanbul, Istanbul, Turkey, 34060

Contact: SIBEL HALFON, PhD

Contact: Ext. HALFON

Principal Investigator: SIBEL HALFON, PhD

Sub-Investigator: BURCU BESIROGLU, MA

Sub-Investigator: PELINSU BULUT, MA

IPDSharing

Plan to Share IPD: Yes

After publication of the primary objective, published data might be provided to interested scientists on request for meta-analyses or secondary analyses of variables of interest in an anonymized way, with permission from the trial team.

Supporting Information:

Study Protocol

Statistical Analysis Plan (SAP)

Informed Consent Form (ICF)

Time Frame:

At the end of the study

Access Criteria:

URL:

References

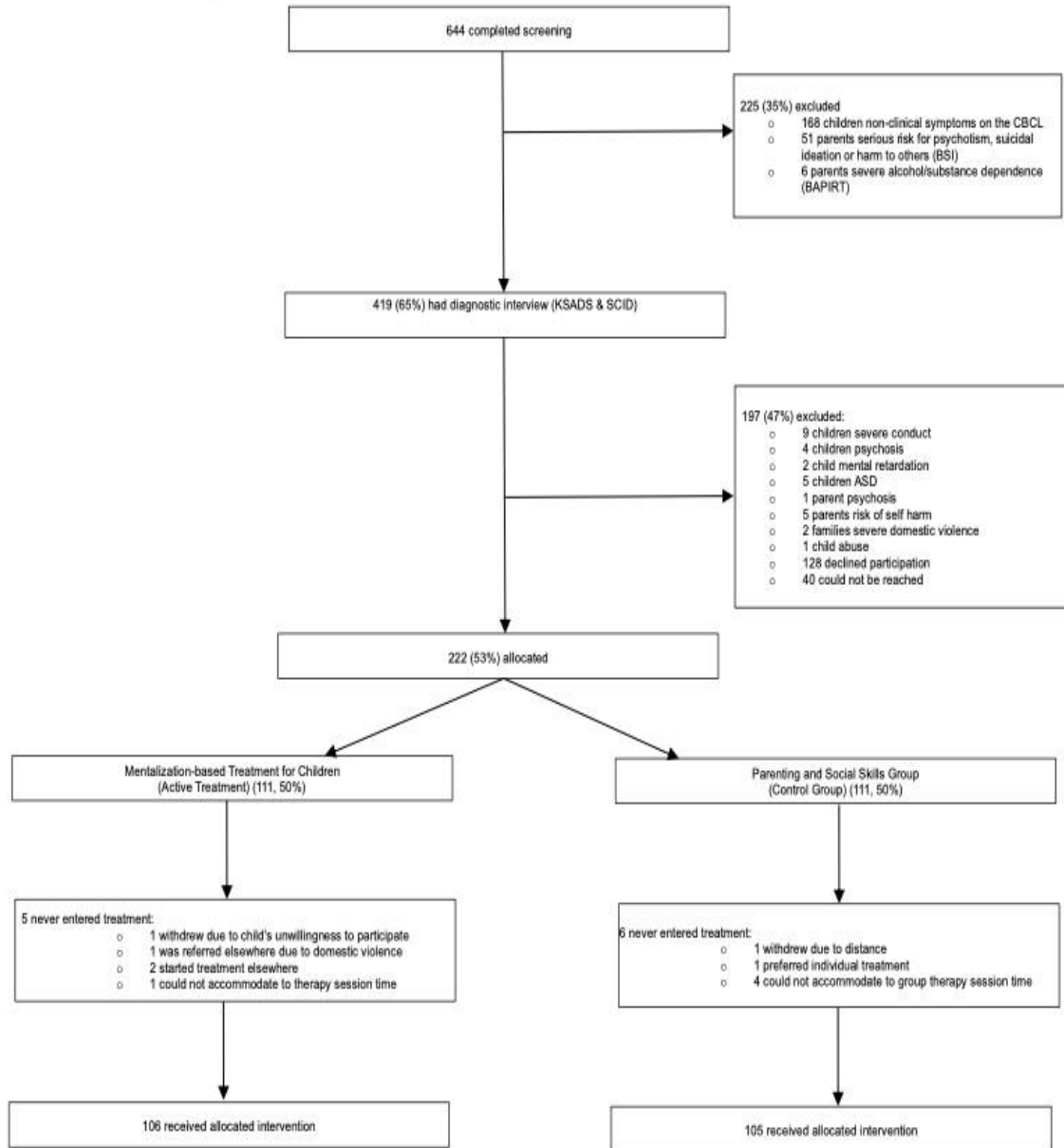
Citations: Midgley, N., Ensink, K., Lindqvist, K., Malberg, N., & Muller, N. (2017).
Mentalization-based treatment for children: A time-limited approach. American
Psychological Association. <https://doi.org/10.1037/0000028-000>

Links:

Available IPD/Information:

APPENDIX B: Randomized Controlled Trial Consort Flow

CONSORT Flow Diagram



APPENDIX C: 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

____ Diğer (Çocukla olan ilişkisi: _____)

Çocuğunuzun davranışlarıyla ilgili bu formu lütfen görüşlerinizi yansıtacak biçimde yanıtlayınız. Her bir madde ile ilgili bilgi verebilir ve 2. sayfadaki boşluklara yazabilirsiniz. Lütfen bütün maddeleri işaretlemeye çalışınız. Tesekkür ederiz.

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

- | | | | |
|-------|---|---|---|
| 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): |
| <hr/> | | | |
| 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. Güçl kle karřılařtıęında  abuk vazge er.
- 0 1 2 30. Kolay kıskanır.
- 0 1 2 31. Yenilip i ilmeyecek řeyleri yer ya da i er (kum, kil, kalem, silgi gibi). (a ıklayınız):
-
- 0 1 2 32: Bazı hayvanlardan, ortamlardan ya da yerlerden korkar. (a ıklayınız):
-
- 0 1 2 33. Duyguları kolayca incinir.
- 0 1 2 34.  ok sık bir yerlerini incitir, bařı kazadan kurtulmaz.
- 0 1 2 35.  ok kavga d v ř eder.
- 0 1 2 36. Her řeye burnunu sokar.
- 0 1 2 37. Anne-babasından ayrıldıęında  ok tedirgin olur.
- 0 1 2 38. Uykuya dalmakta g  l k  eker.
- 0 1 2 39. Bař aęrıları vardır (tıbbi nedeni olmayan).
- 0 1 2 40: Bařkalarına vurur.
- 0 1 2 41. Nefesini tutar.
- 0 1 2 42. D ř nmeden insanlara ya da hayvanlara zarar verir.
- 0 1 2 43. Hi bir nedeni yokken mutsuz g r n r.
- 0 1 2 44.   kelidir.
- 0 1 2 45. Midesi bulanır, kendini hasta hisseder (tıbbi nedeni olmayan).
- 0 1 2 46. Bir yerleri seyirir, tikleri vardır (a ıklayınız):
-
- 0 1 2 47. Sinirli ve gergindir.
- 0 1 2 48. Gece kabusları, korkulu r yalar g r r.
- 0 1 2 49. Ařır  yemek yer.
- 0 1 2 50: Ařır  yorgundur.
- 0 1 2 51. Hi bir neden yokken panik yařar.
- 0 1 2 52. Kakasını yaparken aęrısı, acısı olur.
- 0 1 2 53. Fiziksel olarak insanlara saldırır, onlara vurur.
- 0 1 2 54. Burnunu karıřtırır, cildini ya da v cudunun dięer taraflarını yolar. (a ıklayınız):
-
- 0 1 2 55. Cinsel organlarıyla  ok fazla oynar.
- 0 1 2 56. Hareketlerinde tam kontroll  deęildir, 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: Doğru değil (Bildiğiniz kadarıyla) 1: Bazen ya da biraz doğru 2: Çok ya da sıklıkla doğru

- 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.

(aıklayınız):

- | | | | |
|---|---|---|---|
| 0 | 1 | 2 | 81. İnatı, somurtkan ve rahatsız edicidir. |
| 0 | 1 | 2 | 82. Duyguları deęiřkendir, bir anı bir anını tutmaz. |
| 0 | 1 | 2 | 83. ok sık kser, surat asar, somurtur. |
| 0 | 1 | 2 | 84. Uykusunda konuřur, aęlar, baęırır. |
| 0 | 1 | 2 | 85. fke nbetleri vardır, ok abuk fkelenir. |
| 0 | 1 | 2 | 86. Temiz, titiz ve dzenlidir. |
| 0 | 1 | 2 | 87. ok korkak ve kaygılıdır. |
| 0 | 1 | 2 | 88. İřbirlięi yapmaz. |
| 0 | 1 | 2 | 89. Hareketsiz ve yavařtır, enerjik deęildir. |
| 0 | 1 | 2 | 90. Mutsuz, zgn, kkn ve keyifsizdir. |
| 0 | 1 | 2 | 91. ok grltcdr. |
| 0 | 1 | 2 | 92. Yeni tanıdıęı insanlardan ve durumlardan ok tedirgin olur. |

(aıklayınız):

- | | | | |
|---|---|---|---|
| 0 | 1 | 2 | 93. Kusmaları vardır (tıbbi nedeni olmayan). |
| 0 | 1 | 2 | 94. Geceleri sık sık uyanır. |
| 0 | 1 | 2 | 95. Alıp bařını gider. |
| 0 | 1 | 2 | 96. ok ilgi ve dikkat ister. |
| 0 | 1 | 2 | 97. Sızlanır, mızırdanır. |
| 0 | 1 | 2 | 98. İe kapanıktır, bařkalarıyla birlikte olmak istemez. |
| 0 | 1 | 2 | 99. Evhamlıdır. |
| 0 | 1 | 2 | 100. ocuęunuzun burada deęinilmeyen bařka sorunu varsa ltfen yazınız: |
| 0 | 1 | 2 | |

—
0 1 2

—
0 1 2

—

APPENDIX D: 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:

____)

Çocuğunuzun davranışlarıyla ilgili bu formu lütfen görüşlerinizi yansıtacak biçimde yanıtlayınız. Her bir madde ile ilgili bilgi verebilir ve 2. sayfadaki boşluklara yazabilirsiniz. Lütfen bütün maddeleri işaretlemeye çalışınız. Teşekkür ederiz.

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

Çocuğunuz her birine ne kadar zaman ayırır?

Bilmiyorum Normalden az Normal Normalden Fazla

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 olduğı kuruluş, kulüp ya da takımları a, b, c şıklarına yazınız. Örneğın: 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. Örneğın: Gazete alma, bakkala gitme, pazara gitme, bahçe-tarla işleri, hayvancılık, elektrik-su faturası yatırma, çocuk bakımı, sofrı 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
☐ ☐ ☐ ☐

**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
☐ ☐ ☐

VI. Yaşıtlarıyla karşılaştırıldığında çocuğunuzun:

a. Kardeşleriyle arası nasıldır?

Kötü Normal Sayılır Oldukça İyidir Kardeşi Yoktur
☐ ☐ ☐ ☐

b. Diğer çocuklarla arası nasıldır?

Kötü Normal Sayılır Oldukça İyidir Kardeşi Yoktur
☐ ☐ ☐ ☐

c. Size karşı davranışları nasıldır?

Kötü Normal Sayılır Oldukça İyidir Kardeşi Yoktur
☐ ☐ ☐ ☐

d. Kendi başına oyun oynaması ve iş yapması nasıldır?

Kötü Normal Sayılır Oldukça İyidir Kardeşi Yoktur
☐ ☐ ☐ ☐

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

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

Diğer derslerde nasıldır?

Örneğin: Yabancı dil, bilgisayar

(Beden eğitimi, resim ve müziği katmayınız)

- e. _____ O O O
O
f. _____ O O O
O
g. _____ 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 – Kaçınıcı 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 öfkeliendiren 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 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 yakını.
- 0 1 2 34. Başkalarının ona karşı olduğu, zarar vermeye, ya da açığını yakalamaya çalıştığı hissine kapılır.
- 0 1 2 35. Kendini değersiz, önemsiz ya da yetersiz hisseder.
- 0 1 2 36. Bir yerlerini kaza ile sık sık incitir.
- 0 1 2 37. Çok kavgaya çıkarır, kavgaya karışır.

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

- 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 1 2 67. Evden kaçır.
- 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: Doğru değil (Bildiğiniz kadarıyla) 1: Bazen ya da biraz doğru 2: Çok ya da sıklıkla doğru

- 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. Şüphelidir, 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 kaçır, dersini asar.
0 1 2 102. Hareketleri yavaştır, enerjik değildir.
0 1 2 103. Mutsuz, üzgün ve çökkündür (depresyondadır).
0 1 2 104. Çok gürültücüdür.
0 1 2 105. Sağlık sorunu olmadığı halde madde kullanır (içki ve sigarayı katmayınız)
(açıklayınız):

-
- 0 1 2 106. Çevresindeki kişi ve eşyalara kasıtlı olarak zarar verir, zorbalık eder.
0 1 2 107. Gündüz altını ıslatır.
0 1 2 108. Gece yatağını ıslatır.
0 1 2 109. Mızırdanır, sızlanır.
0 1 2 110. Karşı cinsiyetten biri olmayı ister.
0 1 2 111. İçine kapanıktır, başkalarıyla kaynaşmaz.
0 1 2 112. Evhamlıdır, her şeyi dert eder.
113. Çocuğun yukarıdaki listede belirtilmeyen başka sorunu varsa

lütfen yazınız:

0 1 2

**APPENDIX E: Coding Sheet for Therapy Process Observational Coding System-
Alliance (TPOCS-A)**

		0	1	2	3	4	5	
		Hiç		Biraz		Çok		
Sorular							Değer	Kodlama Kriteri
1	Çocuk ne derece terapistin anlayışlı ve destekleyici olduğunu belirtti?							sıklık & yoğunluk
2	Çocuk ne derece terapistte düşmanca, eleştirel veya savunmacı bir tutumla davrandı?							sıklık & yoğunluk
3	Çocuk ne derece terapistte olumlu duygular ifade etti?							sıklık & yoğunluk
4	Çocuk ne derece deneyimini terapist ile paylaştı?							sıklık
5	Çocuk ne derece terapist ile etkileşiminde rahatsız görünüyordu?							sıklık
6	Çocuk ve terapist ne derece birbirleriyle etkileşim halindeyken huzursuz veya rahatsız görünüyorlardı?							sıklık
7	Çocuk ne derece terapötik görevleri seans dışında, hayatında değişiklik yapmak için kullandı?							sıklık & yoğunluk
8	Çocuk ne derece terapötik görevlere uyum göstermedi?							sıklık & yoğunluk
9	Çocuk ve terapist ne derece terapötik görevler üzerinde beraber, eşit bir şekilde çalıştılar?							sıklık & yoğunluk

Appendix F: Explanations of Moving Against Markers (Eubanks & Muran, 2023)

(1) Patient Complains about/Criticizes Therapist	The patient may express that they are not supported, encouraged, helped, or respected by therapists.
(2) Patient Complains about/Criticizes Activities/Interventions	The patient complains about or criticizes the activities or interventions of therapy.
(3) Patient Complains about/Criticizes Parameters	The patient expresses dissatisfactions about the parameters of treatment such as the therapy schedule, appointment times, session length, number of sessions or research requirements.
(4) Patient Complains about/Criticizes Progress	The patient expresses complaints, concerns, or skepticism about the progress achieved or achievable in therapy.
(5) Rejects Therapist's Idea	The patient disregards or dismisses the therapist's opinions, suggestions, or interpretations in a noncollaborative way.
(6) Defends Self	The patient defends their thoughts, emotions, or behavior against what they comprehend to be the therapist's criticism or judgment.

(7) Hostile Denial

The patient denies an obvious emotional state or denies the importance of interpersonal relationships that seem important and relevant to the work of therapy in a hostile way.

(8) Patient Controls/Pressures Therapist

The patient controls the therapist or the session, or puts pressure on the therapist to fix the patient's problems rapidly.

APPENDIX G: Explanations of Moving Away Markers (Eubanks & Muran, 2023)

(1) Avoidant Denial	The patient denies a feeling state that is evident or denies the importance of interpersonal relationship.
(2) Minimal Response	The patient becomes silent or gives little response to questions that were intended to sustain conversation.
(3) Gives Up	The patient becomes hopeless about therapist or the therapy. They may express their hopelessness about the effectiveness of therapy task or therapist.
(4) Abstract Communication	The patient avoids feelings, concerns or issues by using abstract language. The abstract language functions to keep the other at a distance.

(5) Avoidant Storytelling

The patient tells a story that functions to move away from the therapist or the therapy work.

(6) Topic Shift

The patient shifts the topic to move away from the work of therapy.

(7) Deferential/Appeasing

The patient is overly conforming that is not a genuinely express underlying feelings of dissatisfaction or disappointment.

(8) Content/Affect Split

The patient exhibits emotion that does not fit the content of their narrative.

APPENDIX H: Rupture Resolution Rating System Revised – Moving Against/Moving Away Coding (Eubanks & Muran, 2023)

Confrontation: Patient/therapist moves against

Rating	Label Description
1	Movements against are not salient. There are no confrontation markers in this segment, or there is only one possible marker that does not stand out because it is of very low intensity and clarity (e.g., one very slight, brief interruption of the other that might constitute some control/pressure).
2	
3	Movements against are somewhat salient. Confrontation markers stand out somewhat and are generally of moderate intensity and clarity. There should be <i>at least one clear confrontation marker.</i>
4	
5	Movements against are very salient. Confrontation markers stand out very much and are generally very intense and clear. Usually, a rating of 5 will mean there were multiple confrontation markers in the segment, but it is possible to have a segment in which one marker is so intense and clear that it warrants a 5 (e.g., a very direct and harsh criticism of the other).

Withdrawal: Patient/therapist moves away

Rating	Label Description
1	Movements away are not salient. There are no withdrawal markers in this segment, or there is only one possible marker that does not stand out because it is of very low intensity and clarity (e.g., one very brief smile that the coder thinks might constitute masking via content/affect split).
2	
3	Movements away are somewhat salient. Withdrawal markers stand out somewhat and are generally of moderate intensity and clarity. There should be <i>at least one clear withdrawal marker.</i>
4	
5	Movements away are very salient. Withdrawal markers stand out very much and are generally very intense and clear. Usually, a rating of 5 will mean there were multiple withdrawal markers in the segment, but it is possible to have a segment in which one marker is so intense and clear that it warrants a 5 (e.g., spending the entire 5 minutes telling a very avoidant story).

APPENDIX I: Ethical Approval

ETHICS BOARD APPROVAL

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

