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MENTALIZATION AND ITS RELATION WITH CHILD AND PARENT CHARACTERISTICS AND THERAPY OUTCOME

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Mentalization and Its Relation with Child and Parent Characteristics and Therapy Outcome

Zihinselleştirme ve Zihinselleştirmenin Çocuk ve Ebeveyn Özellikleri ile Terapi Sonucuyla İlişkisi

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ABSTRACT

This thesis includes two articles, focusing on mentalization which is the ability to understand, infer, and influence one's own and others' behaviors based on mental states like beliefs, wishes, intentions, needs, and feelings. The first article consists of the research investigating the psychometric properties of the Reflective Function (RF) coding system on the Parent Development Interview (PDI), one of the gold assessment tools of mentalization. The research was conducted with 115 Turkish mothers (M_{age} = 36.01 years, *SD* = 4.96) and their children (M_{age} = 6.99 years, *SD* = 2.09, 41.7% girls). The findings revealed that the RF coding system on the PDI is a reliable and valid tool in measuring parental mentalization of clinical sample in Turkey. Analyses revealed multidimensional structure of parental reflective function (PRF) as self-, child-, and relation-focused PRF and their differential associations with parent (number of children mother has, education level, socioeconomic status, and attachment organization) and child variables (expressive language, affect regulation, externalizing problems, and positive and adverse experiences). The second article includes the study examining the influence of baseline parental and child's mentalization on the changes in problem behaviors in psychodynamic psychotherapy. This study extends the literature on the importance of mentalization for treatment outcome and is the first known to be conducted in psychodynamic child psychotherapy. The study was conducted with 60 Turkish school-age children (M_{age} = 7.90, *SD* = 1.35, 43.3% girls) and their mothers. Multilevel modeling analyses revealed that parents' child-focused and children's self-focused mentalization predicts the changes in emotional and behavioral problems. The findings reveal the importance of investigation focusing on multidimensional structure of mentalization and are discussed in relation to existing literature and their clinical implications.

Keywords: parental reflective function, Parent Development Interview, mental state talk, psychodynamic child psychotherapy, emotional and behavioral problems

ÖZET

Zihinselleştirme, kişinin kendisinin ve başkasının davranışlarını, altında yatan inanç, istek, niyet, ihtiyaç ve duygu gibi zihinsel süreçleri göz önüne alarak anlama, anlamlandırma ve etkileme becerisidir. Bu tez zihinselleştirme kapasitesini inceleyen iki makaleyi içermektedir. İlk makaledeki çalışma, zihinselleştirme kapasitesini ölçen ideal ölçüm yöntemlerinden Ebeveyn Gelişim Görüşmesi üzerinden yapılan yansıtıcı işleyiş kodlama sisteminin psikometrik özellikleri incelemektedir. Çalışmaya 115 Türk anne ($Ort_{yaş}$ = 36.01 yaş, *SS* = 4.96) ve çocukları ($Ort_{yaş}$ = 6.99 yaş, *SS* = 2.09, 41.7% kız) katılmıştır. Bu çalışmanın sonuçları yansıtıcı işleyiş kodlama sisteminin ebeveynin zihinselleştirme kapasitesini ölçmek için Türkiye'de klinik örneklemde geçerli ve güvenilir bir yöntem olduğunu kanıtlamaktadır. Ebeveyn yansıtıcı işleyiş kapasitesinin kendi-, çocuk- ve ilişki-odaklı olmak üzere çok boyutlu yapısının olduğu ve bu boyutların ebeveyn (annenin sahip olduğu çocuk sayısı, eğitim seviyesi, sosyoekonomik statüsü ve bağlanma stili) ve çocuk değişkenleriyle (ifade edici dil becerisi, duygu regülasyonu, dışa-dönük problem davranışları ve olumlu ile olumsuz deneyimleri) farklı yönde ilişkili olduğu bulunmuştur. İkinci makaledeki çalışma psikodinamik psikoterapide başlangıçta ölçülen ebeveyn ve çocuk zihinselleştirme kapasitelerinin problem davranışlarda görülen değişiklere etkisini incelemektedir. Bu çalışma zihinselleştirme kapasitesinin terapi sonucundaki önemini inceleyen literatürü genişletmekte ve konuyu psikodinamik çocuk psikoterapisinde inceleyen bilinen ilk çalışmadır. Çalışmaya 60 Türk okul-çağı çocuk ($Ort_{yaş}$ = 7.90, *SS* = 1.35, 43.3% kız) ve annesi katılmıştır. Çok düzeyli modelleme analizleri ebeveynin çocuk-odaklı ve çocuğun kendi-odaklı zihinselleştirme kapasitelerinin duygusal ve davranışsal problemlerinin değişimini yordadığını kanıtlamaktadır. Bulgular zihinselleştirme becerilerinin çok boyutlu incelenmesinin önemini göstermiş, literatür ve klinik etki üzerinden tartışılmıştır.

Anahtar kelimeler: ebeveyn yansıtıcı işleyiş, Ebeveyn Gelişim Görüşmesi, zihin durumu konuşması, psikodinamik çocuk psikoterapisi, duygusal ve davranışsal problemler

CHAPTER 1
INTRODUCTION

Mentalization is the capacity of understanding mental states of oneself and others such as beliefs, wishes, intentions, needs, and feelings to understand, infer, and influence behaviors (Fonagy, Target, Steele, & Steele, 1998). It is an umbrella term with multidimensional aspects, consisting of four dimensions with two polarities: implicit-explicit, external-internal, cognitive-affective, and self-other aspects (Fonagy et al., 1998; Luyten & Fonagy, 2014). It is the capacity to mentalize one's own or others' (self-other) affects like happiness and sadness or cognitions like beliefs and thoughts (cognitive-affective) based on their external features like behaviors and facial expressions or inner states like affects and cognitions (external-internal) in an automatic or deliberate way (implicit-explicit). Mentalization capacity emerges in a secure attachment relationship context through parents' accurate, marked, and timely mirroring of child's mental experiences (Fonagy, Gergely, Jurist, & Target, 2002).

Recently, the focus in the field of clinical psychology and psychotherapy has turned to examine mentalization (Ekeblad, Falkenström, & Holmqvist, 2016). Mentalization of parents (e.g., Schiborr, Lotzin, Romer, Schulte-Markwort, & Ramsauer, 2013; Sharp & Fonagy, 2008), children (e.g., Ensink, Normandin, Target, Fonagy, Sabourin, & Berthelot, 2015; Scopesi, Rosso, Viterbori, & Panchieri, 2015), and therapists (e.g., Cologon, Schweitzer, King, & Nolte, 2017; Reading, Safran, Origlieri, & Muran, 2019) has been investigated. In addition, research has recently started to investigate the relation of mentalization with therapy outcome (e.g., Antonsen, Johansen, Rø, Kvarstein, & Wilberg, 2016; Müller, Kaufhold, Overbeck, & Grabhorn, 2006) and therapy alliance (e.g., Ekeblad et al., 2016; Taubner, Kessler, Buchheim, Kächele, & Staun, 2011). There are different operationalizations of mentalization such as theory of mind, reflective function (RF), mind-mindedness, insightfulness, and metacognition measured via different assessment tools from different theoretical backgrounds.

In this thesis, we investigated the parental reflective function (PRF), which is defined as parents' capacity to reflect on their own and children's mental states (Slade, 2005) as well as the influence of parental and child's mentalization on therapy outcome. PRF is crucial for the socio-emotional development of children. It predicts children's attachment security, mentalization, affect regulation, and linguistic aptitude (Camoirano, 2017; Fonagy et al., 2002; Fonagy, Steele & Steele, 1991; Oppenheim, 2006; Steele & Steele, 2008; Taumoepeau & Ruffman, 2006; Wade et al., 2018). PRF is also a protective factor against emotional and behavioral problems via helping children to regulate their emotions (Benbassat & Priel, 2012; Ha, Sharp & Goodyer, 2011; Halfon, Bekar, Ababay & Coklu-Dorlach, 2017).

In the first article, we investigated the psychometric properties of the Reflective Function (RF) coding system on the Parent Development Interview (PDI), one of the gold assessment tools of mentalization. Despite the abundant research on the parental mentalization, particularly PRF, studies on parental mentalization in Turkey are limited. They have investigated parental mentalization through parenting behaviors mostly via scales or directly via play-based measures focusing on the use of mental state language or theory of mind capacity. However, these tools are not enough to measure parental mentalization since it is much broader concept, consisting of cognitive, emotional, and interpersonal aspects of the mental states (Allen, 2006). The first study in the thesis fills this gap and investigates the psychometric properties of one of the mostly used interview-based measurement tool, the RF coding system on the PDI, which assesses PRF, with a Turkish sample of mothers who applied to a university mental health clinic seeking services for their children.

In the second article, we examined the influence of baseline parental and child's mentalization on the changes in problem behaviors in psychodynamic child psychotherapy. The effect of mentalization on therapy outcome has mostly been studied in adult psychodynamic psychotherapy (Ekeblad et al., 2016; Müller et al., 2006; Taubner et al., 2011). However, in psychodynamic child psychotherapy, the relations between baseline parental and child's mentalization on therapy outcome,

operationalized as changes in child's emotional and behavioral problems have not been investigated yet. We operationalized parental mentalization as PRF and child's mentalization as mental state talk (MST). Therefore, the second study in the thesis extends the literature on the importance of mentalization for treatment outcome and is the first known to be conducted in psychodynamic child psychotherapy.

CHAPTER 2
MANUSCRIPT ONE

The Psychometric Properties of The Reflective Functioning on the Parent Development Interview

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Abstract

Parental reflective function (PRF) is parents' ability to reflect upon their own and children's mental states, and their relationship. In the current study, we examined the psychometric properties of the RF coding system on the Parent Development Interview (PDI) which assesses PRF as parents talk about their relationship with their child. Data collected from 115 Turkish mothers (M_{age} = 36.01 years, SD = 4.96) and their children (M_{age} = 6.99 years, SD = 2.09, 41.7% girls) with internalizing (19.1%), externalizing (9.5%), comorbid (51.3%) problems, and 20% of the children were in the non-clinical range. Parents were interviewed using the PDI, coded via RF coding system based on their reflective capacity about mental states. The external validity of the coding was measured via parents' socio-demographic information and attachment organization and children's attachment security, mentalization, affect-regulation, linguistic aptitude, history of maltreatment, and problem behaviors. Factor analyses revealed three-dimensional structure as self- (PRF about own feelings), child- (PRF about child's feelings), and relation-focused PRF (PRF about mother-child relationship). Analyses revealed good internal consistencies. Self-focused PRF was associated with the number of children mother has, children's expressive language, affect regulation, and externalizing problems. Child-focused PRF was associated with socioeconomic status. Relation-focused PRF was related to parents' avoidant attachment style, education level, socioeconomic status, number of children mother has, and children's positive and adverse experiences. The results demonstrated that the RF coding on the PDI is a good measure to assess self- and relation-focused PRF, yet need improvement on child-focused PRF of clinical sample in Turkey.

Keywords: parental mentalization, reflective function, Parent Development Interview, psychometric properties

Öz: Yansıtıcı İşleyiş Kodlama Sisteminin Psikometrik Özellikleri

Ebeveynin yansıtıcı işleyiş kapasitesi ebeveynin kendisi, çocuğu ve ikisi arasındaki ilişkiye dair zihinselleştirme yapabilme becerisidir. Bu çalışmada, Ebeveyn Gelişim Görüşmesi üzerinden yapılan yansıtıcı işleyiş kodlama sisteminin psikometrik özellikleri incelenmiştir. Ebeveyn Gelişim Görüşmesi ebeveynlerin yansıtıcı işleyiş kapasitesini çocuğuyla ilişkisi hakkında yaptığı konuşma üzerinden değerlendirmektedir. Çalışmaya 115 Türk anne ($Ort_{yaş}$ = 36.01 yaş, *SS* = 4.96) ve çocukları ($Ort_{yaş}$ = 6.99 yaş, *SS* = 2.09, 41.7% kız) katılmıştır. Ebeveynlerle görüşme Ebeveyn Gelişim Görüşmesi ile yapılmış, görüşme ebeveynlerin zihin durumlarını yansıtma kapasitesini inceleyen zihinselleştirme kapasitesi kodlama sistemi üzerinden değerlendirilmiştir. Geçerlik incelemesi ebeveynlerin sosyodemografik bilgileri ve bağlanma stili ile çocukların güvenli bağlanma seviyesi, zihinselleştirme kapasitesi, duygu regülasyonu, ifade edici dil becerisi, olumsuz deneyimleri ve problem davranışları ile yapılmıştır. Faktör analizi kendi- (ebeveynin kendi duygularını yansıtıcı işleyiş kapasitesi), çocuk- (ebeveynin çocuğunun duygularını yansıtıcı işleyiş kapasitesi) ve ilişki-odaklı (ebeveynin anne-çocuk arasındaki ilişkiyle ilgili yansıtıcı işleyiş kapasitesi) olmak üzere 3 faktör yapısının anlamlı olduğunu göstermiştir. Her faktörün iç tutarlılık değerlerinin yeterli olduğu görülmüştür. Kendi-odaklı yansıtıcı işleyiş kapasitesi annenin sahip olduğu çocuk sayısı, çocuğun ifade edici dil becerisi, duygu regülasyonu ve dışa-dönük problem davranışlarıyla ilişkilidir. Çocuk-odaklı yansıtıcı işleyiş kapasitesi sosyoekonomik statü ile pozitif yönde ilişkilidir. İlişki-odaklı yansıtıcı işleyiş kapasitesi ise ebeveynin bağlanma stili, eğitim seviyesi, sosyoekonomik statüsü, annenin sahip olduğu çocuk sayısı ve çocuğun olumlu ve olumsuz deneyimleri ile ilişkilidir. Sonuçlar Ebeveyn Gelişim Görüşmesi üzerinden yapılan yansıtıcı işleyiş kodlama sisteminin Türkiye'deki klinik örneklemde kendi- ve ilişki-odaklı yansıtıcı işleyiş kapasitesini ölçmek için yeterli olduğunu, çocuk-odaklı yansıtıcı işleyiş kapasitesini ölçmek için geliştirilmesi gerektiğini kanıtlamaktadır.

Anahtar kelimeler: ebeveynin zihinselleştirme kapasitesi, yansıtıcı işleyiş, Ebeveyn Gelişim Görüşmesi, psikometrik özellikler

The Psychometric Properties of The Reflective Functioning on the Parent Development Interview

Mentalization is the ability to understand, infer, and influence behaviors of oneself and others based on mental states such as beliefs, wishes, intentions, needs, and feelings (Fonagy, Target, Steele, & Steele, 1998). It is a multidimensional construct, consisting of implicit-explicit, external-internal, cognitive-affective, and self-other aspects (Fonagy et al., 1998; Luyten & Fonagy, 2014). Mentalization can be automatic with little effort or require more conscious and deliberate processes. Inferences in mentalising can be based on one's own or others' external features like behaviors and facial expressions or inner states like affects and cognitions such as beliefs, thoughts, needs, and intentions. Mentalization develops in the context of a secure attachment relationship via the caregiver's capacity to be sensitive to child's mental states which they regulate and reflect back to the child. This process allows children to have a better understanding of what they are feeling, which in turn helps form tentative hypotheses about the link between emotions and behaviors (Fonagy & Target, 1998; Fonagy, Steele, Steele, Moran, & Higgitt, 1991; Luyten & Fonagy, 2014). Thus, parents' capacity to be sensitive toward their children and reflect upon their mental states (a.k.a. parental mentalization) plays a significant role in children's affect development and regulation, self-knowledge, and social understanding, which are the key aspects of sense of agency and control (Fonagy, Gergely, Jurist, & Target, 2002; Fonagy & Target, 1998; Grienenberger, Kelly, & Slade, 2005; Slade, 2005).

The notion of reflective function (RF) was first developed by Fonagy and colleagues (1991) from psychoanalytic, attachment, and theory of mind (i.e., ability to attribute mental states to oneself and others) perspectives (Fonagy & Target, 2005). RF measures one's capacity to reflect upon their own and parents' mental states in their remembered childhood relationships via Adult Attachment Interview (AAI; Fonagy et al., 1998). Parental reflective function (PRF) taps parents' ability to describe and reflect upon their own and children's mental states in their ongoing relationship (Slade, Bernbach, Grienenberger, Levy, & Locker, 2005). PRF was first assessed via AAI

which does not directly evaluate but infer adults' capacity to hold their own children in mind (Slade, 2005). Then, Parent Development Interview (PDI) was developed to specifically assess parental mentalization in parent-child relationship and parenting experiences (Slade, Aber, Bresgi, Berger, Kaplan, 2003). Despite being the gold standard for the measurement of mentalization (Sleed, Slade, & Fonagy, 2018), this coding system has not yet been adapted to Turkey. The main goal of the study is to test the psychometric properties of the RF coding system on the PDI with a Turkish sample of mothers who applied to a university mental health clinic seeking services for their children.

Assessment of Parental Reflective Function

Play- and interview-based measurement tools from different theoretical backgrounds have been used to assess parental mentalization (see Schiborr, Lotzin, Romer, Schulte-Markwort, & Ramsauer, 2013; Sharp & Fonagy, 2008 for reviews). These measurement tools give clinically rich and detailed information about parent's capacity to reflect on their child's mind and see the child as a psychological agent (Luyten et al., 2017). Play-based measures focus on the evaluation of mentalization through observation of here-and-now interaction between parent and child in a free or structured play context like mind-mindedness (Meins & Fernyhough, 2015), parental embodied mentalizing (Shai & Belsky, 2011), and parents' use of mental state language (e.g., Ruffman, Slade, & Crowe, 2002; Slaughter, Peterson, & Carpenter, 2008). In contrast, interview-based measures assess parents' reflective stance of themselves as a parent, their children, and the parent-child relationship through their verbal and declarative expressions. Instead of direct observation, they focus on parents' narrative organization about their experiences with their children like parental meta-emotion philosophy (Gottman, Katz, & Hooven, 1996), parental insightfulness (Oppenheim & Koren-Karie, 2002), caregiver's representational model (George & Solomon, 1989), and parental accuracy in mentalization (Sharp, Fonagy, & Goodyer, 2006).

PRF focuses on parents' capacity to understand their own and children's perspectives and hold and regulate their own and children's emotions (Slade, Bernbach

et al., 2005). It has been assessed via an interview-based measurement tool, mostly coded on the PDI. The PDI specifically assesses parents' capacity to reflect upon their own experiences as a parent, their children's mental experiences, and the relationship between them (Slade et al., 2003). It includes questions about parents' current relationship with their children and demands parents to provide examples from everyday life (Slade, 2005; Slade, Bernbach et al., 2005). The PRF coding asks the parents to label mental states as well as reflect upon them. Parents can reflect on mental states in four different ways. One of these ways is about the awareness of the nature of mental states. For example, parents should acknowledge that they cannot be sure of their child's mental states but only speculate about them. Also, mental states can be modified to reduce negative affect. Thus, parents should be aware of the use of one mental state to defend against another such as forgetting a painful situation to alleviate its burden. Another RF type taps parents' explicit effort to identify mental states underlying behavior. For instance, parents should recognize that their own or child's affect can be unrelated to the external and observable situation but influenced from another situation outside the interaction context. Also, parents should attempt to understand the effect of their own mental states on their own or child's behavior or mental states. Another type is about parent capacity to recognize the developmental features of mental states. For example, parents should explicitly be aware of the effect of their own childhood experiences on their parenting behaviors. In addition, since parents' own affect regulation capacity has a crucial role to sooth their child, they should acknowledge this role and understand the dependency of their child's emotional state on their own regulation capacity. The other type taps parents' willingness to reflect in other relations, assessed through relationship with the interviewer. Parents should explicitly acknowledge that the interviewer might not share their mental states and their statements can be strange for him/her. Thus, they should not assume interviewer's knowledge about the topic in which he or she has no access to. Therefore, they should not get so absorbed in their own thoughts but explicitly help the interviewer

to keep track of the narrative and clarify the confusing aspects via providing additional information.

The presence of these different ways reveals higher level of PRF. The use of statements tapping into different aspects of RF throughout the interview shows parents' having a higher level of PRF; representing the ability to preserve their RF capacity in emotionally-laden situations and awareness of important aspects of mentalization in an interaction. Parents' use of mental state language without reflection represents low or rudimentary levels of PRF. It represents that parents have a capacity to mentalize about themselves and their children and frequently use mental state language. However, they lack reflective capacity. They cannot genuinely understand the effect of mental states on their own and child's behaviors and state of mind. Negative or limited PRF represents the use of hostile, evasive, bizarre (in which it is hard to understand without the assumption of irrationality), and/or inappropriate (like over-familiarity) statements without reflection on mental states. For instance, parents can resemble their child to devil or attribute their child's underlying behaviors with the aim of taking a revenge and putting them in a harsh and shameful situation.

Research has mostly focused on PRF as a unitary construct and used overall PRF score. Yet, some studies revealed the multidimensional structure of the PRF as having child-focused (i.e., parents' capacity to mentalize and reflect upon their children), self-focused (i.e., parents' capacity to mentalize and reflect upon their own parenting behaviors), and relation-focused (i.e., parents' capacity to mentalize and reflect upon parent-child interaction) dimensions (Borelli, St John, Cho, & Suchman, 2016; Smaling, Huijbregts, Van der Heijden, Van Goozen, & Swaab, 2016; Suchman, DeCoste, Leigh, & Borelli, 2010). Suchman et al. (2010) and Borelli et al. (2016) identified a two-dimensional structure as child- and self-focused PRF. Also, Smaling and colleagues (2016) revealed three-dimensional structure as child-, self-, and relation-focused PRF. The PRF dimensions were differentially associated with parents' and children's behaviors. Self-focused PRF was positively related to children's externalizing problems and negative emotionality (Smaling et al., 2016) and parents'

sensitivity to cues and fostering ability for socio-emotional and cognitive growth (Suchman et al., 2010). Child-focused PRF was positively related to children's attachment security and mediated its relation between parents' attachment avoidance (Borelli et al., 2016). Relation-focused PRF was associated with children's less physical aggression (Smaling et al., 2016).

The validity of the PRF coding has been mostly investigated on the AAI (Sleed et al., 2018). Thus, little is known about the psychometric properties of the RF coding on the PDI. Sleed and colleagues (2018) were the first to investigate the reliability and validity of the coding system in relation to the socio-demographic factors. Their findings revealed high interrater reliability (ICC = .87) and internal consistency (α = .90) for the overall PRF score. They showed that single factor solution fit the model best. Further analyses with the overall PRF score demonstrated significant associations with children's and mothers' age, number of children in the household, maternal education, non-verbal IQ level, and long-term maternal unemployment.

PRF functions differently in children's different developmental stages and particularly important in middle childhood (Borelli et al., 2016). Parents should make more effort to understand their children's cognitions and emotions since they have very limited chance to directly observe them due to increased time spent at school and with peers. Also, with age, children become more proficient in controlling and hiding their emotions as well as give more emphasis on their individuality. These factors alleviate the feelings of relatedness which is highly important in Turkish context (Kagitcibasi, 2007; Sunar, 2002) and in turn, increase parents' sense of threat and anxiety, requiring more close monitoring of parents' own mental states (Borelli et al., 2016).

Despite limited investigation, research in middle childhood revealed associations of PRF with children's attachment security (Borelli et al., 2016) and mentalization (Scopesi, Rosso, Viterbori, & Panchieri, 2015). Research demonstrated the mediator role of PRF for the transmission of attachment security from parents to children in both low- and high-risk samples (see Katznelson, 2014, for review). Parents with secure attachment are found to have high levels of PRF, which in turn help them

engage in more secure attachment relationships with their children (Alvarez-Monjarás, McMahon, & Suchman, 2019; Fonagy & Allison, 2013; Grienenberger, 2007). Parents with secure attachment are able to deactivate their own attachment needs, see their children as a separate and psychological beings, and reflect more upon them (Alvarez-Monjarás et al., 2019). Thus, they can soothe their children via containing their frustrations (Fonagy et al., 2002). Yet, parents with insecure attachment have some disruptions in their mentalization capacity (Fonagy et al., 2002; Luyten, Nijssens, Fonagy, & Mayes, 2017). They generally have an inability to hold their children's mental states in their mind or make malevolent attributions about their children's actions.

Higher PRF, in turn, promotes children's mentalization (Camoirano, 2017). Specifically, higher level of PRF is related to children's more use of mental state language (Scopesi et al., 2015) and higher reflective function (Benbassat & Priel, 2012). It has a crucial role in children's emotional and cognitive development such as affect regulation (Camoirano, 2017; Fonagy et al., 2002) and linguistic aptitude (Taumoepeau & Ruffman, 2006; Wade et al., 2018). Also, PRF influences parenting behaviors such as sensitivity and responsiveness, and in turn children's behavioral adjustment as protective factor for internalizing (Benbassat & Priel, 2012) and risk factor for externalizing problems (Borelli et al., 2016; Ha, Sharp, & Goodyer, 2011). Moreover, PRF has an inverse association with traumatic childhood history (Berthelot et al., 2015; Ensink, Normandin, Plamondon, Berthelot, & Fonagy, 2016; Wade et al., 2018).

Parental Mentalization in Turkey

The sociocultural context in Turkey is characterized by strong and close ties within the family (Corapci, Aksan, & Yagmurlu, 2012; Sen, Yavuz-Muren, & Yagmurlu, 2014). Parents living in urban areas show diversity in their parenting motivations, goals, and practices (Nacak, Yagmurlu, Durgel, & van de Vijver, 2011). Turkish parents, in general, encourage their children to maintain their emotional closeness with the family members (Kagitcibasi, 2007). Parents' reactions toward their

child's emotional expressions are strongly associated with child's socio-emotional functioning (Ersay, 2014; Yagmurlu & Altan, 2010). For example, there is a positive relation between maternal responsiveness and child's affect regulation (Yagmurlu & Altan, 2010) and between maternal obedience-demanding and child's prosocial behaviors (Yagmurlu & Sanson, 2009). In Turkey, parents with low level of educational attainment generally do not encourage the expression of negative emotions such as anger, sadness, and fear (Altan-Aytun, Yagmurlu, & Yavuz, 2013). Whereas obedience-demanding mothers give punitive and minimization responses toward child's negative emotions, mothers who use inductive reasoning encourage the expression of these emotions and provide problem-focused responses. Corapci et al. (2012) and Ersay (2014) investigated parents' specific reactions towards their child's emotion expressions. In general, Turkish mothers give more rewarding and less neglecting response to child's emotions. They accept the expression of sadness more than anger since sadness promotes emotional intimacy with the child. When their child is sad, mothers accept this feeling, prefer to empathize with their child, and offer distraction or assistance. On the other hand, the expression of anger is restrained in the family (Sunar, 2002) since it challenges the hierarchy and cohesion of the family. Thus, mothers mostly disapprove and reject the child's aggressive feelings. Though mothers minimize the expression of these emotions, their aim differs. They minimize sadness to relieve it and anger to lead the child to conform the social norms. Also, mothers are less likely to neglect their child's fear and pay attention to their child's joy.

Parents' reactions toward their children's emotion expressions also change according to the cultural norms in families within middle-high socioeconomic status (Corapci, Friedlmeier, Benga, Strauss, Pitica, & Susa, 2017). When their children display anger, in comparison to European American and Romanian mothers, Turkish parents generally choose to alleviate anger and anger-related behaviors with comforting, reassuring, and reasoning in terms of referring to the societal norms (e.g., showing anger is inappropriate and should be restrained; Sunar, 2002) and others' empathic understanding. When their children are sad or fearful, Turkish parents prefer

displaying more emotional intimacy like comforting, reassuring, and giving support instead of reasoning and focusing on problem-solving. When they reason with their fearful children, they generally use didactic language via talking about the facts and necessities. In comparison to negative emotions, parents can tolerate expression of happiness (Sunar, 2002) and choose to increase and strengthen their children's happy feelings (Corapci et al., 2017). Also, parents with higher education level are more sensitive and responsive toward their children's needs, reason with and provide explanations to their children, and stimulate their children's cognitions via asking more questions, giving new information, and being less repetitive in the parent-child interaction (Baydar & Akcinar, 2015; Sen et al., 2014). They generally emphasize the importance of shared knowledge and mutual understanding of facts (Selcuk, Brink, Ekerim, & Wellman, 2018). On the other hand, Turkish parents with lower socioeconomic status show less emphasis on autonomy and lower tolerance and more belittling and punitive attitudes for their children's emotion expressions than parents with middle-high socioeconomic status (Corapci et al, 2012; Nacak et al., 2011). They less frequently encourage their children to express their emotions and care about the expression of negative emotions such as anger, fear, and sadness than parents with higher education level (Corapci et al., 2012; Yagmurlu & Altan, 2010).

Although Turkish parents' reactions vary in terms of their children's mental states, these associations have been investigated through parenting behaviors toward infants and toddlers. Very few studies have examined parental mentalization more directly. It has been revealed that parents of school-age children mostly talk about their own and child's cognitions in comparison to emotions in the play context (Halfon, Bekar, Ababay, & Çoklu-Dorlach, 2017). Parents of older children rarely refer to their child's mental states. Parents' reference to their child's mental states is negatively associated with interactive role-play (i.e., playing interactively with multiple play characters). Parents' and children's references to their own mental states promote child's affect regulation in play. On the other hand, parents' and child's talk about the child's mental states, especially their cognitions are strongly associated with higher

levels of externalizing and total problems. Parents' theory of mind, especially emotion recognition capacities (measured via reading the mind in the eyes test) are also found to be closely related to their anxious attachment style (Yıldız-Inanıcı, Akgün, & Karataş, 2019).

Aims

Parental mentalization is crucial for the socio-emotional development of children. Yet, studies on parental mentalization in Turkey are limited and investigated through parenting behaviors mostly via scales or directly via play-based measures focusing on the use of mental state language or theory of mind capacity. However, these tools are not enough to measure parental mentalization since it is an umbrella term and highly complex construct, including more than parenting experiences, theory of mind, and reference to mental states. Parents should not only be able to infer mental states of themselves and their children but also reflect upon and make links between mental states and behaviors. Therefore, there is a need to investigate higher-order mentalization capacity such as PRF. PRF examines parents' awareness of mentalization in emotionally-laden situations via the RF coding system on the PDI. Yet, this coding system has not been investigated in Turkey yet. Therefore, in this study, our aim was to examine the reliability and validity of this coding system with a Turkish sample of mothers who applied to a university mental health clinic seeking services for their children. We investigated the psychometric properties of the RF coding system on the PDI in a school-age sample of mothers. First, we examined the factor structure of RF coding on the PDI to test whether it has unidimensional or multidimensional structure. We investigated its reliability via internal consistency. Since PRF has associations with parent variables like age, education, socioeconomic status, number of children they have, and attachment organization as well as child variables such as age, expressive language, attachment security, mentalization, affect regulation, traumatic experiences, and problem behaviors, we examined these associations to test the external validity of the coding system.

Method

Data

In the current study, data from the Istanbul Bilgi University Psychotherapy Research Laboratory within the psychological counseling center of the university was used. The center offers psychodynamic psychotherapy with low cost, following mentalization principles (Verheugt-Pleiter, Zevalkink, & Schmeets, 2008 for details). The therapists in the center were master's level students at their second and third year in clinical psychology graduate program. Referrals to the counseling center were made by parents themselves or outside professionals working in the areas of education, medicine, and child welfare. Children and their parents were first interviewed by a licensed clinical psychologist for understanding the referral reason and evaluate whether they fit to the inclusion criteria of the study protocol which were having no psychotic symptoms, risk of suicide attempts, and drug abuse as well as child's age being between 3 and 10 years old. If they fit to the inclusion criteria, parents were informed about the research. The study received approval by Istanbul Bilgi University Ethics Committee.

Participants

Data were collected from 115 mothers whose children were referred to the psychological counseling center (see Table 1.1 for demographic information). Mothers' age ranged between 24 and 53 years (M_{age} = 36.01 years, SD = 4.96). Forty-eight girls (41.7%) and 67 boys (58.3%) were referred to the psychological counseling unit. The age of the children ranged between 3 and 10 years (M_{age} = 6.99 years, SD = 2.09). Twenty-five children (22.3%) were preschoolers and the others were at elementary school.

Measures

Intake Form. Demographic information about mothers' age, educational attainment, socioeconomic status, marital status, number of children they have, and children's age were obtained from the standard intake form. Maternal education was assessed based on the level of formal education they completed (from 0 = illiterate to 6 = graduate or professional degree).

Parental Mentalization. PRF was assessed via Parent Development Interview-Short (PDI-S; Slade et al., 2003). The interview was translated to Turkish via forward- and back-translation method by an academician in clinical psychology who received PDI training in English and a clinical psychologist who received her master's degree in clinical psychology. The translation was compared with the original interview by a clinical psychologist with at least 10 years of experience and finalized based on the suggestions. The PDI-S is a semi-structured clinical interview, focusing on mother's ongoing, evolving, and specific relationship with one child, the referred child in the current study. The interview has 29 items, consisting of permit and demand questions, assessing parents' views of the child and mother-child relationship, affective experiences as a parent, and child's reactions toward separations and upsets. The permit questions (14 items; e.g., "What do you most like about your child?", "Can you describe yourself as a parent?") prepare parents to think reflectively about their own and child's mental states without necessitating the use of mental state language. On the other hand, the demand questions (15 items; e.g., "What gives you the most joy in being a parent?", "When your child is upset, what does s/he do? How does that make you feel? What do you do?") explicitly ask parents to demonstrate their reflective capacity with referring to mental states.

The interview was transcribed verbatim and coded based on The Addendum to the Reflective Functioning Scoring Manual (Slade, Bernbach et al., 2005). The PRF capacity requires parents to think about their own and/or others' mental states and reflect upon them. Therefore, the coding was done only for the demand questions which lead mothers to explicitly use mental state language and reflective capacity. Raters evaluated and coded each passage of demand questions and the overall interview according to the illustrations of negative/limited RF, use of mental state language, and presence of RF types. They were coded on an 11-point scale (from -1 = 'negative RF' to 9 = 'full/exceptional RF', 5 = 'ordinary RF', meaning the presence of basic RF capacity). Raters first start with assigning the odd numbers as anchors and then adjust their scoring depending on elaboration or spoiling (e.g., parents' fluctuation of

narratives from first person to second or third person to distance themselves from uncomfortable feelings, use of direct speech to describe the situation without narrating, and incoherence that spoils the fluency of narrative like contradictions and inconsistencies). Parents who give hostile, actively evasive (i.e., anti-reflective), bizarre, and inappropriate answers receive -1 since it represents that parents resist to take a reflective stance. For example, parents who mention their desire to hit their child from wall to wall, attributing their child's glance with full of hatred, think that their child's faulty behaviors are on purpose to steer them would receive -1. The score of 1 represents absent but not repudiated RF meaning parents' answers being passively rather than actively evasive with little or no hostility and lack of any kind of reflective stance. For instance, parents who state never feeling a certain emotion before, focusing on their own parenting from an egocentric point of view, and focusing on adjectives or behaviors instead of mental states would receive 1. Parents who generally use mental state language without elaboration and reflective stance (e.g., 'She is an emotional child', 'He thinks he can do everything') would receive the score of 3, tapping questionable or low RF. If they explicitly use one of RF types (e.g., reference to the nature or developmental aspects of mental states) to make links between mental states and behaviors without being cliché (e.g., 'My mother and child was very afraid and I became panicked when I saw them in this situation. At that moment, my fear of loss arose'), they would receive 5, representing definite or ordinary RF. The other scores of 7 (marked RF) and 9 (full or exceptional RF) are given based on the number of RF types in elaborated statements. The score of 7 should have unusual detail with causal links of mental states in influencing each other and/or behaviors (e.g., 'Like every mother, I have fear of being inadequate. I worry about whether I do anything wrong, let others down, or make anything inadequate. Sometimes I receive criticism from my son and daughter, and become upset when I am criticized. Because I believe in making a lot of effort, while I am trying this hard. Or it is due to being a single parent. Because of that I raised them alone without my husband. Maybe since I took every burden on myself, I expect a lot from them, I expect understanding. Maybe I feel upset when they

criticize me. I have worries that I am inadequate'). On the other hand, parents who understand and explicitly state the perspectives of all protagonists in the interaction and give statements about charged and emotionally-laden situations would receive the score of 9 (e.g., '… What my daughter told me was a lie. Different thing had happened. She explained things differently to us. When this happened, I became sad and very ashamed. I am ashamed from my husband and myself due to my reactions. She disappointed me since she made me ashamed […] When I become angry, I ask her to go to her room. Then, I go to my room as well and wait to be calmed down. During this time, nobody comes together. We wait to calm down in different rooms. After calming down, we talk each other about what happened wrong. In general, I move away when I get angry… When I get angry, she fears. I am not sure whether she becomes upset or afraid. Yet, when I get angry and raise my voice, I feel as if she gets afraid. Because her facial color changes. Yet, I do not know whether she feels any regret or questions herself').

Interviews were double-coded by four raters who were trained by a certified expert at the Anna Freud Center. The training approximately lasted 3 days with 18 hours in total. In the half of the first day, introduction to RF and its types, PDI, and coding system was given. The rest of the training was then focused on coding pilot transcripts and answering questions. During training, approximately 10 transcripts were coded in total. Then, raters received accreditation after coding a reliability set of 10 interviews. Interrater reliability for the overall PRF score based on 25% of the randomly selected data was good (ICC = .84).

Parent Attachment. Mothers' attachment organization was assessed via Experiences in Close Relationships-Revised (ECR-R; Fraley, Waller, & Brennan, 2000). The scale has 36 items, measuring avoidant attachment, tapping discomfort with intimacy and seek for independence (18 items; e.g., "I prefer not to show a partner how I feel deep down") and anxious attachment, tapping fear of rejection and abandonment (18 items; e.g., "My desire to be very close sometimes scares people away"). The scale is rated on a 7-point Likert scale (from 1 = 'strongly disagree' to 7 = 'strongly agree').

It had high internal consistency (αs = .91 for avoidance, .93 for anxiety) and good test-retest stability (βs = .90 and .92, R^2s = .84 and .85 for avoidance and anxiety, respectively; Sibley, Fischer, & Liu, 2005). The Turkish form of the scale (Selcuk, Gunaydin, Sumer, & Uysal, 2005) also had high internal consistencies (αs = .86 for avoidance, .90 for anxiety) and good test-retest reliability (rs = .81 for avoidance, .82 for anxiety). In the current study, the subscales showed high internal consistencies (αs = .83 for avoidance, .87 for anxiety).

Child History of Trauma. Mothers filled out the Adverse Childhood Experiences Study Questionnaire for their children (Child ACE; Murphy et al., 2014), assessing experiences of abuse, neglect, and dysfunction in household during first 18 years. The questionnaire has 24 items with 2 general scores for positive and adverse experiences are also calculated. Sixteen items are rated on a 5-point Likert scale (from 0 = 'never' to 4 = 'very often'). Whereas 13 of them are converted to binary scores (0 = 'never' as 'no' and 1 = the other points as 'yes'), 3 items are converted to 3-point scores (0 = 'never, once/twice, and sometimes', 1 = 'often', and 2 = 'very often'). The other items are rated as binary (0 = 'no' and 1 = 'yes'). The original scale and the Turkish form (Gündüz, Yaşar, Gündoğmuş, Savran, & Konuk, 2018) had high internal consistencies for adverse experiences (αs = .88 and .74, respectively). In the current study, the questionnaire demonstrated good internal consistencies for positive and negative childhood experiences (αs = .87 and .75, respectively).

Child Affect Regulation. Mothers evaluated their children's affect regulation capacities via Emotion Regulation Checklist (ERC; Shields & Cicchetti, 1997). The checklist consists of 24 items and 2 subscales as emotion regulation, tapping emotion awareness, adaptive regulation of emotional displays, and empathy (8 items; e.g., "Is empathic towards others; shows concern when others are upset or distressed") and emotional lability/negativity, tapping lack of flexibility, anger dysregulation, and mood lability (16 items; e.g., "Is prone to angry outbursts/tantrums easily"). The checklist is rated on a 4-point Likert scale (from 1 = 'never' to 4 = 'almost always'). The original and Turkish forms (Batum & Yagmurlu, 2007) had high internal consistencies (αs =

.83 and .73 for emotion regulation, .96 and .75 for emotional lability/negativity, respectively). In the current study, the scale showed adequate internal consistencies (αs = .62 for emotion regulation, .79 for emotional lability/negativity).

Child Problem Behaviors. Mothers rated their children's problem behaviors via the Child Behavior Checklist (CBCL; Achenbach, 1991). CBCL has two form, specifically designed for children of 1.5-5 and 6-18 years. These checklists have 99 and 112 items, respectively and assesses children's internalizing (i.e., emotional reactivity, depression, anxiety, withdrawal, and somatic complaints for 1.5-5 years and depression, anxiety, and somatic complaints for 6-18 years), externalizing (i.e., attention problems and aggressive behaviors for 1.5-5 years and rule-breaking and aggressive behaviors for 6-18 years), and total problems (i.e., sleep problems for 1.5-5 years and social, thought, and attention problems for 6-18 years in addition to internalizing and externalizing problems). It is rated on a 3-point Likert scale (from 0 = 'not true' to 2 = 'very true or often true'). The subscales of internalizing, externalizing, and total problems had high internal consistencies and test-retest reliabilities (αs = .90, .94, and .97, rs = .91, .92, and .94, respectively) in the original (Achenbach & Rescorla, 2001) and (αs = .87, .90, and .94, rs = .93, respectively) in the Turkish form (Erol & Şimşek, 2010). In this study, the internalizing, externalizing, and total problems revealed high internal consistencies (αs = .88, .92, and .94 for 1.5-5 years, .88, .90, and .95 for 6-18 years, respectively).

Child Attachment. Children evaluated their perception of attachment security for their mother via the Kerns Security Scale (KSS; Kerns, Klepac, & Cole, 1996). The scale contains 15 items measuring the degree of children's belief in their mothers' responsivity, sensitivity, and openness to communication, especially in stressful situations. The questions are asked in the format of 'Some kids… [versus] other kids…' (e.g., "Some kids find it easy to trust their mom BUT other kids are not sure if they can trust their mom"). Children are first asked to choose the statement which describes their relationship with their mother more. Then, they indicated the degree of trueness of the statement (as 'really true' or 'somewhat true'). In other words, the scale is rated on a

4-point scale, higher scores indicating more secure attachment. The original scale and Turkish form (Sümer & Anafarta-Şendağ, 2009) showed good internal consistency (αs = .84). In the current study, the scale also revealed good internal consistency (α = .78).

Child Expressive Language. Expressive Language subtest of the Turkish Expressive and Receptive Language Test (TİFALDİ; Berument & Güven, 2010) was used to assess children's expressive language. This test is the Turkish equivalent of Peabody Picture Vocabulary Test. Children are instructed to name the black-and-white pictures on the card. These cards are shown one-by-one. In total, there are 80 cards in the subtest. The subtest starts with the picture designated according to the children's chronological age and ends when children give a certain number of incorrect answers. The scores were calculated with three-parameter item response theory, based on item difficulty, probability of correct answer without knowing but by guessing, and item load on the rate of success. The subtest is reliable (αs ranging between .86 and .90) and valid in the assessment of expressive language abilities of typically developing children ages between 2 and 12 years.

Child Mentalization. Children's mentalization capacities, particularly their mental state talk (MST) were assessed in the attachment context via the Attachment Doll Story Completion Task (ASCT; Bretherton, Oppenheim, Buchsbaum, Emde, & the MacArthur Narrative Group, 1990). The Turkish adaptation of the task was done by Uluç and Öktem (2009). The story stems about attachment-related every-day situations are given via family figure dolls and children are instructed to complete them. There are 5 story stems about accidentally spilling juice on the floor, falling off a high rock and hurting the knee, separation from parents to sleep but crying due to the monster in the bedroom, parents' departure for a one-week trip and leaving the child with a babysitter, and parents' return from the trip and reunion of the family members.

Children's completion of the story stems was transcribed and coded based on the Coding System for Mental State Talk in Narratives (CS-MST; see Bekar, Steele, & Steele, 2014, for details), assessing the frequency and direction of the mental state language. Bekar and Corapcı (2016) adapted the CS-MST to Turkish and Bekar

adapted it to ASCT narratives. During the adaptation phase, Bekar coded 25 play segments and gave training to the coders. The CS-MST had good interrater reliability (ICC = .92 for all coding variables, ranged between .83 and .99 for 25% of the randomly selected data). If there were three or more differences in the counts of any mental state word categories, the raters revised their coding and reached to an agreement. When all the raters became reliable, the remaining transcripts were not double-coded but coded by one rater. In the current study, we aggregated children's use of self- and other-focused cognition and emotion words to create a composite score for child mentalization.

Procedure

The research protocol was administered to mothers and children. Mothers were interviewed via PDI-S which approximately lasted for 90 minutes and asked to fill out intake form, ECR-R, ERC, Child ACE, and CBCL. While mothers were filling the intake form and scales, children were separately administered ASCT and expressive language subtest of TIFALDI and given KSS to fill out in a silent room, whose administrations lasted about 20, 10 and 5 minutes, respectively. The interview and child's individual assessments were videotaped, transcribed, and coded for PRF and MST. The researchers did not code PRF and MST of the participants to whom they administered the research protocol.

Data Analysis Plan

The factor structure of the PRF coding on PDI-S was analyzed with exploratory (EFA) and confirmatory (CFA) factor analyses. The EFA was performed using Principal Component Analysis, orthogonal Varimax rotation, and suppression of small coefficients below .40 via SPSS version 26. Communalities below .30 were excluded from the data and the number of factors were decided based on eigenvalue above 1, scree plot, internal consistency, and interpretability. The CFA was performed with Mplus version 8.2 (Muthén & Muthén, 1998-2018) to investigate the model fit. Goodness of fit indices were compared with Hu and Bentler's criteria (1999), cutoffs as CFI $\geq$ .95, TLI $\geq$ .95, RMSEA $\leq$ .06 (90% CI $\leq$ .06), and SRMR $\leq$ .08. After

controlling the distribution of PRF dimensions and overall PRF score, their relations with parent variables which were age, education, socioeconomic status, number of children they have, and attachment style and child variables which were age, attachment security, expressive language, mentalization, affect regulation, history of trauma, and problem behaviors were examined using Pearson correlation.

Results

Descriptive Analysis of Demand Questions and Overall PRF Score

The descriptive information of the PRF scores for each demand question and overall interview were presented in Table 1.2. Tests of normality demonstrated that PRF scores were not normally distributed ($p \leq .001$ for Kolmogorov-Smirnov test, $p \leq .021$ for Shapiro-Wilk test). Ten demand questions were found to be positively skewed while the others were normally distributed. Normal Q-Q plots and boxplots showed there were some non-extreme outliers. Therefore, the outliers were not excluded from the analysis.

Factor Structure of Reflective Functioning

When the EFA was performed, the communality value of the mother's feeling toward separations was .29. Since it was lower than .30, we excluded this item from the analysis and rerun the EFA. The communalities of all items were ranging between .32 (for mother feeling guilty) and .72 (for mother's feeling of losing the child). The Kaiser-Meyer-Olkin measure of sampling adequacy was .85, indicating the appropriateness of the factor analytic model on this data set. The Bartlett's test of sphericity was significant, $\chi^2(91) = 384.22$, $p = .001$, indicating strong relationships among items. The examination of the scree plot indicated that 3-factor solution was the best for the data with eigenvalues greater than 1 (see Table 1.3). The 3 factors explained a cumulative variance of 50.91%. Then, the internal consistencies of the factors found via the EFA were examined. The first factor with 4 items had low reliability ($\alpha = .66$). Yet, when the item of mother feeling guilty was deleted, the factor was found to have acceptable internal consistency ($\alpha = .70$). Thus, this item was excluded from the first

factor. The second and third factors also had an acceptable internal consistency (α = .70 and .71, respectively).

Due to non-normal distribution of demand items, robust maximum likelihood (MLR) estimation method in CFA was used. Based on the literature and results from the EFA, one- and three-factor models were examined. The one-factor model demonstrated excellent fit, $\chi^2(90) = 95.73$, *ns*, CFI = .98, TLI = .98, RMSEA = .02, 90% CI = .00 - .06, SRMR = .06. Yet, the model of 3 factors exhibited slightly better fit than one-factor model, $\chi^2(62) = 65.43$, *ns*, CFI = .99, TLI = .99, RMSEA = .02, 90% CI = .00 - .06, SRMR = .05 (see Figure 1). According to literature and item contents, Factor 1 was defined as child-focused (PRF about their child's feelings), Factor 2 as relation-focused (PRF about mother-child relationship), and Factor 3 as self-focused PRF (PRF about their own feelings).

Descriptive Analysis of PRF Dimensions

Tests of normality demonstrated that PRF dimensions and overall PRF score were not normally distributed. The child-focused PRF (M = 2.68, SD = .09) and self-focused PRF (M = 2.92, SD = .08) were positively skewed ($p < .001$ and $p = .001$ for Kolmogorov-Smirnov and Shapiro-Wilk tests, respectively). On the other hand, the relation-focused PRF (M = 2.76, SD = .07) was negatively skewed ($p = .01$ for Kolmogorov-Smirnov test, $p = .06$ for Shapiro-Wilk test). Also, the overall PRF score (M = 3.03, SD = .10) was positively skewed ($p < .001$ for Kolmogorov-Smirnov and Shapiro-Wilk tests). Normal Q-Q plots and boxplots showed some non-extreme outliers; thus, they were not excluded from the analysis. Due to non-normal distribution, PRF dimensions and overall PRF score were normalized with log transformation.

The associations among the PRF dimensions and overall PRF score revealed related but distinct associations. There were positive associations of child-focused PRF with relation- and self-focused PRF (rs = .57, ps < .001) as well as between relation- and self-focused PRF (r = .48, p < .001). Moreover, the overall PRF score was

positively associated with relation- (r = .67, p < .001), child- (r = .64, p < .001), and self-focused PRF (r = .74, p < .001).

Associations between Reflective Functioning and Maternal Characteristics

Zero-order correlations revealed differential associations of PRF dimensions with parent variables (see Table 1.4). Self-focused PRF was negatively associated with the number of children. Child-focused PRF was positively associated with socioeconomic status. Relation-focused PRF was negatively related to mothers' avoidant attachment style and number of children they have and positively associated with their education level and socioeconomic status. Their age and anxious attachment style were not significantly associated with PRF dimensions. The overall PRF score was only related to mothers' education level and socioeconomic status.

Associations between Reflective Functioning and Child Characteristics

Mothers' self-, child-, relation-focused PRF and overall PRF score were not significantly different between boys and girls. Zero-order correlations showed self-focused PRF was positively associated with children's expressive language, affect regulation, and externalizing problems (see Table 1.5). Child-focused PRF was not significantly associated with any child variables. Relation-focused PRF was related to children's positive and adverse experiences. Children's age and emotional negativity/lability were not significantly associated with PRF dimensions. The overall PRF score was not significantly associated with any child variables.

Discussion

The aim of the current study was to investigate the psychometric properties of the RF coding system on the PDI, gold standard measure for parental mentalization. We investigated the factor structure of the RF coding as well as its reliability and validity. To test the validity, the associations of PRF with parent variables like age, education, socioeconomic status, number of children they have, and attachment organization as well as child variables such as age, expressive language, attachment security, mentalization, affect regulation, traumatic experiences, and problem behaviors were investigated. Factor analyses revealed excellent fit of three-factor

model. The PRF dimensions showed good internal consistencies and validity analyses revealed their differential associations with parent and child variables.

In the current study, the PRF scores were non-normally distributed and showed positive skewness. Mothers' PRF scores generally ranged between negative (-1) and marked PRF (6 or 7). This finding is in line with the studies conducted in high-risk populations such as clinical samples (Pajulo et al., 2012; Sleed et al., 2018). Contrary to low-risk samples where PRF scores show normal distribution, high-risk samples are at great risk for low levels of PRF but are able to show considerable range.

Our factor analyses supported the three-dimensional structure of PRF as self-, child-, and relation-focused PRF, respectively. The first two dimensions have been found by prior studies, investigating the multidimensional structure of PRF (Borelli et al., 2016; Smaling et al., 2016; Suchman et al., 2010), supporting the self and child dimensions of mentalization (Luyten et al., 2017; Luyten & Fonagy, 2014). Besides these dimensions, we also found relation-focused PRF, similar to the findings of Smaling and colleagues (2016). The PRF is an interpersonal construct and its quality is related to the parent-child relationship (Fonagy et al., 1991; Katznelson, 2014; Sharp & Fonagy, 2008; Slade, 2005). Thus, this dimension supports the PRF as being a relationship-specific construct (Luyten & Fonagy, 2014; Smaling et al., 2016). Our analyses revealed that PRF dimensions showed more associations with parent and child variables than overall PRF score in the current study. The overall PRF score was only related to parents' education level and socioeconomic status. Yet, PRF dimensions were differentially associated with parent and child variables. These findings demonstrate the importance of the analysis of dimensions in the mentalization.

We found a significant association of child- and relation-focused PRF with socioeconomic status as well as between relation-focused PRF and parents' education level. Parents with risk factors like low level of income and education have a tendency to attribute malevolence to others' behaviors (Luyten et al., 2017) and consistently report low level of PRF capacities (Sleed et al., 2018; Stacks et al., 2014; Suchman et al., 2010). Since PDI depends on the verbal expression of PRF capacity, the quality and

richness of parents' narratives are also influenced from their education level (Sleed et al., 2018). Our findings revealed the association of self- and relation-focused PRF with the number of children in the family. Though having more children in the family facilitates the mentalization capacity of children due to more conversational opportunities (McAlister & Peterson, 2007), it may cause more distress for parents since reflecting on each child individually becomes challenging for them (Fonagy et al., 2002; Sleed et al., 2018). As a result, their PRF capacities, especially their reflective stance for their own mental experiences and the relationship with their children may diminish when the number of children increases. On the other hand, we could not find a relation between PRF dimensions and parents' history of childhood trauma. Literature also shows that it is not the presence of parents' history of childhood trauma itself but parents' capacity to mentalize about these early experiences and the resolution of them are associated with PRF (Berthelot et al., 2015; Ensink, Normandin et al., 2016; Stacks et al., 2014).

Mothers with avoidant attachment had low level of mentalization capacity to reflect on the relationship with their children. Parents with avoidant attachment do not sensitively respond to their children's needs for proximity, comfort, and support (Slade, Grienenberger, Bernbach, Levy, & Locker, 2005). Rather they would reject or fail to regulate these needs. They mostly focus on logic and reasoning to avoid uncomfortable emotions, suppress their emotions, and detach themselves from others (Grienenberger, 2007). They attribute malevolence in others' behaviors, show low level of interest to their children's subjective experiences (Fonagy et al., 2002; Luyten et al., 2017), and cannot mirror their children's distress since it activates their painful experiences. On the contrary, mothers' anxious attachment and PRF were not significantly correlated. This finding could be in line with their ambivalent reactions. Parents with anxious attachment style have the capacity to reflect on mental states in mother-child interaction. However, in stressful situations, they can use statements with limited mentalization, lose their reflective stance, or make more malevolent attributions. Parents with anxious attachment show intrusive hypermentalization (Fonagy et al.,

2002; Luyten et al., 2017), meaning that they show a tendency to be overly certain about their children's mental states. They lack the idea of separateness of minds, represent their children's mental states with excessive clarity, and make malevolent attributions. They are also overly dependent on others, especially preoccupied with their children, get overwhelmed if the affect is uncontained, and show ambivalent reactions towards them (Grienenberger, 2007). These mentalization problems occur in emotionally intense relationships.

We could not find the link of PRF dimensions with child attachment and mentalization. Fonagy and colleagues (2002) emphasized the importance of complex and emotional relationships in the family context on children's development of self-other differentiation, attachment, and mentalization capacity. Most of the studies have investigated the transmission of attachment security from parents to children through parental mentalization (Camoirano, 2017; Fonagy et al., 1991; Slade, 2005; Slade, Grienenberger et al., 2005). Yet, the intergenerational association found by Fonagy and colleagues (1991) has not been replicated by most of the studies (Ensink, Normandin et al., 2016). Instead, the PRF has been found to influence children's attachment security through parenting behaviors such as atypical maternal behavior like hostility and intrusiveness in dyadic affective communication (Grienenberger et al., 2005), parental support, satisfaction, communication, involvement, limit setting, allowance of autonomy (Rostad & Whitaker, 2016) and sensitivity (Ensink, Normandin et al., 2016; Smaling et al., 2016; Stacks, et al., 2014; Suchman et al., 2010). PRF promotes positive parenting behaviors and enables parents to respond to their children's mental states positively, consistently, and effectively. They stay emotionally engaged and in control during their relationships with their children, contain their children's arousals, and transform them to tolerable experiences (Grienenberger, 2007), in turn supporting children's secure attachment (Alvarez-Monjarás et al., 2019 and mentalization capacity (Benbassat & Priel, 2012; Camoirano, 2017). In addition to the indirect link, limited findings revealed no association between PRF and child mentalization in middle childhood (Ensink, Bégin, Normandin, & Fonagy, 2016). This reason for non-

association can be children being less dependent on their parents' mentalization capacity with their increased autonomy.

Our findings revealed association of self-focused PRF with children's affect regulation. Parents' reflective stance is crucial for children to view arousals as manageable and to organize and regulate these difficult affects (Fonagy et al., 2002). Especially parents' mentalization about their own attachment experiences have an important role for the recognition and regulation of affective states. Parents' use of cognition terms in reference to themselves is critical for children's affect regulation (Gocek, Cohen, & Greenbaum, 2008). Parents' self-focused cognition terms can show their tendency to reflect upon their own mental states and willingness to share these inner states with their children. This can imply that parents, in turn, can be sensitive to their children's mental states and welcome them, as well. Also, the questions tapping self-focused PRF are about parents' own difficult affects as a parent and their way of handling them. Thus, these questions also include parents' own affect regulation strategies, which in turn can influence children's own affect regulation via role-modeling. We found that self-focused PRF was positively related to children's externalizing problems, similar to the Smaling et al.'s findings (2016). This association can be explained via self-absorption paradox. Parents with high self-focused PRF can be absorbed in their own mental states more, needing more effort to focus on their children's mental states, especially in distressing situations. Thus, they would become more impatient towards them, attribute more malevolence to their children's actions, and describe their children to be acting out or oppositional. Their children can also exhibit more externalizing problems to regain their parents' attention. We found no association between PRF dimensions and internalizing problems. Internalizing problems are harder to detect and reflect on (Wilmshurst, 2015), which could partially explain the lack of significant associations. Self-focused PRF and children's expressive language were also positively associated. Parents' use of rich verbal scaffolding during interaction with their children promotes children's understanding of words, use of grammatical rules (Wade et al., 2018), and expression of their and others' mental states

(Taumoepeau & Ruffman, 2006). Also, we found an association between relation-focused PRF and children's positive and negative experiences. There is a positive relation between children's negative experiences and parents' withdrawal from social interactions, inhibition of their mentalization capacity, struggle to detect underlying mental states accurately, and dysregulation of their affective states in the ongoing relationship (Fonagy & Allison, 2013; Fonagy et al., 2002).

We could not find an association between age and PRF dimensions. The role of PRF can vary in children's different developmental stages (Smaling et al, 2016). PRF during the prenatal period is about parents' capacity to reflect upon the relationship with the baby when there is no concrete basis for the relationship. PRF during the early ages like infancy and early childhood serves a critical role since children's survival depends on their parents. Also, since these children's linguistic aptitude and mentalization capacity have not been well-developed, parents should reflect upon their nonverbal behaviors more (Luyten et al., 2017). On the other hand, PRF during middle childhood necessitates parents to reflect on their children when the direct relationship with the children decreases due to the time spent at school and with friends (Borelli et al., 2016). With time, children get more proficient in clearly communicating their own mental states. Yet, they can also prefer to hide their actual emotions which increases anxiety and threat for parents to accurately monitor their own and children's mental states. PRF during adolescence is mostly helpful in understanding and coping with the developmental changes and social competence (Benbassat & Priel, 2012).

Clinical Implications

Our findings suggest the clinical utility of RF coding on the PDI to assess mentalization capacity of parents, especially their reflective stance towards their own and children's mental states, and the relationship between them. The PDI can be used for a general assessment; yet, investigation of PRF dimensions would give richer and more detailed information about parents' mentalization deficits. Moreover, the differential associations of PRF dimensions with parent and child variables can be used during interventions. For example, we found the association of parents' attachment

organization with relation-focused PRF. Although parents with avoidant attachment think of their children as having separate minds and encourage their independence and mastery, they are uncomfortable with the issues of dependency, intimacy, and intense affects like being needy, depressive, shameful, and vulnerable (Grieneberger, 2007). They have a limited capacity to acknowledge their impact on their relationship with their children. Therefore, interventions with these parents should focus on their mentalization capacity to reflect upon their relationship. These parents, in general, press therapists for concrete childrearing advice in order not to reflect on their children. Yet, these parents should be challenged to think about their children's needs for closeness and comfort as well as their defenses to not access their affects during parent sessions. On the other hand, parents with anxious attachment see their children as having mind equivalent to their own minds. Although they can be empathic towards their children, this stance is not stable, especially when they get frustrated by anxiety, insecurity, or fear of loss. Interventions should focus on their struggle to understand the nature of opacity and differentiate their own and children's mental states. Thus, cognitive structuring during parent sessions would allow them to slow down, stop rumination or overthinking, and think about difficult feelings in a contained context which is facilitated through regular clarification, acknowledgment, and help of organization and integration of affects.

We found associations of self-focused PRF and children's affect regulation, linguistic aptitude, and externalizing problems. High level of self-focused PRF enables children to regulate their own affects and express themselves. If children experience problems of affect regulation and expression of themselves, therapists could first focus on parents' own mental states, expression of their arousals, and the way of regulating these overwhelming affects during their relationship with their children. Therapists can model for parents to develop reflective stance via focusing on the expression of their inner experiences and regulation strategies. As a result, parents would feel more validated and understood and, in turn, can be role-models for their children. Yet, therapists should be alert on parents' tendency to self-absorb. If parents' focus on their

mental states increases, this could impair their abilities to reflect on the underlying mental states of their children. The tolerance for their children's actions can be hampered and increased the use of more malevolent attributions to children. These can in turn be related to children's externalizing problems. Thus, in addition to working on parents' inner experiences, at the same time, therapists should interpret children's inner experiences, especially mental states behind their negative behaviors. This would increase parents' curiosity for their children and help them to think about their interactions. Therapists can use stop-and-rewind technique (Midgley, Ensink, & Lindqvist, 2017, p.154-155) in which parents are stopped and asked specifics of the interaction with their children to help them understand where they lose their mentalization capacity and their related strong emotions, especially in the emotionally charged situations causing distress.

PRF is open to change and improvement through interventions especially in high-risk populations (Pajulo et al., 2012; Slade, Grienenberger et al., 2005). The accumulation of psychosocial risk factors such as low socioeconomic status, parental education, disruptions in attachment relationships, and early and current trauma hinders parents' mentalization and regulatory capacities (Alvarez-Monjarás et al., 2019; Luyten et al., 2017; Sleed et al., 2018; Wade et al., 2018). Parents generally withdraw from social interactions or use mechanisms that cause dysregulation in the case of cumulative adversity. These risk factors are more detrimental for parents' mentalization capacity in general. As a result, children lose their secure and safe base. Thus, families with high risk factors should receive mentalization-based interventions whose aim is to enhance PRF in high-risk populations (Camoirano, 2017; Pajulo et al., 2012). These interventions also do not have the limitations of behavioral and psychoeducational parenting interventions (Camoirano, 2017).

Cultural Implications

In comparison to other PRF dimensions, relation-focused PRF had the best psychometric properties as being associated with most of the parent (education level, socioeconomic status, number of children in the family, and attachment organization)

and child characteristics (positive and adverse experiences). This finding supports PRF as being interpersonal construct and the importance of relatedness in Turkey where having emotional ties is to be reckoned with (Kagitcibasi, 2007; Sunar, 2002). Collectivistic values like harmony, cohesion, interdependence, and obedience are highly valued in Turkish population (Göregenli, 1997), especially in the context of low socioeconomic status (Imamoğlu & Karakitapoğlu-Aygun, 2006). Self-focused PRF had better psychometric properties as being associated with parent (number of children in the family) and child characteristics (expressive language, emotion regulation, and externalizing problems). In addition to close ties, Turkish parents emphasize their own needs for individuality, which in turn facilitate their children's autonomy via prioritizing their own needs and defend their rights (Akyil, Prouty, Blanchard, Lyness, 2014). Moreover, they want to be friends with their children and share activities with them. During parent-child interaction, they emphasize their role of modeling to create a close family atmosphere where family members can easily share their own problems.

On the other hand, child-focused PRF was not associated with any parent and child characteristics aside from socioeconomic status. Socioeconomic status is a strong factor which influences parenting behaviors and children's developmental outcomes (Baydar & Akcinar, 2015). Thus, its relation with child-focused PRF is no surprise. Yet, we did not expect to find a lack of relation of child-focused PRF with other variables. The reason for this lack of association can be due to characteristics of our sample. Our study was conducted with families with low socioeconomic status in which there is less emphasis on autonomy of children (Corapci et al., 2012; Nacak et al., 2011). On the other hand, middle childhood is the period of individuation with the time mostly spent outside home (Borelli et al., 2016). This could influence the change of interaction between parents and children. School-aged children's attempts for autonomy and individuality might challenge parents' cultural values. As a result, they could feel the threat of separation with their children, which in turn increases their anxiety. Thus, their focus can shift from their children to themselves due to their need to closely monitor their own mental states (Borelli et al., 2016). Moreover, in Turkey,

families with low socioeconomic status show lower tolerance and more belittling and punitive attitudes for their children's emotion expressions (Corapci et al., 2012; Nacak et al., 2011). They less frequently encourage their children's expression of emotion, especially the negative ones such as anger, fear, and sadness since they disrupt the harmony (Corapci et al., 2012; Yagmurlu & Altan, 2010). On the other hand, items comprising child-focused PRF are about children's reactions to normal separations and routine upsets. These emotions can be the hard ones for Turkish parents to think and reflect about. Therefore, some modification on the PDI should be done and more specific questions about children's mental states including a wide range of positive and negative emotions should be added. Moreover, in future studies, the psychometric properties of the RF coding system on the PDI should be investigated in samples with high socioeconomic status and a comparison should be conducted between different socioeconomic statuses.

Limitations and Directions for Future Research

The use of different measurement tools (interview, observation, and self-reports) to assess parent and child variables and examination of the psychometric properties of the RF coding system on the PDI beyond socio-demographic factors were the strengths of the study. In contrast to prior studies, we found higher internal consistency scores for all PRF dimensions and supported the multidimensional structure with further confirmatory analysis following exploratory analyses. Also, we showed the differential associations of PRF dimensions and overall PRF score, supporting the separate investigation of PRF dimensions. Yet, there are some limitations of the current study such as selective bias and relatively small sample size for the factor analysis. We collected our data from parents who applied to mental health clinic seeking services for their children. These parents can be more sensitive to their children's inner states in comparison to non-clinical or clinical sample who did not get any therapeutic help. The use of larger sample with control groups like normative sample would give more general information about the reliability and validity of the coding system. Also, we examined the PRF of mothers, only. This limits our chance to

talk about PRF among fathers. Thus, similar type of study should be conducted with fathers in the future.

Though we defined the dimensions according to PRF definition and previous findings, the labeling of the dimensions are, to some extent, arbitrary and speculative (Smaling et al., 2016). Most of our demand questions loaded on dimensions match the items of dimensions previously found by Smaling and colleagues (2016). Yet, there are also some discrepancies. For example, few items in the dimensions did not match with Smaling et al.'s findings (2016) and most of the items loaded on child-focused PRF in Borelli and colleagues' study (2016) were loaded on the relation-focused PRF in the current study. Moreover, PDI might have some methodological issues in this respect. For instance, the questions loaded on child-focused PRF explicitly ask children's mental experiences. Yet, questions loaded on the self-focused PRF ask parents' own mental experiences as well as their influence on the child's mental experiences, sharing some components of the relation-focused PRF. Thus, some adjustments should be applied to the PDI.

In the current study, the focus was mostly on the child variables. We only investigated correlations among PRF and child characteristics. In the future research, direct and indirect links should be investigated. For instance, the mediator role of children's emotion regulation or mentalization capacity on the link between PRF and children's attachment or problem behaviors can be examined. Also, some of the parent variables could have been included to the study. For example, most of the studies have found a close link between PRF and parenting behaviors, especially parental sensitivity (Ensink, Normandin et al., 2016; Smaling et al., 2016; Stacks, et al., 2014; Suchman et al., 2010). PRF is a general term containing parental capacity to reflect upon and regulate children's inner states as well as parental ability to transmit these states to the child through behavioral enactments (Alvarez-Monjarás et al., 2019). Literature also demonstrated that parental sensitivity did not adequately explain the transmission gap in intergenerational attachment processes (van IJzendoorn, 1995), but PRF was the crucial factor in this transmission (Grienenberger et al., 2005). Therefore, we did not

examine parental sensitivity. Yet, studies have shown the mediator role of parenting behavior on the associations of PRF with children's attachment security and mentalization capacity. Thus, the relation between PRF dimensions and some aspects of parenting behaviors should be investigated in the future studies.

This study was the first to investigate the psychometric properties of the RF coding on the PDI with a Turkish sample of mothers who applied to a university mental health clinic seeking services for their school-age children. Our findings demonstrated the validity and reliability of the coding system as well as the importance of the examination of the multidimensional structure of PRF, as relation-focused PRF being the most representative one in Turkey. Our findings also revealed the differential associations of PRF dimensions with parent and child characteristics. This would help the clinicians to detect the major impairments of parental mentalization, which, in turn, would increase the efficiency of psychotherapies.

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Table 1.1

Demographic Information of the Sample (*N* = 115)

Mothers' Age (years): *N* (%)	
24-36 years old	61 (55.5)
37-53 years old	49 (45.5)
Mean (*SD*)	36.01 (4.96)
Median	36.00
Maternal Education: *N* (%)	
Primary/middle school	38 (34.5)
High school	34 (30.9)
Bachelor's degree or higher	38 (34.5)
Monthly Gross Income[a]: *N* (%)	
Less than 487 USD	23 (20.0)
487-650 USD	77 (67.0)
More than 650 USD	15 (13.0)
Mean (*SD*)	560.51 (164.13)
Median	487.10
Mothers' Number of Children: *N* (%)	
1-2 children	93 (81.6)
3-4 children	21 (18.4)
Mean (*SD*)	1.94 (.73)
Median	2.00
Children's Age (years): *N* (%)	
3-5 years old	27 (23.5)
6-8 years old	58 (50.4)
9-10 years old	30 (26.1)
Mean (*SD*)	6.99 (2.09)
Median	7.00

Children's Sex: *N* (%)	
Female	48 (41.7)
Male	67 (58.3)
Children's Referral Reason: *N* (%)	
Externalizing complaints like rule-breaking and aggression	48 (42.1)
Internalizing complaints like anxiety and depression	36 (31.6)
Problems related to school	22 (19.3)
Problems in social relations	8 (7.0)
Children's Clinical Characteristics, CBCL[b]: *N* (%)	
Internalizing problems	22 (19.1)
Externalizing problems	11 (9.5)
Comorbid problems	59 (51.3)
Non-clinical range	23 (20)

Note. Sex was dummy coded (0 = female, 1 = male). CBCL = The Child Behavior Checklist.

[a]Converted to USD.

[b]Cutoff criteria for CBCL = t score < 60: Non-clinical, 60 ≤ t score: Borderline or Clinical Range (Achenbach, 1991).

Table 1.2

Descriptives for PRF Scores of Demand Questions (*N* = 115)

	Mean (*SD*)	Min	Max	Skewness (*SD*)	Kurtosis (*SD*)
Feeling clicked	2.67 (.95)	0	5	-.22 (.23)	.39 (.45)
Feeling not clicked	2.80 (1.14)	-1	6	.02 (.23)	.90 (.45)
Relation affecting child's personality	3.08 (1.22)	-1	7	.52 (.23)	1.59 (.46)
Joy of parenting	2.54 (1.04)	0	6	.42 (.23)	.79 (.45)
Pain or difficulty of parenting	2.76 (1.02)	1	6	.78 (.23)	.66 (.45)
Having the child changed mother	2.72 (1.13)	0	6	.71 (.23)	.78 (.45)
Mother feeling needy	2.53 (1.24)	-.50	6	.40 (.23)	.17 (.46)
Mother feeling angry	3.28 (1.46)	0	7	.59 (.23)	.02 (.45)
Mother feeling guilty	3.03 (1.42)	0	7	.34 (.23)	-.22 (.45)
Child feeling upset	2.92 (1.29)	0	7	.82 (.23)	1.74 (.45)
Child feeling rejected	2.45 (1.17)	0	6	.67 (.23)	.24 (.46)
Parents of the mother	3.52 (1.35)	1	7	.99 (.23)	.58 (.45)

Child's feeling about separations	2.66	1	6	.56	-.01
	(1.15)			(.24)	(.47)
Mother's feeling about separations	2.84	1	5.5	.64	.44
	(.95)			(.23)	(.45)
Mother's feeling of losing the child	2.52	1	7	.74	.64
	(1.24)			(.23)	(.45)

Note. PRF = Parental Reflective Function.

Table 1.3

Factor Loadings for Three-Factor Model of the PRF on PDI Based on EFA (*N* = 115)

	Factor 1	Factor 2	Factor 3
Child feeling rejected	**.74**		
Child's feeling about separations	**.72**		
Child feeling upset	**.67**		
Mother feeling guilty	**.40**		
Relation affecting child's personality		**.64**	
Joy of parenting		**.62**	
Feeling clicked		**.53**	
Having the child changed mother[a]		**.52**	.43
Feeling not clicked[a]	.68	**.44**	
Mother's feeling of losing the child			**.70**
Mother feeling needy			**.63**
Pain or difficulty of parenting			**.53**
Mother feeling angry[a]	.47		**.48**
Parents of the mother[a]	.58		**.43**
Eigenvalues	4.85	1.25	1.02
% of variance	34.66	8.96	7.28

Note. PRF = Parental Reflective Function. PDI = Parent Development Interview. EFA = Exploratory Factor Analysis. Items chosen for the factor were bolded.

[a]These saliently cross-loading items were designated to the factor in which they were determined to fit better theoretically

Table 1.4

Zero-order correlations among PRF Dimensions and Maternal Characteristics (*N* = 115)

	Child-focused PRF	Relation focused PRF	Self-focused PRF	Overall PRF score	1	2	3	4	5	6
1. Age	.12	.08	.12	.09	-					
2. Education	.04	.27**	.16	.28**	.05	-				
3. Socioeconomic status	.19*	.28**	.18	.23*	.14	.48***	-			
4. Number of children in the household	-.11	-.21*	-.23*	-.15	.08	-.14	-.06	-		
5. Attachment avoidance	-.13	-.20*	-.06	-.11	.01	-.12	.11	-.04		
6. Attachment anxiety	.00	-.09	.05	-.06	-.10	-.16	.10	.01	.41	-

Note. PRF = Parental Reflective Function. *$p < .05$, **$p \leq .01$, ***$p \leq .001$.

Table 1.5

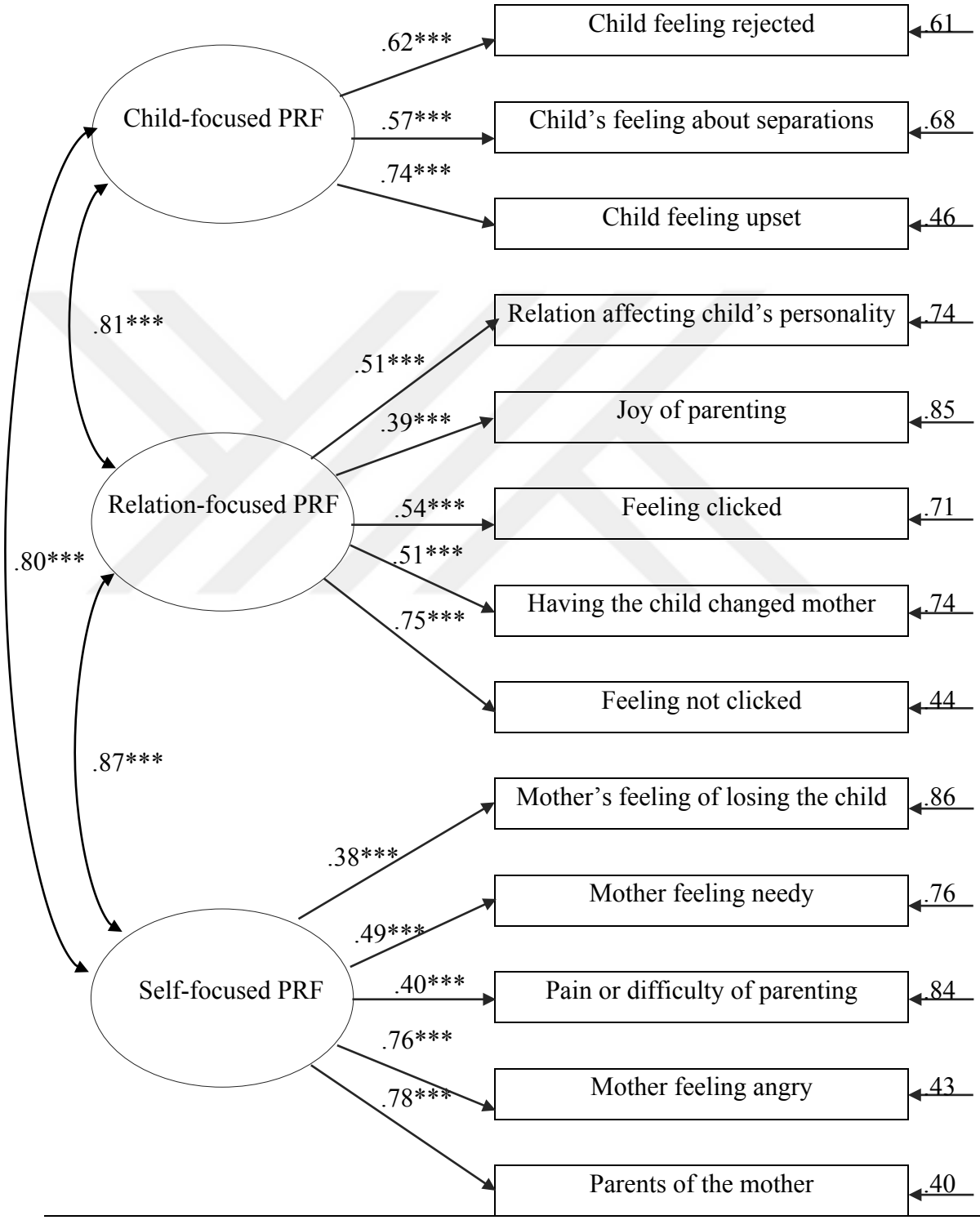
Zero-order correlations among PRF Dimensions and Child Characteristics (*N* = 115)

	Child-focused PRF	Relation focused PRF	Self-focused PRF	Overall PRF score	1	2	3	4	5	6	7	8	9	10
1. Age	.06	.10	-.03	.02	-									
2. Expressive language	.19	.08	.27*	.18	.11	-								
3. Adverse experiences	-.10	-.22*	-.04	-.13	.09	-.03	-							
4. Positive experiences	.09	.27*	.09	.16	.11	.02	-.52***	-						
5. Attachment	.06	-.05	-.05	.07	.03	.04	-.19	.05	-					
6. Mentalization	-.13	-.12	.04	-.10	.37***	.24*	-.07	.16	-.11	-				
7. Emotion regulation	.09	.02	.20*	.14	-.14	.24*	-.36***	.26*	.33**	-.08	-			
8. Emotional lability/negativity	-.09	-.04	.06	-.08	-.13	-.04	.20	-.12	-.20	-.18*	-.09	-		
9. Internalizing problems	.04	-.03	.07	-.06	-.11	-.10	.30**	-.21	-.16	-.07	-.39***	.31***	-	

10. Externalizing problems	.05	.02	.20*	.01	-.30***	-.10	.28*	-.15	-.30*	-.22*	-.11	.58***	.45***	-
11. Total problems	.03	-.05	.14	-.05	-.15	-.19	.35***	-.20	-.27*	-.10	-.26**	.53***	.77***	.84***

Note. PRF = Parental Reflective Function. *$p < .05$, **$p \leq .01$, ***$p \leq .001$.

Figure 1. **Three-Factor Model of the PRF on the PDI based on CFA (*N* = 115).**



Note. PRF = Parental Reflective Function. PDI = Parent Development Interview. CFA = Confirmatory Factor Analysis. ***$p < .001$.

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This data has the subsample of participants from a larger data, collected at Istanbul Bilgi University Psychotherapy Center. The larger data contains 195 patients (consecutively admitted from Fall 2014-2020). Analyses with different subsamples have been published in separate manuscripts.

CHAPTER 3
MANUSCRIPT TWO

Parental Reflective Function and Children's Attachment-based Mental State Talk as Predictors of Outcome in Psychodynamic Child Psychotherapy

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Abstract

Objective: Mentalization is defined as the capacity to understand and interpret mental states underlying behaviors. It is a multidimensional construct including self-focused (i.e., mentalizing about one's own thoughts and feelings) or other-focused aspects (i.e., mentalizing about others' thoughts and feelings). Literature in adult psychotherapy revealed predictive effect of patients' mentalization on therapy outcome; yet, this link has not been investigated in psychodynamic child psychotherapy yet. This study focused on psychodynamic child psychotherapy and investigated the predictive effect of baseline parental reflective function (PRF) and child's mental state talk (MST) on change in problem behaviors. Method: The sample included 60 Turkish school-age children (M_{age} = 7.90, SD = 1.35, 43.3% girls) with internalizing (18.3%), externalizing (5%), comorbid (56.7%) problems, and 20% of the children were in the non-clinical range. Mothers were interviewed using the Parent Development Interview (PDI), in which narratives were coded for self- and child-focused PRF. Children were administered an attachment-based story-stem task, coded for self- and other-focused MST. The Brief Problem Monitor was administered every month over the course of treatment with a total of 366 sessions. Results: Multilevel modeling analyses revealed the predictive effect of child-focused PRF and self-focused MST on changes in problem behaviors. Discussion: Parental mentalization about their child's and child mentalization about their own mental states could be predictors of therapy outcome in psychodynamic child psychotherapy.

Keywords: parental Reflective Function, mental state talk, psychodynamic child psychotherapy, emotional and behavioral problems, therapy outcome

Question: This study investigated whether parental and child mentalization in the attachment context predicted therapy outcome in psychodynamic child psychotherapy. Findings: Parental reflective function about their child's and child's mental state talk about their own inner experiences predicted changes in problem behaviors. Meaning: Parents' reflective stance about their child's and child's capacity to identify their own mental states might help them benefit more from psychodynamic child psychotherapy.

Next steps: Future research should examine the reason behind the association of parental and child mentalization with therapy outcome in psychodynamic child psychotherapy. They should also investigate whether this link is present in other types of treatment or not. There can be some mediators like therapeutic alliance and child's affect regulation capacity, influencing this association. It is also important to study whether gains in mentalization capacity over the course of treatment predict change in problem behaviors.

Parental Reflective Function and Children's Attachment-based Mental State Talk as Predictors of Outcome in Psychodynamic Child Psychotherapy

Mentalization is the capacity to understand and interpret one's own and others' behaviors based on affective (like feelings) and cognitive mental states (like needs, wishes, and beliefs; Fonagy, Target, Steele, & Steele, 1998). Child mentalization develops through parents' ability to accurately, markedly, and timely mirroring of child's inner experiences, which is the building block for secure attachment (Fonagy, Gergely, Jurist, & Target, 2002). In the development of mentalization capacity, parents' own mentalization plays a crucial role. Parental mentalization predicts children's attachment security and development of mentalization capacity (Fonagy, Steele, & Steele, 1991; Oppenheim, 2006; Steele & Steele, 2008). Also, parental and child mentalization in secure attachment relationship context promote children's affect regulation, which in turn, protect them against problem behaviors (Benbassat & Priel, 2012; Ha, Sharp, & Goodyer, 2011; Halfon, Bekar, Ababay, & Coklu-Dorlach, 2017).

Psychodynamic child psychotherapy focuses on reflecting children's inner experiences. Parents' and children's less recognition of child's mental states might cause no or limited change of problem behaviors. The predictor effect of mentalization has been examined in psychodynamic adult psychotherapy and revealed mixed findings (e.g., Müller, Kaufhold, Overbeck, & Grabhorn, 2006; Taubner & Curth, 2013). Yet, this predictor effect has not been investigated in psychodynamic child psychotherapy yet. Therefore, the aim of the current study was to investigate the predictor effect of baseline parental (operationalized as parental reflective function; PRF) and child mentalization (operationalized as child's mental state talk; MST) on the change in problem behaviors in psychodynamic child psychotherapy.

Parental Reflective Function, Emotional and Behavioral Problems

Parental mentalization is parents' capacity to understand and reflect upon their own and children's mental states as well as interpret their impact on behaviors and relationship between them (Luyten, Nijssens, Fonagy, & Mayes, 2017; Slade, 2005). Different methodologies have been used to examine parental mentalization like mind-

mindedness (i.e., parents' use of mental state language in their here-and-now interaction with their child; Meins et al., 2003), parental insightfulness (i.e., parents' capacity to see their child's perspectives, motives, and emotions underlying their behaviors and parents' openness to new or unexpected situations related to their child; Oppenheim & Koren-Karie, 2002), and accuracy of parents' cognitions about their child's intentions in distressing situations (Sharp, Fonagy, & Goodyer, 2006). The Reflective Function coding system (RF; Slade, Bernbach, Grienenberger, Levy, & Locker, 2005) on the Parent Development Interview (PDI; Slade, Aber, Bresgi, Berger, & Kaplan, 2003) assesses parents' reflective function (PRF; parents' capacity to reflect upon their own and child's mental experiences; Slade, 2005) as parents explicitly answer specific questions about their relationship with their children.

PRF has been mostly investigated in infancy and there is a gap in the literature on the parents' reflective capacity about their school-age children. In the current study, we focused on PRF in middle childhood to fill the gap in the literature. PRF has differential influences on different developmental stages. During infancy, PRF is mostly related to parents' attributions of mental states based on children's nonverbal behaviors (Luyten et al., 2017). On the other hand, in middle childhood, children become more competent in understanding and expressing their own and others' thoughts and emotions. Thus, parents have to understand their children's inner experiences while children are good at hiding their real mental states (Borelli, St John, Cho, & Suchman, 2016). Moreover, parents' shared time with their children decreases due to the time spent mostly at school and with peers, causing less direct observation. Middle childhood is also the period where children's individuality attempts increase. All of these changes create more threat, distress, and anxiety in the parents, which in turn oblige them to monitor their own mental states more closely. PRF in middle childhood is associated with children's attachment security (Borelli, et al., 2016), MST (Scopesi, Rosso, Viterbori, & Panchieri, 2015), and mentalization regarding themselves (Ensink, Normandin, Plamondon, Berthelot, & Fonagy, 2016), beyond parental attachment security (Rosso, Viterbori, & Scopesi, 2015). Moreover, it is

associated with children's behavioral adjustment through the influence of parenting behaviors like sensitivity and responsiveness (Benbassat & Priel, 2012; Benbassat & Shulman, 2016; Borelli, West, DeCoste, & Suchman, 2012). PRF, more generally parental mentalization, is a protective factor against internalizing and externalizing problems of school-age children (Benbassat & Priel, 2012; Ensink, Bégin, Normandin, & Fonagy, 2016, Taubner & Curth, 2013). Low level of parental mentalization predicts children's problem behaviors like anxiety (Esbjørn et al., 2013) and conduct and oppositional defiant disorders (Centifanti, Meins, & Fernyhough, 2016). Sharp et al. (2006) found an inverse association between parents' capacity to accurately predict their children's responses and children's psychopathology (Sharp et al., 2006). Moreover, Halfon, Bekar, Ababay et al. (2017) found an inverse link between parents' MST about play characters in a pretend play context and children's internalizing problems.

PRF has been mostly examined as a unitary construct. However, it can have a multidimensional structure as having child- and self-focused dimensions. Whereas the child-focused PRF is about parents' capacity to reflect upon their child's mental states, the self-focused PRF is about parents' capacity to reflect upon their own mental states underlying their parenting behaviors (Luyten et al, 2017). Child- and self-focused dimensions of PRF have been identified in recent studies (Borelli et al, 2016; Smaling, Huijbregts, Van der Heijden, Van Goozen, & Swaab, 2016; Suchman, DeCoste, Leigh, & Borelli, 2010) and these PRF dimensions were differentially associated with child characteristics. Child-focused PRF was positively related to child's attachment security (Borelli et al., 2016) and self-focused PRF was inversely associated with child's negative emotionality and externalizing problems (Smaling et al., 2016).

Child Mentalization, Emotional and Behavioral Problems

Child mentalization has been assessed via various measurement tools from different theoretical backgrounds, each assessing different aspects of mentalization (see Vrouva, Target, & Ensink, 2013, for a review). Most of these measurement tools focus on either cognitive (i.e., theory of mind involving perspective taking and false

belief understanding) or affective aspects (e.g., emotion understanding) of child mentalization. On the other hand, Child Reflective Function (CRF) combines these aspects and measures child's capacity to recognize mental states and their link with the behaviors in attachment context via the Child Attachment Interview (CAI; Shmueli-Goetz, Target, Fonagy, & Datta, 2008). Yet, such interview-based measurement tools can only be used for children whose age is over 8 years since they only require child's verbal expressions about their interpersonal processes. Also, child's mental state talk (MST; Bekar, Steele, & Steele, 2014) combines these aspects and measures child mentalization from a multidimensional perspective. It investigates child's use of mental state language in discourse as a sign of explicit mentalization practice. There is a close association of children's MST with their developing capacities for reasoning with such mental states (see Carpendale & Lewis, 2004; Symons, 2004, for reviews), affect regulation, and problem behaviors (Halfon, Bekar, Ababay et al., 2017; Halfon, Bekar, & Gürleyen, 2017).

Child mentalization is related to their behavioral adjustment. Inverse associations of CRF with depression and externalizing problems (Ensink, Bégin et al., 2016) as well as somatic and conduct disorders (Bizzi, Ensink, Borelli, Mora, & Cavanna, 2019) have been found. Child mentalization deficits like distorted mentalizing (i.e, attribution of intentions to others in a biased way) are related to externalizing problems (Sharp et al., 2006; Sharp, Croudace, & Goodyer, 2007), specifically conduct disorders (Ha et al., 2011). Similarly, pseudo-mentalization (i.e., self-serving mentalization to manipulate or control behaviors) is related to psychopathy (Sharp, 2008) and externalizing problems (Sutton, Reeves, & Keogh, 2000). Similar to the child- and self-focused dimensions of PRF, child mentalization can have separate dimensions as self- (i.e., capacity to understand own mental states) and other-focused (i.e., capacity to understand others' mental states; Ensink et al., 2015). These dimensions can be differentially associated with children's problem behaviors, like children with internalizing disorders having impairment in reflecting upon their own mental states, but not of others (Bizzi et al., 2019).

Parental and child mentalization has differential associations with demographic variables like children's age, sex, linguistic aptitude, and parents' educational attainment (Pears & Moses, 2003; Sleed, Slade, & Fonagy, 2018) and distress (Stacks et al., 2014), and children's problem behaviors (Wilson, Hurtt, Shaw, Dishion, & Gardner, 2009). It has been showed that child mentalization increases with age (Hughes & Dunn, 1998; Sleed et al., 2018), with girls having better mentalization capacity (Bosacki, 2000; Cutting & Dunn, 1999; Rutherford et al., 2012). Mentalization is a higher-order capacity and needs advanced verbal and symbolic understanding of mental states (Rutherford et al., 2012). Therefore, parents' use of frequent MST has a close association with children's better linguistic aptitude (Taumoepeau & Ruffman, 2006), which is linked with better child mentalization, operationalized as theory of mind capacity (Milligan, Astington, & Dack, 2007) and CRF (Camoirano, 2017). Children's linguistic aptitude is also inversely related to their problem behaviors (Camoirano, 2017). Higher level of educational attainment of parents is related to higher PRF and children's fewer problem behaviors (Carneiro, Meghir, & Parey, 2013; Ensink, Bégin et al., 2016). On the other hand, it is positively associated with child mentalization (Cutting & Dunn, 1999). Parental distress is also important in mentalization, specifically it reduces parental sensitivity and PRF as well as children's socio-emotional functioning (Stacks et al., 2014). On the other hand, it increases children's externalizing problems (Valiente, Chalfant, & Reiser, 2007).

Mentalization as Predictor of Psychotherapy Outcome

Most of the therapy techniques bolster up parental and child mentalization in order to improve parent-child interaction and increase child's behavioral adjustment and psychosocial functioning (e.g., Midgley, Ensink, & Lindqvist, 2017; Verheugt-Pleiter, Zevalkink, & Schmeets, 2008). The effectiveness of PRF improvement has been demonstrated by specific reflective parenting programs (e.g., Sadler et al., 2013; Sleed, Baradon, & Fonagy, 2013). Parents' insightfulness about their child's inner experiences and difficulties might reduce child's symptoms. Oppenheim, Goldsmith, and Koren-Karie (2004) found that only children whose parents increased their

insightfulness after therapeutic preschool intervention showed improvement in their problem behaviors. An association between improvement in parental mentalization and decline in child's internalizing problems was revealed in Parent Child Interaction Therapy (Zimmer-Gembeck et al., 2019) and attachment-focused intervention (Moretti, Obsuth, Mayseless, & Scharf, 2012). In an evidence-based single case study of two patients with anxiety problems, the child with more explicit mentalization capacity before psychotherapy showed more clinical change in internalizing symptoms than the child with more mentalization deficits (Halfon, Bekar, & Gürleyen, 2017). Yet, as far as we know, no study has extensively investigated the predictive effect of parental and child mentalization on problems behaviors in psychodynamic child psychotherapy.

The predictor effect of mentalization has been mostly examined in psychodynamic adult psychotherapies using the Adult Reflective Functioning Scale (ARFS; Fonagy et al., 1998) and revealed mixed findings. Some studies revealed predictor effect of baseline mentalization on therapy outcome (Ekeblad, Falkenström, & Holmqvist, 2016; Müller et al., 2006). On the other hand, some could not support this finding (Rudden, Milrod, Target, Ackerman, & Graf, 2006; Taubner, Kessler, Buchheim, Kächele, & Staun, 2011), yet showed the predictor effect of RF on the change in general distress and therapeutic alliance (Taubner et al., 2011). Few studies compared psychodynamic psychotherapy and cognitive-behavioral therapy (CBT). They revealed that the predictor effect of baseline RF on therapy outcome did not change depending on treatment type (Ekeblad et al., 2016; Katznelson et al., 2019). Yet, RF increases more in psychodynamic psychotherapy than CBT, which in turn influences outcome only in psychodynamic psychotherapy (Katznelson et al., 2019). Moreover, patients with low level of RF were found to benefit more from psychodynamic psychotherapy in contrast to step-down treatment (i.e., outpatient treatment following day hospital treatment), especially within 8-36 months (Gullestad, Johansen, Høglend, Karterud, & Wilberg, 2013). On the other hand, patients with medium-high RF benefited from both treatments, especially for the first 8 months.

Culture and Mentalization

Despite the presence of abundant research and mentalization-focused psychotherapies, mentalization from a cross-cultural perspective has not been studied in detail before. There is only one review study (Aival-Naveh, Rothschild-Yakar, & Kurman, 2019) which examined five mentalization-related concepts which were theory of mind, empathy, perspective-taking (i.e., seeing others' point of view), alexithymia (i.e., inability to identify and describe one's own and others' emotions), and mindfulness (i.e., deliberate and nonjudgmental attention on one's own internal and external experiences in the present moment). This study revealed that individuals in collectivistic cultures have a tendency to attribute behaviors more to external and situational factors than mental states. Individuals from individualistic cultures focus more on their own mental states. On contrast, people from collectivistic countries are more prone to take others' perspectives and empathize with others. Children in collectivistic cultures develop the capacity to understand others' lack of knowledge faster than children in individualistic cultures and before their capacity to understand having diverse beliefs (Selcuk, Brink, Ekerim, & Wellman, 2018). This shows the importance of shared knowledge and mutual understanding which facilitates the harmonious group relations and conformity to authority figures in collectivistic culture. Also, parents' mind-minded comments enhance and fully mediate the link between culture and child's theory of mind (Hughes, Devine, & Wang, 2017). All of these findings support the importance of relatedness and being other-oriented in collectivistic cultures as well as influence of culture on parent and child mentalization.

Turkey has experienced a rapid and substantial transformation from a traditional and patriarchal society to a modern and egalitarian society (Sunar & Okman-Fişek, 2005). Due to these social and political changes, Turkish culture combines both individualistic and collectivistic elements (Göregenli, 1995). While Turkey is high on collectivistic elements such as conservatism, hierarchy, and harmony, it is relatively lower on individualistic elements like autonomy, egalitarianism, and mastery

(Schwartz, 1999). Its sociocultural context is mostly characterized by emotional interdependence, defined with relatedness and strong and close ties among family members (Corapci, Aksan, & Yagmurlu, 2012; Sen, Yavuz-Muren, & Yagmurlu, 2014). Therefore, this cultural structure promotes the children's dependency on parents (Kagitcibasi, 2007; Yagmurlu & Sanson, 2009). While children's loyalty and obedience to their parents are highly valued all the time, their self-assertion has started to be accepted (Kagitcibasi & Ataca, 2005). Parents mostly encourage their child's dependency and control their behaviors. Although they let their child to develop autonomy, they expect emotional closeness from them.

Parents' reactions toward their children's mental states, especially their emotions are related to child's affect regulation (Yagmurlu & Altan, 2010) and prosocial behaviors (Yagmurlu & Sanson, 2009). In general, Turkish parents with lower socioeconomic status and educational attainment de-emphasize their child's autonomy and discourage the expression of negative emotions like anger, sadness, and fear (Altan-Aytun, Yagmurlu, & Yavuz, 2013; Corapci et al, 2012; Nacak et al., 2011). They generally minimize the negative emotions and neglect positive emotions like joy and happiness (Corapci et al., 2012; Ersay, 2014). They never neglect their child's fear. They accept the expression of sadness more than anger. When their child is sad, they empathize with their child and offer distraction or assistance to them. On the other hand, when their child is angry, they generally disapprove and reject this feeling. Cultural differences also have an influence on parents' reactions toward their child's emotion expressions. Corapci and colleagues' cross-cultural study (2017) revealed that Turkish parents generally try to reduce anger-related behaviors via comforting, reassuring, and reasoning. They show more emotional intimacy in case of fear and sadness. In comparison to negative emotions, they try to amplify their child's happiness. Also, parents of school-age children mostly talk about cognitions rather than emotions in the play context and they refer to mental states of their children less as children get older (Halfon, Bekar, Ababay et al., 2017). Parents use of less psychological control like intrusion on adolescents' emotional and psychological

space, invalidation of emotions, love withdrawal, guilt induction, and disrespect to adolescents' identity promotes the interaction and knowledge sharing between them, which in turn reduces problem behaviors and increases prosocial behaviors (Mouratidis, Sayıl, Kumru, Selçuk, & Saonens, 2018).

Aims

The predictor effect of baseline mentalization on therapy outcome has been shown in adult psychotherapies with mixed findings; yet, it has not been investigated in psychodynamic child psychotherapy yet. In the current study, we assessed parental mentalization, operationalized as PRF, via the RF coding system on the PDI, the gold standard to measure parental mentalization. Since PRF has self- and child-focused dimensions, having differential relations to child's behavioral adjustment and psychosocial functioning (Borelli et al., 2016; Smaling et al., 2016; Suchman et al., 2010), we investigated the predictive effect of these dimensions separately. Since child MST has been shown to have significant associations with children's problem behaviors (Halfon, Bekar, Ababay et al., 2017; Halfon, Bekar, Gürleyen, 2017), we operationalized child mentalization as MST. Since assessment of mentalization in attachment context is the best indicator of mentalization capacity (Ensink et al., 2015), we measured MST via an attachment-based story stem task and coded the verbal data from children. Similar to the dimensions of PRF, the direction of the MST has differentially been related to child's behavioral adjustment. Thus, we examined the predictive effect of self- and other-focused MST separately. Since, parental and child mentalization has been shown to be related, we included interactions of these variables into the model. Given the links with mentalization and problem behaviors revealed in the literature, we controlled for demographic factors which were child's age, sex, and linguistic aptitude and parents' educational attainment and distress. We hypothesized that (1) self- and child-focused PRF would predict changes in child's problem behaviors; (2) self- and other-focused MST would predict changes in child's problem behaviors; (3) children who have more reflective parents (self- and child-focused) and

use more MST (self- and other-focused) would show more changes in problem behaviors.

Method

Data

Data came from Istanbul Bilgi University Psychotherapy Research Laboratory, offering psychodynamic psychotherapy with low cost. Parents themselves or outside professionals like medicine made the referrals. A licensed doctoral level clinical psychologist, with over 10 years of clinical experience, and trained in developmental psychopathology and psychiatric interviewing techniques screened the parents and children to determine whether the patients fit the study protocol inclusion criteria. The inclusion criteria were about children's age being between 6-10 years, children being without significant developmental delays, children's and parents' having no psychotic symptoms, risk of suicide attempts, and drug abuse. Out of 80 patients (admitted between Fall 2018-Spring 2019), 69 of them gave consent to the participation to the study and recording of the sessions. Written informed consents were taken from the parents and oral assents were taken from the children. Due to drop-outs during the assessment phase, 9 patients were excluded from the sample. The study got approval by Istanbul Bilgi University Ethics Committee.

The final sample of the current study comprised 60[1] patients, living in Istanbul, the largest metropolitan center in Turkey, with low-middle socioeconomic backgrounds, and mostly intact families (89%). The demographic characteristics of the sample are presented in Table 2.1.

Therapists

The therapists were 26 second- and third-year master's level students in clinical psychology (93% female), whose age ranged from 23 to 27 years old. They received education for two years in psychodynamic play therapy with mentalization principles

[1] This data has the subsample of participants from a larger data, collected at Istanbul Bilgi University Psychotherapy Center. The larger data contains 195 patients (consecutively admitted from Fall 2014-2020). Analyses with different subsamples have been published in separate manuscripts.

(see Verheugt-Pleiter et al., 2008, for details). On average, they had 3 patients (ranging between 1 and 5). Their individual and group supervisions lasted one to two years by licensed psychodynamic supervisors with at least 10 years of experience.

Treatment

At İstanbul Bilgi University Psychological Counseling Center, the treatment focuses on psychodynamic play therapy, following Winnicott's object relations theory (Winnicott, 1971) combined with mentalization principles (see Verheugt-Pleiter et al., 2008, for details). In 50 min sessions, done once in a week, therapist and child work on child's self-other representations and expressions of mental states through play. In addition to individual sessions with children, parents' sessions are conducted once in a month to increase PRF (Slade, 2005). In parent sessions, therapist and parent(s) work on parent(s)'s capacity to reflect on their child's mental states, on their own mental states underlying parenting behaviors, and on the influence of mental states on their relationship. Patients, in general, receive approximately 30 sessions, lasting 10 months (M = 32.83, SD = 16.64, range = 15-65 sessions in the current study).

Therapists follow the treatment principles for adherence in child psychotherapy sessions conducted individually with the child: (1) actively listening and promoting child's interaction, encouraging his/her mental states expression and reflective stance through play, (2) identifying the boundaries of the play context to differentiate the acts aiming to harm from symbolic aggression, (3) asking questions to promote child's thinking about and expression of mental states in play, (4) cautiously interpreting the play context to help the child see the links between one's own and other's conflicting needs and emotions, and (5) identifying repetitive play content to link with child's experiencing in real life.

The parent sessions are conducted individually with the parents. Both parents are encouraged to attend and in case fathers cannot attend, the sessions are conducted individually with the mothers. Therapists focus on the core principles in the parent sessions: (1) reflecting on the parents' and child's issues together with the parents rather than giving suggestions, (2) holding the perspectives of parents in mind and

having an empathic bond to create the feeling of being understood, (3) showing genuine interest in the mental states, not just behaviors, and (4) modeling a reflective stance via showing curiosity and openness about mental states and linking feelings with behaviors especially at times of conflict.

Measures

Background information. Demographic information such as age, education, socioeconomic and marital status were obtained using a standard intake form and from information obtained in the initial intake interview. Maternal education was assessed based on the level of formal education ranging from 0 as being illiterate to 6 having graduate or professional degree.

Expressive language. Turkish Expressive and Receptive Language Test (TİFALDİ; Berument & Güven, 2010) was used to measure expressive language skills of children. This test is the Turkish equivalent of Peabody Picture Vocabulary Test. Cards with a black-and-white picture were shown one-by-one and the child named the picture on the card. The test was administered adaptively, progression depending on performance. The vocabulary knowledge scores were calculated with three-parameter item response theory.

Parenting distress. The Parental Distress (PD) subscale of the Parenting Stress Index-Short Form (PSI-SF; Abidin, 1995) was used to measure parenting stress. The PD subscale yields a score that denotes level of distress from factors such as depression or discord with a partner and from life restrictions because of the demands of child-rearing. The subscale consists of 12 items (e.g., "feel that I cannot handle things", "never able to do things that I like to do"), rated on a 5-point Likert-type scale (from 1 = *'strongly agree'* to 5 = *'strongly disagree'*). The scale has shown high internal consistency (αs ranging from .80 and .91) and good test-retest reliability (rs ranging from .68 to .85). The Turkish adaptation of the scale had good internal consistency (α = 0.71) and test-retest reliability (rs ranging from .88 to .95; Mert, Hallıoğlu, & Ankaralı-Çamdeviren, 2008). The PD subscale showed high internal consistency (α = .89) in this study.

Problem behavior measure. The Child Behavior Checklist (CBCL; Achenbach, 1991) was used to assess children's baseline problem levels completed by the mothers. CBCL, a widely-used method to identify problem behaviors in children, has 112 items rated on a 3-point scale (0 = *"not true"*, 1 = *"somewhat true"*, and 2 = *"very true or often true"*). The checklist gives information about children's problems for internalizing (e.g., depression and anxiety), externalizing (e.g., aggression and violence), or total problems. This scale has high levels of internal consistency (α = .97) and one-week test–retest reliability (r = .94). The Turkish adaptation of the scale had good internal consistency and test-retest reliability for total problems scales (α = .94, r = .93; Erol & Şimşek, 2010). The CBCL Total Problem subscale showed high internal consistency (α = .92) in the current study.

Brief Problem Monitor (BPM; Achenbach, McConaughy, Ivanova, & Rescorla, 2011) is has 19 items, chosen from items included on the comprehensive CBCL (Achenbach, 1991) through item response theory and factor analysis. The BPM uses the same 3-point scale and is applicable to children within the same age-range of CBCL forms. Mothers rate their children's problem behaviors, specifically internalizing (e.g., "self-conscious or easily-embarrassed", "feels too guilty"), externalizing (e.g., "argues a lot", "stubborn, sullen, or irritable"), and attention problems (e.g., "fails to finish tasks s/he starts", "impulsive or acts without thinking"). The scale showed satisfactory internal consistency (α = .74), test-retest reliability in an 8- to 16-day interval (r = .77), and criterion-related validity (Achenbach et al., 2011). In the current study, BPM Total Problem subscale showed good internal consistency (α = .87).

Child mentalization measure. An adapted version of the Attachment Doll Story Completion Task (ASCT; Bretherton, Oppenheim, Buchsbaum, Emde, & the MacArthur Narrative Group, 1990) was used to collect verbal data. For the purposes of this study, ASCTs were not used to classify attachment patterns but to evaluate MST in the attachment context. ASCT was originally designed for 3-year-olds and later adapted to school-age children by Granot and Mayseless (2001). ASCT comprises of

five story-stems 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. The attachment stories are: (1) spilled juice: while the family is seated at dinner table, the child accidentally spills juice on the floor, (2) hurt knee: the child falls off a high rock and hurts his/her knee, (3) monster in the bedroom: the child is sent to bed and cries out that there is a monster in his/her bedroom, (4) departure story: the mother and father leave for a one-week trip and a babysitter stays with the child, and (5) reunion story: the babysitter sees the parents as they return the following morning and announces their return to the child.

We used the Coding System for Mental State Talk in Narratives (CS-MST; see Bekar et al., 2014, for details) to measure the frequency (total number of mental state words) and direction of mental state words used in ASCT narratives. The scale has shown good convergent and divergent validity in predicting children's socio-behavioral functioning (Bekar, Steele, Shahmoon-Shanok, & Steele, 2018), play styles (Halfon, Bekar, Ababay et al., 2017), and psychotherapy progress (Halfon, Bekar, & Gürleyen, 2017). The Turkish adaptation of the CS-MST was first done by Bekar and Corapcı (2016) through Turkish mothers' and their preschoolers' narratives; then, adapted to ASCT narratives by Dr. Özlem Bekar. During the adaptation phase, 25 play segments were coded by Dr. Bekar and a group of four master's level research assistants following a one-day training workshop. An average intraclass correlation coefficient (ICC) of .92 was reached on all coding variables. 25 percent of the randomly selected data was then coded by two independent raters on each of the CS-MST categories, and ICC was between .83 and .99, suggesting good reliability. In case of a difference of three or more counts in any of the mental state word categories, the raters revised their coding and came to an agreement. The remaining transcripts were coded by one of the reliable raters. In this study, we used emotion (e.g., happy and sad) and cognition (e.g. think and believe) categories, which are most frequently associated mental states with children's adaptation (Bekar et al., 2018). The working mechanism of projective measures relies on the assumption that children project their own mental

states onto the main child character in the stories and indirectly talk about their psychic reality. Thus, we operationalized children's attributions to the main child characters' mental states as self-focused MST. Children's representations of the others, such as their narratives about family members' mental states, comprised the other-focused MST.

Parent mentalization measure. PRF was measured via the Parent Development Interview-Revised (PDI-R; Slade et al., 2003) coded according to the Addendum to the Reflective Functioning Scoring Manual (Slade et al., 2005). The PDI-R is a 17-item interview that assesses the parents' representations of their relationships with their child, their own internal experience of parenting, and the child's reactions to normal separations, and routine upsets. An overall PRF score as well individual scores to demand questions (ranging from -1 to 9; 5 indicating the presence of a basic mentalizing capacity; a rudimentary understanding of how mental states work together and influence behavior) were assigned using the manualized guidelines. While lower PRF scores tap refusal, distortions, naivety, and hyperactivity in the usage of RF, higher PRF scores indicate explicit effort in recognition, awareness and acknowledgment of nature and developmental aspects of mental states, including the interviewers' (see Slade et al., 2005, for details).

Studies testing the validity of this measure have linked it to adult attachment, child attachment, and parental behavior both in normal and drug-using samples (Borelli et al., 2016; Slade, Belsky, Aber, & Phelps, 1999; Stacks et al., 2014; Suchman et al., 2010). In a validation study of the PDI, Sleed et al. (2018) reported high interrater reliability (ICC = 0.87), internal consistency for the total RF score (α = .90), and criterion validity. In the current study, all protocols were coded by two research assistants at master's level, who were trained and got reliability on coding the PDI. Interrater reliability for the total RF score was excellent (ICC = .91). We created self and child-focused PRF via taking mean scores of questions tapping into these dimensions. Self-focused PRF measured parent's emotional experiences as a parent (i.e., feelings of pain/difficulty, being needy and angry, and feelings about losing the

child) and their own parents' influences on their parenting. Child-focused PRF measured parent's capacity to reflect on child's upsets, rejections and his/her feelings towards separation. Internal consistencies of self-focused (α = .78) and child-focused PRF (α = .76) were good.

Procedure

The mothers and children were invited for a meeting to administer the research protocol by one of the four master's level research assistants. The mothers were administered the PDI-R, which lasted about 90 minutes. Then, they filled out the standard intake form, the PSI-SF, and the CBCL. The children were individually administered the ASCT and expressive language subscale of TIFALDI in a silent room. Assessments of the ASCT and TIFALDI lasted about 20 and 10 minutes for each child, respectively. All assessments were videotaped, transcribed, and coded for PRF and MST by trained coders. Care was taken so that the assistants who conducted the administration of a particular family did not also complete their coding. The BPMs were filled out by the mothers every five sessions in treatment.

Data Analytic Strategy

The psychotherapy sessions (N = 366) were nested within patients (N = 60), and patients were nested within therapists (N = 26). Thus, a multilevel modeling approach was used with MLwiN version 2.36 (Rasbash, Steele, Browne, & Goldstein, 2016). First, due to shared therapist by multiple clients, we examined the degree of interdependency via two- (sessions nested within patients) and three-level (sessions nested within patients nested within therapists) "empty" multilevel models. In these models, we entered BPM Total Problems as the dependent variable without predictors. The therapist level ICC was found to be .00, *ns.*, revealing therapists having no account on the variance in BPM Total Problems. It means that therapists were not associated with the variance in the session measures. Contrarily, the between patient ICC was .58, $p < .01$ and accounted for 26% of the variance in BPM Total Problems. This showed that the influence of patient characteristics on change in BPM Total Problems. In total, these findings revealed the appropriateness of not three-level, but two-level model

since not only session-level variables but also patient-level variables were attributed to all variance. Thus, we continued with the two-level models, only. Due to the high number of variables, MLM analyses were ran in three steps. First, we ran a simple model to examine the main effects of time. Then, we included our main effect variables. Next, we ran the models including the interaction variables.

We used maximum likelihood (ML) estimation to analyze the change in BPM Total Problems that nested change in time within the patients. To model the linear change in BPM Total Problems throughout treatment, we created a time variable via converting session numbers into phases (1 = 1-5 sessions, 2 = 6-10 sessions, 3 = 11-15 sessions, etc.). Thus, the multilevel modeling (MLM) equation in which the BPM Total Problem score of patient *j* in phase *i* was the outcome was as follows:

Level 1: BPM Total Problems$_{ij} = \beta_{0ij} + \beta_{1j}$*phase$_{ij}$ + e_{ij}

Level 2: $\beta_{0ij} = \beta_0 + u_{0j}$

Next, we included demographic variables (child's age, sex, and age-scaled linguistic aptitude measured via TIFALDI and parental education attainment and distress) and CBCL Total Problem into the model as control variables. To test hypotheses 1 and 2, self- and child-focused PRF and self- and other-focused MST were added as level-2 predictors into the MLM model. All of the variables were grand-mean centered. Thus, the equation described above was as follows:

BPM Total Problems$_{ij}$= $\beta_{0j} + \beta_{1j}$*phase$_{ij}$ + Maternal Education $_j$ + Parental Distress $_j$ + Age $_j$ + Sex $_j$ + Expressive Language $_j$ + CBCL Total Problem $_j$ + Self-focused PRF $_j$ + Child-focused PRF $_j$ + Self-focused MST $_j$ + Other-focused MST $_j$

$\beta_{0ij} = \beta_0 + u_{0j}$; $\beta_{1j} = \beta_1 + u_{1j}$

Finally, we included interactions between PRF (self- and child-focused) and MST (self- and other-focused) variables in order to address Hypothesis 3. Thus, the equation tested was:

BPM Total Problems$_{ij}$= $\beta_{0j} + \beta_{1j}$*phase$_{ij}$ + Maternal Education $_j$ + Parental Distress $_j$ + Age $_j$ + Sex $_j$ + Expressive Language $_j$ + CBCL Total Problem $_j$ + Self-

focused PRF $_j$ + Child-focused PRF $_j$ + Self-focused MST $_j$ + Other-focused MST $_j$ + Self-focused PRF $*$ Self-focused MST $_j$ + Self-focused PRF $*$ Other-focused MST $_j$ + Child-focused PRF $*$ Self-focused MST $_j$ + Child-focused PRF $*$ Other-focused MST $_j$

Results

Descriptive statistics and the inter-correlations between the variables of aggregated BPM Total Problems, demographic variables (child's age, sex, and linguistic aptitude and parents' educational attainment and distress), CBCL Total Problems, PRF, and MST were presented in Table 2.2. Since there were significant links between baseline characteristics (demographic variables and CBCL Total Problems) and main variables (aggregated BPM Total Problems, PRF, and MST), we controlled for them in the main analyses. Since it was related to the hypothesis 3, which was about the predictive effect of interaction between PRF and MST, we investigated their distribution where the higher PRF represented with a score of 3 or higher (indicating a baseline capacity to recognize mental states; Fonagy et al., 1998) and higher MST represented with scores above sample mean. We found that 38.3% of the patients were in low MST-low PRF; 31.7% in low MST-high PRF; 21.7% in high MST-low PRF; and 8.3% in high MST-high PRF categories. Also, the correlation and chi-square tests of independence analyses (χ^2 (1, N = 60) = 1.60, p = .21) indicated no association between PRF and MST categories.

Mixed-effects multilevel models analyses revealed the main effect of time (i.e., phase) on BPM Total Problems, indicating linear decrease (see Table 2.3). Child-focused PRF predicted change in BPM Total Problems, which partially supported the hypothesis 1. Self-focused MST also predicted change in BPM Total Problems, which partially supported the hypothesis 2. Yet, self-focused PRF and other-focused MST were not significant predictors of change in BPM Total Problems. Also, demographic variables were not significant predictors of the change in BPM Total Problems in the model. None of the interactions were found to be significant (see Table 2.4).

Discussion

The aim of the current study was to test the predictive effect of parental (self- and child-focused PRF) and child mentalization (self- and other-focused MST) on the change in child's problem behaviors. Child-focused PRF and self-focused MST predicted change in problem behaviors after controlling for demographic variables (child's age, sex, and linguistic aptitude and parental educational attainment and distress). Yet, self-focused PRF and other-focused MST did not predict the therapy outcome. Also, the predictive effects of interaction between PRF and MST were not significant.

The predictive effect of mentalization on therapy outcome has been only investigated in adult psychotherapies, mostly in psychodynamic adult psychotherapy. Whereas some research revealed the predictive effect of RF on therapy alliance and outcome (Ekeblad et al., 2016; Müller et al., 2006; Taubner et al., 2011), some found its moderation effect on therapy outcome (Antonsen, Johansen, Rø, Kvarstein, & Wilberg, 2016; Gullestad et al., 2013). The current study was the first to investigate and find the predictive effect of parental and child mentalization on therapy outcome in psychodynamic child psychotherapy. Our findings supported the multidimensional structure of parental and child mentalization as well as their differential effects on therapy outcome.

More specifically, we revealed that child-focused but not self-focused PRF predicted change in problem behaviors. The reason can be related to children being in the middle childhood. Borelli and colleagues (2016) showed the association between child-focused but not self-focused PRF and attachment security of school-age children. Middle childhood is the period for children to form their own identity. Thus, in this developmental stage, children's individuality attempts increase and they spend less time with their parents (Borelli et al., 2016). These attempts can need parents to worry about their child's experiences and psychosocial functioning. Therefore, they can make more effort to understand their child's mental states, especially their negative emotions such as separation, upset, and rejection, measured via PDI. These efforts can

validate child's individuality attempts and help them develop feeling of being understood by their parents. In turn, their problem behaviors can decrease. On the other hand, these individuality attempts can be related to parents' more reflection upon their own mental states, risking parents' self-absorption. For example, parents with depression experience difficulties in attending their child's needs and soothing them to reduce their distress (Borelli et al., 2012; Suchman et al. 2010). Thus, self-focused PRF is a risk factor for children's negative emotionality and externalizing problems (Smaling et al., 2016). It can be assumed that children with problem behaviors can experience more difficulty, as a result, increase their acting-out behaviors to regain the attention of their self-absorbed parents. Since our sample consists of children with externalizing and comorbid problems, they might benefit more from child-focused PRF, but not self-focused PRF. In the future research, the differential associations of self- and child-focused PRF on different developmental aspects and problem behaviors should be investigated.

Moreover, in the current study, child mentalization about their own mental states (a.k.a., self-focused MST) predicted change in problem behaviors. Self-focused MST was assessed via a story-stem task, requiring the child to think about the mental states in attachment-related context which evoke negative emotions of fear, hurt, upset, and separations. If children can mentalize about such negative emotions related to attachment, they can benefit more from psychodynamic psychotherapy since it requires children to think about and reflect upon their own difficult emotions. The mentalization capacity to reflect upon these difficult emotions in attachment context can be more prognostic than other mental states since these emotions are strongly associated with children's internalizing and externalizing problems (see Groh, Fearon, van IJzendoorn, Bakermans-Kranenburg, & Roisman, 2017, for a review). Thus, the mentalization capacity solely related to such negative emotional experiences should be examined. Studies investigating symptom-specific RF demonstrated its difference with general RF in patients with different disorders like OCD, depression, and panic

disorder. For example, some patients with average level of RF capacity had impaired capacity to specifically reflect about their symptoms (Kullgard, Persson, Möller, Falkenström, & Holmqvist, 2013; Rudden et al., 2006). In the future, a developmentally appropriate symptom-specific interview can be developed for children to measure the relations between their negative emotional experiences and therapy outcome.

Yet, other-focused MST did not predict therapy outcome. In comparison to other-understanding, self-understanding is a more complex achievement (Bodgan, 2003). Infants make sense of their inner experiences through sensitivity and attunement of their parents. Parents verbalize their children's inner experiences and children match their inner experiences with their parents' expressions. As a result, they learn to label and understand their own mental states (self-focus and understanding; Fonagy et al., 2002). In other words, children's meaning making about their own mental states develops through their parents' mind. Also, self- and other-focused mentalization are related with different kind of deficits. For example, children with internalizing problems are good at understanding others' state of mind, yet experience specific deficits in understanding their own mental states (Bizzi et al., 2019). In other words, self-focused child mentalization might be more prognostic in psychodynamic child psychotherapy.

The interactions between PRF and MST were not significant and did not have any predictive effect on therapy outcome. Studies in mentalization literature demonstrated indirect link of PRF with child mentalization and problem behaviors through attachment (Ha et al., 2011), abuse (Ensink et al., 2015), and parenting behaviors like sensitivity (Suchman et al., 2010). The effect of these mediating factors on change in problem behaviors should be assessed in the future research. Also, in our sample, there was only a small percentage of children who had both higher level of PRF and MST, probably causing no association in comparison of different groups. Limited literature revealed no significant relation between parental and child mentalization in middle childhood (Ensink, Bégin et al., 2016). It suggests that

children with better mentalization capacities become more independent from PRF with time. Yet, research with larger sample size should be conducted to compare high and low mentalization groups to determine which group benefit more from which type of therapy.

Clinical Implications

Our findings suggest the use of PDI and attachment-based story stems to measure parental and child mentalization profiles (Midgley et al., 2017), particularly focusing on child-focused PRF and self-focused MST characteristics. Global and item-specific assessment of parental mentalization deficits can be done via the PDI. For example, it would be more informative to investigate whether parents show global deficits on all child-related questions on the PDI. If so, this could suggest parents' underdeveloped capacity to reflect upon child's mental states. Also, in some cases, parents' mentalization deficits can be related to specific situations. They can have generally intact reflective capacity about their child's mental states, yet experience difficulty in reflecting on certain child-related PDI questions like either about rejections, upsets, or separations. This would imply parents' loss of their mentalization capacity under certain stressful contexts. In such cases, detecting these difficulties and working on them at the initial stages of psychotherapy would help children with treatment prognosis. The global and specific deficits should be held differently in psychotherapy. In case of parents' global mentalization deficits, it might be important to first help parents to develop a reflective stance (Slade, 2007) since these parents lack the capacity to see their child's state of mind. Thus, therapists can model reflectiveness through representing the mental states of the child in the therapy session. They can start with child's negative behaviors and together they can try to understand mental states underlying these behaviors. Also, they can talk about the impact of these behaviors and mental states on parents' own state of mind. Parents' focus on their own mental states can help them feel more validated and understood. After these feelings, they can feel ready to reflect upon their own child's mental states. Therapists can also work on parents' own childhood experiences and together they can explore parents'

experiences of being parented as a child. With this way, their curiosity about their child's mental states can increase and they can empathize with them. If mentalization deficits are specific to certain situations of rejections, upsets, and/or separations, these events should be worked on to understand and control the triggering emotional states. The "stop and rewind" technique in mentalization-based treatment for children (MBT-C; Midgley et al. 2017, p.154-155) can be used to increase parents' control during these emotions. Firstly, therapists should slow down the parents, then ask detailed questions about the specific features of the interaction with the child to detect the certain moments and related strong emotions that lead to parents to lose their mentalization capacity. This technique would help parents to regain their reflective stance against these strong emotions.

The attachment-based story-stems can be used to assess child mentalization deficits. If any mentalization deficit is detected, then therapists should support child mentalization at the initial stages of psychotherapy. This assessment can be done in play context where the child is expected to talk about the mental states of the child figure (which represents the child's own mental states) in the story-stems. In addition to MST, therapists should be alert about whether the child can enter to the play, which is the key aspect of symbolic thinking and mentalization (Fonagy et al., 2002). Global mentalization deficits of children would imply that they cannot enter to the pretend mode or experience hard times to attribute mental states to play characters' behaviors. If so, in addition to story-stems, an extensive assessment should be done with other measures to assess child's attention-control and self-regulation capacities. If children have any problem in attention-control and self-regulation, they would experience hard time to create a play space and attend to characters' mental states. Then, therapists' primary aim should be on enhancing these capacities, especially at the initial stages of the psychotherapy. They should try to clarify and verbalize the mental states of the play figures. In addition to global deficits, children may experience difficulty in certain story-stems which are triggering separation anxiety, hurt, or fears of punishment. If so, these triggers and certain contexts should be explored in a detailed way. If necessary,

these certain situations can be learned with the help of parents. After learning the triggers, the technique of "stimulate the play narrative" in MBT-C (Midgley et al., 2017, p.135) can be used. In this technique, therapists facilitate child's use of MST via asking more questions about details of the play characters' mental states who may encounter similar stressful situations in the play narrative.

Cultural Implications

Our findings revealed the predictive value of mentalization about child's mental states and behaviors on the change in problem behaviors as therapy outcome. Psychodynamic child psychotherapy works on enhancing children's self-knowledge and self-agency via focusing on their own ability to verbally express their mental states and regulate their intense emotions (Verheugt-Pleiter et al., 2008). Therefore, children's mentalization about their own mental states are crucial in treatment. Also, parents' capacity to see their child as a psychological agent in parent-child interaction is critical for children's socio-emotional outcomes (Sharp et al., 2018). The treatment is effective when it is designed according to child-specific factors. Though these can be accepted as universal aspects, our finding is also important in Turkish context.

Turkey combines both individualistic and collectivistic elements (Göregenli, 1995; Sunar & Okman-Fişek, 2005). In the Turkish socio-cultural context, economic independence and emotional interdependence are important factors (Kagitcibasi & Ataca, 2005). Turkish parents encourage their child's autonomy in economic realm while expecting the continuation of their emotional closeness with them. Children have more psychological value in Turkish context than utilitarian value. Thus, in parent-child interaction, the relatedness and close ties among family members are crucial (Corapci et al., 2012; Sen et al., 2014). Parents expect their child's loyalty and emotional dependency to themselves. In daily family activities, they can make more elaborate and reflective conversations with their children (Keller, 2011). On the other hand, they can discourage child's autonomy and expression of negative emotions such as fear, sadness, and anger if they challenge this harmony (Kagitcibasi, 2007; Yagmurlu & Sanson, 2009). Middle childhood is an important developmental stage in

this respect. Children's attempts of individuality and identity formation increases in middle childhood (Borelli et al., 2016). They spend more time outside parent-child interaction. These attempts are challenges for parents' value on relatedness and can induce separation feelings, which are hard for Turkish parents to contain. Parents can increase their control in parent-child interaction, which decreases the knowledge sharing among them and increases child's problem behaviors (Mouratidis et al., 2018).

As a result, therapists should be aware of and sensitive to the cultural norms and values in therapeutic context (Aival-Naveh et al., 2019). In psychodynamic child psychotherapy, therapists can assess and work on Turkish parents' attributions about their child's more negative feelings, especially the ones evoking separation feelings in attachment context. They can get more detailed information about parents' separation experiences with their children. For example, they can assess parents' reflective capacity via asking questions about their child's interaction with their friends. They should especially work on encouraging parents to be interested in and curious about their child's mental states. Therapist should help parents understand their child without deeply focusing on their own inner experiences, but giving credit to opaqueness of mental states. Rather than letting parents to distance themselves from their child, therapist can discuss the structure and give support to parents about how to interact with their child in an open and honest way as well as facilitate their child's autonomy (Mouratidis et al., 2018). Therapist can work on the need to create a clear guideline for appropriate behavior and give freedom to children. Most importantly, therapist should not forget that these topics are sensitive for Turkish mothers; thus, they should just invite them to discuss these topics (Aival-Naveh et al., 2019).

Limitations and Directions for Future Research

Its longitudinal design and use of different measures (as interview- and observation-based tools) to assess mentalization of parents and their children were the strengths of the current study. We found different dimensions of mentalization, tapping the self-other distinction (Fonagy et al., 1998; Luyten & Fonagy, 2014). The self- and child-focused PRF dimensions had higher internal consistency scores compared to

prior studies (i.e., Borelli et al., 2016; Suchman et al., 2010), supporting the reliability of these dimensions. Also, our findings were the first to reveal the predictive value of mentalization on treatment prognosis in psychodynamic child psychotherapy. Yet, there were some limitations of this study. Firstly, despite the good amount of total number of sessions, the sample size of the participants was relatively small. Thus, an improved methodology should be conducted with a larger sample size. Also, due to small sample size, we could not have extensively investigated the association between different characteristics of mentalization and problem behaviors by dividing the data into different groups. This association can be investigated in future studies. This study did not have any control group since it was designed as a naturalistic study. Even though the design is limited for internal validity, it accurately reflects the reality in treatment work in psychodynamic child psychotherapy, increasing the external validity. However, it still prevents the use of causal links between mentalization and therapy outcome. Moreover, the therapists were not the experienced ones but graduate students and we collected PRF information only from mothers, but not fathers, all limiting the generalizability of the findings. In the future, the sustainability of therapy benefits over time and their relation with mentalization characteristics should be investigated in a follow-up study.

The assessment tools of the current study also had some limitations. We assessed parental mentalization via an interview-based measurement tool, which extensively depends on parents' verbal expressions and narrative organization. Therefore, it only allows the assessment of explicit mentalization. There are some tools to assess implicit mentalization without depending on verbal expressions like parental embodied mentalizing (Shai & Belsky, 2011) and self-awareness (Fogel, 2011), related to children's problem behaviors. Also, we measured child mentalization via a play-based attachment task. Research has revealed the differential influence of structured and unstructured contexts on the use of MST (e.g., Beeghly, Bretherton, & Mervis, 1986; Kuersten-Hogan & McHale, 2000). We assessed child mentalization in structured context. The play-based tasks are generally good at investigating

attachment-related constructs since they create a buffer between reality and symbolic world. Yet, it gives more opportunity to reflect on child figure than other play characters, limiting the other-focused MST. Also, direction in these tasks can be confusing since children can also make references to their own and therapists' mental states other than play characters. These limitations can be referred as mentalization deficits. Yet, middle childhood is a transitional stage from pretend play to board game. Therefore, older children can get bored with this tool. Yet, children may perform differently in interview-based tasks like CRF. Therefore, it would be good to measure PRF and MST of school-age children with different tools in the future studies. We also assessed children's problem behaviors via parent-reports. Thus, future studies can collect data from different informants like therapist, parent, child, and teachers.

Studies in psychodynamic adult psychotherapy demonstrated the relation between mentalization and therapeutic alliance. More specifically, Ekeblad et al. (2016) and Taubner et al. (2011) revealed an inverse association between patients' RF and therapeutic alliance with their therapists since they have difficulties in expressing their emotions and thoughts, which is a must in psychotherapy. Also, patients with low level of RF generally have insecure attachment (Fonagy et al., 1991), which limits their capacity to emotionally bond with their therapists. Also, insecurely attached individuals with low level of RF get dysregulated easily when there are strong attachment-related emotions. Therefore, future research should focus on the association between mentalization and therapy outcome, mediated through children's therapeutic alliance and child's affect regulation. In the current study, we investigated only baseline level of parental and child mentalization. However, some of the studies demonstrated change in mentalization capacity in psychodynamic adult psychotherapy literature. For example, gain in parental mentalization is associated with decrease in child's problem behaviors throughout therapy sessions (Oppenheim et al., 2004; Zimmer-Gembeck et al., 2019), an association only found in psychodynamic adult psychotherapy, but not in CBT (Katznelson et al., 2019). Also, the gains in child mentalization like affect attunement and linking between experiences and emotions

over time in psychodynamic child psychotherapy influence child's affect regulation, especially tolerance towards negative emotions via creating safe context, which in turn, influences development in psychosocial functioning (Halfon & Bulut, 2019; Halfon, Yılmaz, & Çavdar, 2019). Therefore, future studies should also investigate the predictive effect of change in mentalization on therapy outcome in different modalities.

This study was the first study to investigate parental and child mentalization in the context of psychodynamic child psychotherapy, assessing their predictive value on change in problem behaviors as therapy outcome. Our findings suggest the use of multidimensional tools to assess different dimensions of parental and child mentalization at the beginning of psychodynamic child psychotherapy. This would help to therapists to determine patient characteristics associated with therapy outcome and adapt specific interventions according to the mentalization deficits.

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Table 2.1

Demographic Information of the Sample (*N* = 60)

Age (years): *N* (%)	
6-7 years old	24 (40.0)
8-10 years old	36 (60.0)
Mean (*SD*)	7.90 (1.35)
Median	8.00
Sex: *N* (%)	
Female	26 (43.3)
Male	34 (56.7)
Referral Reason: *N* (%)	
Externalizing complaints like rule-breaking and aggression	23 (39.0)
Internalizing complaints like anxiety and depression	22 (37.3)
Problems related to school	12 (20.3)
Problems in social relations	2 (3.4)
Clinical Characteristics: CBCL[a], *N* (%)	
Internalizing problems	11 (18.3)
Externalizing problems	3 (5.0)
Comorbid problems	34 (56.7)
Non-clinical range	12 (20.0)
Monthly Gross Income[b]: *N* (%)	
Less than 500 USD	11 (18.6)
500-680 USD	40 (67.8)
More than 680 USD	8 (13.6)
Mean (*SD*)	608.98 (173.78)
Median	681.13
Parental Educational Attainment: *N* (%)	
Primary/middle school	16 (28.1)

High school	20 (35.1)
Bachelor's degree or higher	21 (36.8)

Notes. CBCL = The Child Behavior Checklist. Sex was dummy-coded (0 = female, 1 = male).

[a]Cutoff criteria for CBCL = T score < 60: Non-clinical, 60 ≤ T score Borderline or Clinical Range (Achenbach, 1991).

[b]Converted to USD.

Table 2.2

The Inter-Correlations between Demographic and Symptom Characteristics, Parental Distress, PRF, and MST (*N* = 60)

Variables	*M*	*SD*	1	2	3	4	5	6	7	8	9	10
(1) Child Age	7.90	1.35	-									
(2) Child Sex	.57	.50	.16	-								
(3) Child Linguistic Aptitude	112.48	18.91	.10	.30*	-							
(4) Parental Educational Attainment	3.23	1.50	-.01	.26*	.09	-						
(5) Parental Distress	28.95	9.24	-.32*	.05	-.15	-.24	-					
(6) CBCL Total Problem	64.72	8.82	-.13	-.12	-.28*	-.23	.43***	-				
(7) Self-focused MST	13.82	9.60	.29*	-.04	.19	.26*	-.14	-.17	-			
(8) Other-focused MST	3.48	3.98	.13	-.17	.21	.12	-.11	-.33*	.53***	-		
(9) Self-focused PRF	2.97	.90	.06	.19	.14	.34**	.22	.08	.01	-.09	-	
(10) Child-focused PRF	2.67	1.05	-.03	.15	.12	.28*	.19	.02	.02	-.03	.63***	-
(11) BPM Total Problem	62.5	7.24	-.14	-.20	-.16	-.15	.38**	.74***	-.28*	-.29*	.11	-.07

Notes. CBCL = Child Behavior Checklist; MST = Mental State Talk; PRF = Parental Reflective Function; BPM = Brief Problem Monitor. BPM Total Problem score was aggregated across sessions per each child. Sex was dummy-coded (0 = female, 1 = male).

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

Table 2.3

Summary of Multilevel Model Predicting BPM Total Problem Behaviors, Parental and Children's Mentalization

	BPM Total Problems			
Intercept and Predictors	β	*SE*	*t*-ratio	95 % CI
Intercept (β_{00})	15.061	.384	39.221***	14.308; 15.814
Phase (β_{10})	-.135	.086	-1.570*	-.304; .034
Parental Educational Attainment (β_{01})	.405	.384	1.054	-.348; 1.158
Parental Distress (β_{02})	.063	.068	.926	-.070; .196
Child Age (β_{03})	-.080	.419	-.191	-.901; .741
Child Sex (β_{04})	-.881	1.061	-.830	-2.961; 1.199
Child Linguistic Aptitude (β_{05})	.030	.028	1.071	-.025; .085
CBCL Total Problem (β_{06})	.147	.023	6.391***	.102; .192
Self-focused PRF (β_{07})	.699	.652	1.072	-.579; 1.977
Child-focused PRF (β_{08})	-1.057	.574	-1.841*	-2.182; .068
Self-focused MST (β_{09})	-.128	.063	-2.031*	-.251; -.005
Other-focused MST (β_{10})	-.034	.148	-.230	-.324; .256

Notes. BPM = Brief Problem Monitor; CBCL = Child Behavior Checklist; PRF = Parental Reflective Function; MST = Mental State Talk. BPM Total Problem score was aggregated across sessions per each child. Sex was dummy-coded (0 = female, 1 = male). *$p < .05$, **$p < .01$, ***$p < .001$.

Table 2.4

Summary of Multilevel Model Predicting Children's BPM Total Problem Behaviors, Parental and Child Mentalization and their Interactions

	BPM Total Problems			
Intercept and Predictors	β	*SE*	*t*-ratio	95 % CI
Intercept (β_{00})	15.033	.488	30.805**	14.077; 15.989
Phase (β_{10})	-.134	.086	-1.558	-.303; .035
Parental Educational Attainment (β_{01})	.316	.394	.802	-.456; 1.088
Parental Distress (β_{02})	.065	.070	.929	-.072; .202
Child Age (β_{03})	-.131	.421	-.311	-.956; .694
Child Sex (β_{04})	-.645	1.196	-.539	-2.989; 1.699
Child Linguistic Aptitude (β_{05})	.029	.028	1.036	-.026; .084
CBCL Total Problem (β_{06})	.148	.023	6.434***	.103; .193
Self-focused PRF (β_{07})	.566	.803	.705	-1.008; 2.140
Child-focused PRF (β_{08})	-.979	.592	-1.653*	-2.139; .181
Self-focused MST (β_{09})	-.137	.062	-2.210*	-.259; -.015
Other-focused MST (β_{10})	-.017	.163	-.104	-.336; .302
Self-focused PRF X Self-focused MST (β_{11})	.004	.072	.056	-.137; .145
Self-focused PRF X Other-focused MST (β_{12})	-.301	.361	-.086	-1.009; .407

Child-focused PRF X Self-focused MST (β_{13})	-.023	.081	-.284	-.182; .136
Child-focused PRF X Other-focused MST (β_{14})	.254	.240	1.058	-.216; .724

Notes. BPM = Brief Problem Monitor; CBCL = Child Behavior Checklist; PRF = Parental Reflective Function; MST = Mental State Talk. BPM Total Problem score was aggregated across sessions per each child. Sex was dummy-coded (0 = female, 1 = male). *$p < .05$, **$p < .01$, ***$p < .001$

CHAPTER 4
DISCUSSION

In the thesis, the aim was to examine the parental mentalization in Turkish context and its relation with parent, child, and therapy-related characteristics. Recently, in clinical psychology and psychotherapy research, the focus has been on the mentalization (Ekeblad et al, 2016). Yet, there has been a gap in parental mentalization research in Turkey and psychodynamic child psychotherapy.

The first article in the thesis investigated the psychometric properties of the RF coding system on the PDI with a Turkish clinical sample. The PDI assesses PRF via parents' talk about their reflection on the mental states of their own and child as well as the relationship between them. The findings of the study revealed the dimensions of self- (PRF about own feelings), child- (PRF about child's feelings), and relation-focused PRF (PRF about mother-child relationship). The PRF dimensions and its overall score had good internal consistencies and external validity. Self-focused PRF was related to the number of children in the family and child's expressive language, affect regulation, and externalizing problems. Child-focused PRF was inversely associated with socioeconomic status. Relation-focused PRF was associated to parents' attachment organization (both anxious and avoidant attachment styles), education level, socioeconomic status, number of children in the family, and child's positive and adverse experiences. Among the PRF dimension, relation-focused PRF had the best psychometric properties as being associated with most of the parent and child characteristics, supporting the PRF as being interpersonal construct and the importance of relatedness in Turkey. On the other hand, child-focused PRF was not associated with any parent and child characteristics aside from socioeconomic status. Thus, some modifications should be done to improve the dimension of child-focused PRF.

The second article in the thesis examined the predictive value of baseline self- and child-focused PRF and child's self- and other-focused MST on the changes in children's emotional and behavioral problems. Analyses of the longitudinal study revealed that child-focused PRF and self-focused MST, in other words, parents' and

child's mentalization about child's mental states predicted the changes in total problem behaviors in psychodynamic child psychotherapy. These findings are important since they fill the gap in the association between mentalization and therapy outcome in psychodynamic child psychotherapy. Moreover, the findings indicate the importance of mentalization on the child's mental states in therapeutic context.

To conclude, the studies in the thesis supported the multidimensional structure of PRF and the differential associations of PRF dimensions with parent, child, and therapy-related characteristics. This shows the importance of the investigation of mentalization as a multidimensional construct in future research. These studies also fill important gaps in the clinical psychology and psychotherapy literature. Both of them expands in the knowledge on the importance of the parental mentalization in school-age children. The first study brings the RF coding system on the PDI to be used for clinical samples by researchers and clinicians in Turkey. It also expands the PRF literature in terms of investigating the psychometric properties of the RF coding system on the PDI beyond socio-demographic variables. The second study also extends the literature in terms of investigating the influence of mentalization in psychodynamic psychotherapy as well as being the first to investigate it in child psychotherapy.

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APPENDICES

Appendix A: Intake Form

Medeni Durum: ☐Evli ☐Bekar/Boşanmış/Ayrı/Dul

Annenin Adı Soyadı:

Anne Yaşı:

Annenin Eğitimi: ☐Okula Gitmedi ☐İlkokul ☐Ortaokul ☐Lise

☐Üniversite (2 yıllık) ☐Üniversite (4 yıllık) ☐Mastır/Doktora

Anne Çalışıyor mu? ☐Evet ☐Hayır

Annenin Mesleği:

Babanın Adı Soyadı:

Baba Yaşı:

Babanın Eğitimi: ☐Okula Gitmedi ☐İlkokul ☐Ortaokul ☐ Lise

☐Üniversite (2 yıllık) ☐Üniversite (4 yıllık) ☐Mastır/Doktora

Baba Çalışıyor mu? ☐Evet ☐Hayır

Babanın Mesleği:

Kardeşi var mı? ☐Evet ☐Hayır

Kardeşlerin yaşları:

Appendix B: Parent Development Interview

Bugün, siz ve çocuğunuz hakkında konuşacağız. Öncelikle çocuğunuz ve onunla ilişkinizden başlayıp sonra biraz sizin kendi çocukluk deneyimlerinizle devam edeceğiz.

Çocuk Hakkındaki Görüşler

1. Öncelikle, çocuğunuzun nasıl biri olduğuna dair biraz fikir sahibi olmak istiyorum. Çocuğunuzu tarif eden 3 sıfat/tanım/kelime seçerek başlayabilir miyiz? (Ebeveyn sıfatları sıralarken bekleyin.) Şimdi her sıfatın üzerinden geçelim. _____ ile ilgili aklınıza gelen herhangi bir olay ya da anı var mı? (Her sıfatı inceleyip, o sıfat hakkında belirli bir anı öğrenin.)

2. Peki, şimdi çocuğunuza dönelim... Tipik bir haftada, onun yapmaktan hoşlandığı, vaktini ayırdığı şeyler nelerdir?

3. Ve en fazla problem yaşadığı şeyler nelerdir?

4. Çocuğunuzda en çok ne hoşunuza gidiyor?

5. Çocuğunuzda en az hoşlandığınız şey nedir?

Çocuk ile İlişkisi Hakkındaki Görüşler

1. Çocuğunuzla olan ilişkinizi yansıttığını düşündüğünüz 3 sıfat/tanım/kelime seçmenizi rica ediyorum. (Sıfatları sıralarken bekleyin.) Şimdi de bu sıfatların üzerinden geçelim. _____ ile ilgili aklınıza gelen herhangi bir olay ya da anı var mı? (Her sıfatı inceleyip, o sıfat hakkında belirli bir anı öğrenin.)

2. Son bir hafta içinde, çocuğunuzla gerçekten iyi anlaştığınız bir anı anlatabilir

misiniz? (Gerekirse şu sorular eklenebilir: Bana bu anıdan biraz daha bahsedebilir misiniz? Siz nasıl hissettiniz? Sizce çocuğunuz nasıl hissetti?)

3. Şimdi de son bir hafta içerisinde çocuğunuzla iyi anlaşmadığınız bir anı anlatır mısınız? (Gerekirse şu sorular eklenebilir: Bana bu anıdan biraz daha bahsedebilir misiniz? Siz nasıl hissettiniz? Sizce çocuğunuz nasıl hissetti?)

4. Çocuğunuzla olan ilişkiniz, onun gelişimini ya da kişiliğini nasıl etkiliyor sizce?

Ebeveynlikte Duygusal Deneyim

1. Bir anne/baba olarak kendinizi tanımlayabilir misiniz?

2. Anne/baba olarak size en çok zevk veren şey nedir?

3. Anne/baba olarak sizi en çok zorlayan ya da size en çok acı veren şey nedir?

4. Çocuğunuzla ilgili endişelendiğinizde en çok nelerden endişe duyuyorsunuz?

5. Çocuğunuzun olması sizi nasıl değiştirdi?

6. Son 1-2 hafta içinde, bir anne/baba olarak öfkeli hissettiğiniz bir zamanı anlatır mısınız? (Gerekirse şu sorular eklenebilir: Ne tip durumlar sizi böyle hissettirir? Bu öfke duygularıyla nasıl başa çıkarsınız?)

6a. Bu duygular, çocuğunuzu nasıl etkiliyor?

7. Son 1-2 hafta içinde, bir anne/baba olarak kendinizi suçlu hissettiğiniz bir anı anlatır mısınız? (Gerekirse şu sorular eklenebilir: Ne tip durumlar sizi böyle hissettirir? Bu suçluluk duygularıyla nasıl başa çıkarsınız?)

7a. Bu duygular, çocuğunuzda nasıl bir etki uyandırıyor?

8. Son 1-2 hafta içinde, birinin size bakmasına (bakım vermesine) ihtiyaç duyduğunuz bir zamanı anlatır mısınız? (Gerekirse şu sorular eklenebilir: Ne tip durumlar sizi böyle hissettirir? Bu ihtiyaçla nasıl başa çıkarsınız?)

8a. Bu duygular, çocuğunuzu nasıl etkiliyor?

9. Çocuğunuz üzgün olduğunda ne yapar? Bu *sizi* nasıl hissettirir? Bu zamanlarda siz ne yaparsınız?

10. Çocuğunuzun, kendini hiç reddedilmiş hissettiği olur mu?

D. Ebeveynin Aile Öyküsü

Şimdi size, sizin anneniz ile babanız ile ilgili bazı sorular sormak istiyorum. Ve çocukluk deneyimlerinizin sizin ebeveynliğe dair hislerinizi nasıl etkilediğini öğrenmek istiyorum.

1. Yetiştirilme şeklinizin, sizin anne/baba olmanızı nasıl etkilediğini düşünüyorsunuz?

2. Bir ebeveyn olarak, ne açılardan anneniz gibi olmayı istersiniz ve ne açılardan bunu istemezsiniz? (sorunun ikinci kısmını atlarsa tekrar sorulur)

3. Peki ne açılardan babanız gibi olmayı istersiniz ve de istemezsiniz? (sorunun ikinci kısmını atlarsa tekrar sorulur)

4. Bir ebeveyn olarak annenize benzeyen ve benzemeyen yanlarınız neler? (sorunun ikinci kısmını atlarsa tekrar sorulur)

5. Bir ebeveyn olarak babanıza benzeyen ve benzemeyen yanlarınız neler? (sorunun ikinci kısmını atlarsa tekrar sorulur)

E. Ayrılık/Kayıp

1. Şimdi de çocuğunuzla birlikte olmadığınız, ayrı olduğunuz bir zamanı düşünmenizi rica ediyorum. Bunu bana anlatır mısınız? Bu çocuğunuzu nasıl etkiledi? Sizi nasıl etkiledi? (Not: Eğer ebeveyn yakın zamanda (bir sene içinde) yaşanmış bir ayrılığı anlatmazsa, soruyu, yakın zamanlardaki ayrılıkları sorarak tekrar edin.)

2. Bugüne dek, çocuğunuzun hayatında onu biraz olsun kaybetmekte olduğunuzu hissettiğiniz bir zaman var mı? Bu sizin için nasıl bir histi?

3. Sizin için çok önemli olan çocuğunuzun tanımadığı, ama "keşke çocuğum onunla yakın olsa" dediğiniz biri var mı?

4. Çocuğunuzun hayatında ona engel oluşturacak deneyimler var mı sizce?

F. Geriye ve İleriye Bakış

1. Çocuğunuz şimdi _____ yaşında ve siz deneyimli bir annesiniz/babasınız (Uygun şekilde değiştirin). Tüm bu deneyimi en baştan yeniden yaşasaydınız, neleri değiştirirdiniz? Neleri değiştirmezdiniz?

Appendix C: Experiences in Close Relationships-Revised

Aşağıdaki maddeler romantik ilişkilerinizde hissettiğiniz duygularla ilgilidir. Maddelerde sözü geçen "birlikte olduğum kişi" ifadesi ile romantik ilişkide bulunduğunuz kişi kastedilmektedir. Eğer hâlihazırda bir romantik ilişki içerisinde değilseniz, aşağıdaki maddeleri bir ilişki içinde olduğunuzu varsayarak cevaplandırınız. Her bir maddenin ilişkilerinizdeki duygu ve düşüncelerinizi ne oranda yansıttığını karsılarındaki 7 aralıklı ölçek üzerinde, ilgili rakam üzerine çarpı (X) koyarak gösteriniz.

Eksiksiz doldurduğunuzdan emin olunuz. Teşekkürler.

1----------2----------3----------4----------5----------6----------7 Hiç katılmıyorum			Kararsızım/ fikrim yok				Tamamen katılıyorum
1. Birlikte olduğum kişinin sevgisini kaybetmekten korkarım.	**1**	**2**	**3**	**4**	**5**	**6**	**7**
2. Gerçekte ne hissettiğimi birlikte olduğum kişiye göstermemeyi tercih ederim.	**1**	**2**	**3**	**4**	**5**	**6**	**7**
3. Sıklıkla, birlikte olduğum kişinin artık benimle olmak istemeyeceği korkusuna kapılırım.	**1**	**2**	**3**	**4**	**5**	**6**	**7**
4. Özel duygu ve düşüncelerimi birlikte olduğum kişiyle paylaşmak konusunda kendimi rahat hissederim.	**1**	**2**	**3**	**4**	**5**	**6**	**7**

5. Sıklıkla, birlikte olduğum kişinin beni gerçekten sevmediği kaygısına kapılırım.	**1**	**2**	**3**	**4**	**5**	**6**	**7**
6. Romantik ilişkide olduğum kişilere güvenip dayanmak konusunda kendimi rahat bırakmakta zorlanırım.	**1**	**2**	**3**	**4**	**5**	**6**	**7**
7. Romantik ilişkide olduğum kişilerin beni, benim onları önemsediğim kadar önemsemeyeceklerinden endişe duyarım.	**1**	**2**	**3**	**4**	**5**	**6**	**7**
8. Romantik ilişkide olduğum kişilere yakın olma konusunda çok rahatımdır.	**1**	**2**	**3**	**4**	**5**	**6**	**7**
9. Sıklıkla, birlikte olduğum kişinin bana duyduğu hislerin benim ona duyduğum hisler kadar güçlü olmasını isterim.	**1**	**2**	**3**	**4**	**5**	**6**	**7**
10. Romantik ilişkide olduğum kişilere açılma konusunda kendimi rahat hissetmem.	**1**	**2**	**3**	**4**	**5**	**6**	**7**
11. İlişkilerimi kafama çok takarım.	**1**	**2**	**3**	**4**	**5**	**6**	**7**
12. Romantik ilişkide olduğum kişilere fazla yakın olmamayı tercih ederim.	**1**	**2**	**3**	**4**	**5**	**6**	**7**
13. Benden uzakta olduğunda, birlikte olduğum kişinin başka	**1**	**2**	**3**	**4**	**5**	**6**	**7**

	birine ilgi duyabileceği korkusuna kapılırım.						
14.	Romantik ilişkide olduğum kişi benimle çok yakın olmak istediğinde rahatsızlık duyarım.	**1**	**2**	**3**	**4**	**5**	**6**	**7**
15.	Romantik ilişkide olduğum kişilere duygularımı gösterdiğimde, onların benim için aynı şeyleri hissetmeyeceğinden korkarım.	**1**	**2**	**3**	**4**	**5**	**6**	**7**
16.	Birlikte olduğum kişiyle kolayca yakınlaşabilirim.	**1**	**2**	**3**	**4**	**5**	**6**	**7**
17.	Birlikte olduğum kişinin beni terk edeceğinden pek endişe duymam.	**1**	**2**	**3**	**4**	**5**	**6**	**7**
18.	Birlikte olduğum kişiyle yakınlaşmak bana zor gelmez.	**1**	**2**	**3**	**4**	**5**	**6**	**7**
19.	Romantik ilişkide olduğum kişi kendimden şüphe etmeme neden olur.	**1**	**2**	**3**	**4**	**5**	**6**	**7**
20.	Genellikle, birlikte olduğum kişiyle sorunlarımı ve kaygılarımı tartışırım.	**1**	**2**	**3**	**4**	**5**	**6**	**7**
21.	Terk edilmekten pek korkmam.	**1**	**2**	**3**	**4**	**5**	**6**	**7**
22.	Zor zamanlarımda, romantik ilişkide olduğum kişiden yardım istemek bana iyi gelir.	**1**	**2**	**3**	**4**	**5**	**6**	**7**

23. Birlikte olduğum kişinin, bana benim istediğim kadar yakınlaşmak istemediğini düşünürüm.	**1**	**2**	**3**	**4**	**5**	**6**	**7**
24. Birlikte olduğum kişiye hemen hemen her şeyi anlatırım.	**1**	**2**	**3**	**4**	**5**	**6**	**7**
25. Romantik ilişkide olduğum kişiler bazen bana olan duygularını sebepsiz yere değiştirirler.	**1**	**2**	**3**	**4**	**5**	**6**	**7**
26. Başımdan geçenleri birlikte olduğum kişiyle konuşurum.	**1**	**2**	**3**	**4**	**5**	**6**	**7**
27. Çok yakın olma arzum bazen insanları korkutup uzaklaştırır.	**1**	**2**	**3**	**4**	**5**	**6**	**7**
28. Birlikte olduğum kişiler benimle çok yakınlaştığında gergin hissederim.	**1**	**2**	**3**	**4**	**5**	**6**	**7**
29. Romantik ilişkide olduğum bir kişi beni yakından tanıdıkça, "gerçek ben"den hoşlanmayacağından korkarım.	**1**	**2**	**3**	**4**	**5**	**6**	**7**
30. Romantik ilişkide olduğum kişilere güvenip dayanma konusunda rahatımdır.	**1**	**2**	**3**	**4**	**5**	**6**	**7**
31. Birlikte olduğum kişiden ihtiyaç duyduğum şefkat ve desteği görememek beni öfkelendirir.	**1**	**2**	**3**	**4**	**5**	**6**	**7**

32. Romantik ilişkide olduğum kişiye güvenip dayanmak benim için kolaydır.	**1**	**2**	**3**	**4**	**5**	**6**	**7**
33. Başka insanlara denk olamamaktan endişe duyarım	**1**	**2**	**3**	**4**	**5**	**6**	**7**
34. Birlikte olduğum kişiye şefkat göstermek benim için kolaydır.	**1**	**2**	**3**	**4**	**5**	**6**	**7**
35. Birlikte olduğum kişi beni sadece kızgın olduğumda önemser.	**1**	**2**	**3**	**4**	**5**	**6**	**7**
36. Birlikte olduğum kişi beni ve ihtiyaçlarımı gerçekten anlar.	**1**	**2**	**3**	**4**	**5**	**6**	**7**

Appendix D: Adverse Childhood Experiences Study Questionnaire

A. Bazen ebeveynler ya da yetişkinler çocuklarını incitebilirler. ÇOCUĞUNUZ DOĞDUĞUNDAN BERİ, ne sıklıkla evinizde bir ebeveyn, üvey-ebeveyn ya da yetişkin:

1) Çocuğunuza küfretti, hakaret etti ya da aşağıladı?

Hiç Bir/İki kere Bazen Sıklıkla Çok Sık

2) Öyle bir şekilde hareket etti ki çocuğunuz fiziksel şekilde zarar görmekten korktu?

Hiç Bir/İki kere Bazen Sıklıkla Çok Sık

B. ÇOCUĞUNUZ DOĞDUĞUNDAN BERİ, ne sıklıkla bir ebeveyn, üvey ebeveyn ya da yetişkin:

3) Çocuğunuzu itti, zorla tuttu, itip kaktı, tokatladı ya da ona bir şey fırlattı?

Hiç Bir/İki kere Bazen Sıklıkla Çok Sık

4) Çocuğunuza o kadar sert vurdu ki çocuğunuzun izler oluştu ya da çocuğunuz yaralandı?

Hiç Bir/İki kere Bazen Sıklıkla Çok Sık

C. ÇOCUĞUNUZ DOĞDUĞUNDAN BERİ, çocuğunuzdan en az 5 yaş büyük bir yetişkin, akraba, aile dostu ya da yabancı hiç:

5) Çocuğunuzun vücuduna cinsel şekilde dokundu mu?

Evet Hayır

6) Çocuğunuzu onların vücuduna cinsel şekilde dokundurttu mu?

Evet Hayır

7) Çocuğunuzla herhangi bir cinsel ilişkiye girdi mi?

Evet Hayır

D. 8) ÇOCUĞUNUZ DOĞDUĞUNDAN BERİ, alkol problemi olan, alkolik olan ya da uyuşturucu kullanan biri ile yaşadı mı?

Evet Hayır

E. 9) ÇOCUĞUNUZ DOĞDUĞUNDAN BERİ, depresyonda olan ya da akıl hastalığı bulunan biri ile yaşadı mı?

Evet Hayır

F. Bazen ebeveynler ya da evde yaşayan diğer yetişkinler arasında fiziksel kavgalar olabilir. ÇOCUĞUNUZ DOĞDUĞUNDAN BERİ, bir yetişkin ne sıklıkla:

10) Evdeki başka bir yetişkini itti, zorla tuttu, tokatladı ya da ona bir şeyler fırlattı?

Hiç Bir/İki kere Bazen Sıklıkla Çok Sık

11) Evdeki başka bir yetişkini tekmeledi, ısırdı, yumruk attı ya da sert bir şey ile ona vurdu?

Hiç Bir/İki kere Bazen Sıklıkla Çok Sık

12) Evde yaşayan başka bir yetişkine en az birkaç dakika boyunca tekrar tekrar vurdu?

Hiç Bir/İki kere Bazen Sıklıkla Çok Sık

13) Evde yaşayan başka bir yetişkini bıçak ya da silahla tehdit etti ya da bıçak ya da silah kullanarak incitti?

Hiç Bir/İki kere Bazen Sıklıkla Çok Sık

G. 14) ÇOCUĞUNUZ DOĞDUĞUNDAN BERİ, evde yaşayan birisi hiç hapse girdi mi?

Evet Hayır

H. 15) ÇOCUĞUNUZ DOĞDUĞUNDAN BERİ, ebeveynleri hiç ayrıldı ya da boşandı mı?

Evet Hayır (Eğer ebeveynler hiç birlikte olmadıysa "evet"i işaretleyiniz.)

I. ÇOCUĞUNUZ DOĞDUĞUNDAN BERİ, aşağıdaki ifadeler ne sıklıkla doğruydu?

16) Çocuğumun yeterince yiyeceği olmadı.

Hiç Bir/İki kere Bazen Sıklıkla Çok Sık

17) Çocuğumun kirli kıyafetler giymesi gerekti.

Hiç Bir/İki kere Bazen Sıklıkla Çok Sık

18) Çocuğumun doktora götürecek kimsesi yoktu.

Hiç Bir/İki kere Bazen Sıklıkla Çok Sık

19) Çocuğumun ebeveynleri ya da ev mensupları ona bakamayacak kadar sarhoştu ya da uyuşturucu almıştı.

Hiç Bir/İki kere Bazen Sıklıkla Çok Sık

J. ÇOCUĞUNUZ DOĞDUĞUNDAN BERİ aşağıdaki ifadeler ne sıklıkla doğrudur?

20) Ona bakacak ve onu koruyacak birisi oldu.

Hiç Bir/İki kere Bazen Sıklıkla Çok Sık

21) Çocuğumun özel ve önemli hissetmesine yardımcı olacak birisi oldu.

Hiç Bir/İki kere Bazen Sıklıkla Çok Sık

22) Çocuğumun sevildiğine inanıyorum.

Hiç Bir/İki kere Bazen Sıklıkla Çok Sık

K. 23) Çocuğunuz doğduğundan beri, bir ebeveyn veya doğumundan beri evde yaşayan ya da bakımında temel bir rol üstlenmiş bir akraba ya da yakını vefat etti.

Evet Hayır

L. 24) Çocuğunuz ciddi bir kaza, sakatlık ya da hastalık (çocukluk döneminde sıklıkla karşılaşılan hastalıklar dışında) geçirdi ve hastaneye kaldırılması, tedavi görmesi ya da ameliyat olması gerekti?

Hiç Bir/İki kere Bazen Sıklıkla Çok Sık

Appendix E: Emotion Regulation Checklist

Lütfen aşağıdaki cümleleri okuyun ve çocuğunuz için en uygun olan sayıyı daire içine alın. Cevaplarınızı çocuğunuzun son 6 ay içindeki davranışlarını göz önüne alarak veriniz. **Eksiksiz doldurduğunuzdan emin olunuz.** Teşekkürler.

	Nadiren/ Neredeyse Hiç	**Bazen**	**Sık Sık**	**Her Zaman**
1. Neşeli bir çocuktur.	**1**	**2**	**3**	**4**
2. Duygu hali çok değişkendir. (Çocuğun duygu durumunu tahmin etmek güçtür çünkü olumlu bir duygu halinden olumsuz bir duygu haline çabucak geçer.)	**1**	**2**	**3**	**4**
3. Yetişkinlerin arkadaşça veya nötr yaklaşımlarına olumlu karşılık verir.	**1**	**2**	**3**	**4**
4. Bir faaliyetten diğerine kolaylıkla geçer; sinirlenmez, endişelenmez, sıkıntı duyma ya da aşırı derecede heyecanlanmaz.	**1**	**2**	**3**	**4**
5. Üzüntülü ya da sıkıntılı durumların çabucak üstesinden gelebilir. (Örneğin, duygusal sıkıntı yaratan olaylardan sonra surat asmaz, endişeli veya üzgün durmaz.)	**1**	**2**	**3**	**4**
6. Kolayca hüsrana uğrar.	**1**	**2**	**3**	**4**
7. Yaşıtlarının arkadaşça veya nötr yaklaşımlarına olumlu karşılık verir.	**1**	**2**	**3**	**4**

8. Kolayca sinir krizi/öfke nöbeti geçirmeye eğilimlidir.	**1**	**2**	**3**	**4**
9. Hoşuna giden bir şeye ulaşmayı erteleyebilir. (Örneğin, kendi sırasını bekleyebilir.)	**1**	**2**	**3**	**4**
10. Başkalarının sıkıntılarından keyif duyar. (Örneğin, başka biri incindiğinde ya da cezalandırıldığında güleri başkalarıyla alay etmekten zevk alır.)	**1**	**2**	**3**	**4**
11. Heyecanıyla başa çıkabilir. (Örneğin, çok hareketli oyunlarda kontrolü kaybetmez ya da uygun olmayan durumlarda aşırı heyecanlanmaz.)	**1**	**2**	**3**	**4**
12. Mızmız ve yapışkandır.	**1**	**2**	**3**	**4**
13. Her an ortalığı karıştıran enerji patlamaları ve büyük heyecanlar yaşayabilir.	**1**	**2**	**3**	**4**
14. Yetişkinlerin sınır koymalarına sinirlenir.	**1**	**2**	**3**	**4**
15. Üzüldüğünü, kızdığını veya korktuğunu söyleyebilir.	**1**	**2**	**3**	**4**
16. Üzgün ve sıkıntılı görünür.	**1**	**2**	**3**	**4**
17. Başkalarını oyuna katmaya çalışırken aşırı enerjiktir.	**1**	**2**	**3**	**4**

18. Duygularını göstermez. (Yüzü ifadesizdir.)	**1**	**2**	**3**	**4**
19. Yaşıtlarını arkadaşça veya nötr yaklaşımlarına olumsuz karşılık verir (örneğin, kızgın bir ses tonuyla konuşabilir ya da korku gösterebilir.)	**1**	**2**	**3**	**4**
20. Dürtülerine kapılarak davranır.	**1**	**2**	**3**	**4**
21. Başkalarıyla empati kurar. (Örneğin, başkaları üzgün ya da sıkıntılı olduğunda ilgi gösterir.)	**1**	**2**	**3**	**4**
22. Başkalarının rahatsızlık verici bulacağı kadar enerjik ve heyecanlı davranır.	**1**	**2**	**3**	**4**
23. Yaşıtlarının düşmanca saldırgan veya müdahaleci davranışlarına karşı uygun olumsuz duyguları (kızgınlık, korku, öfke, sıkıntı) gösterir.	**1**	**2**	**3**	**4**
24. Başkalarını oyuna katmaya çalışırken olumsuz duygular gösterir.	**1**	**2**	**3**	**4**

Appendix F: Child Behavior Checklist for 1.5-5 Years

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, ilkokul 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.

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 1 2 21. Yaşam düzenindeki en ufak bir değişiklikten rahatsız olur.

0 1 2 22. Tek başına uyumak istemez.

0 1 2 23. Kendisiyle konuşulduğunda yanıt vermez.

0 1 2 24. İştahsızdır. (açıklayınız): _____

0 1 2 25. Diğer çocuklarla anlaşamaz.

0 1 2 26. Nasıl eğleneceğini bilmez, büyümüş de küçülmüş gibi davranır.

0 1 2 27. Hatalı davranışından dolayı suçluluk duymaz.

0 1 2 28. Evden dışarı çıkmak istemez.

0 1 2 29. Güçlükle karşılaştığında çabuk vazgeçer.

0 1 2 30. Kolay kıskanır.

0 1 2 31. Yenilip içilmeyecek şeyleri yer ya da içer (kum, kil, kalem, silgi gibi). (açıklayınız): _____

0 1 2 32: Bazı hayvanlardan, ortamlardan ya da yerlerden korkar. (açıklayınız): _____

0 1 2 33. Duyguları kolayca incinir.

0 1 2 34. Çok sık bir yerlerini incitir, başı kazadan kurtulmaz.

0 1 2 35. Çok kavga dövüş eder.

0 1 2 36. Her şeye burnunu sokar.

0 1 2 37. Anne-babasından ayrıldığında çok tedirgin olur.

0 1 2 38. Uykuya dalmakta güçlük çeker.

0 1 2 39. Baş ağrıları vardır (tıbbi nedeni olmayan).

0 1 2 40: Başkalarına vurur.

0 1 2 41. Nefesini tutar.

0 1 2 42. Düşünmeden insanlara ya da hayvanlara zarar verir.

0 1 2 43. Hiçbir nedeni yokken mutsuz görünür.

0 1 2 44. Öfkelidir.

0 1 2 45. Midesi bulanır, kendini hasta hisseder (tıbbi nedeni olmayan).

0 1 2 46. Bir yerleri seyirir, tikleri vardır (açıklayınız): _____

0 1 2 47. Sinirli ve gergindir.

0 1 2 48. Gece kabusları, korkulu rüyalar görür.

0 1 2 49. Aşırı yemek yer.

0 1 2 50: Aşırı yorgundur.

0 1 2 51. Hiçbir neden yokken panik yaşar.

0 1 2 52. Kakasını yaparken ağrısı, acısı olur.

0 1 2 53. Fiziksel olarak insanlara saldırır, onlara vurur.

0 1 2 54. Burnunu karıştırır, cildini ya da vücudunun diğer taraflarını yolar. (açıklayınız): _____

0 1 2 55. Cinsel organlarıyla çok fazla oynar.

0 1 2 56. Hareketlerinde tam kontrollü değildir, sakardır.

0 1 2 57. Tıbbi nedeni olmayan, görme bozukluğu dışında göz ile ilgili sorunları vardır. (açıklayınız): _____

0 1 2 58. Cezadan anlamaz, ceza davranışını değiştirmez.

0 1 2 59. Bir uğraş ya da faaliyetten diğerine çabuk geçer.

0 1 2 60. Döküntüleri ya da başka cilt sorunları vardır (tıbbi nedeni olmayan).

0 1 2 61. Yemek yemeyi reddeder.

0 1 2 62. Hareketli, canlı oyunlar oynamayı reddeder.

0 1 2 63. Başını ve bedenini tekrar tekrar sallar.

0 1 2 64. Gece yatağına gitmemek için direnir.

0 1 2 65. Tuvalet eğitimine karşı direnir. (açıklayınız): _____

0 1 2 66. Çok bağırır, çağırır, çığlık atar.

0 1 2 67. Sevgiye, şefkate tepkisiz görünür.

0 1 2 68. Sıkılgan ve utangaçtır.

0 1 2 69. Bencildir, paylaşmaz.

0 1 2 70. İnsanlara karşı çok az sevgi, şefkat gösterir.

0 1 2 71. Çevresindeki şeylere çok az ilgi gösterir.

0 1 2 72. Canının yanmasından, incinmekten pek az korkar.

0 1 2 73. Çekingen ve ürkektir.

0 1 2 74. Gece ve gündüz çocukların çoğundan daha az uyur. (açıklayınız): _____

0 1 2 75. Kakasıyla oynar ve onu etrafa bulaştırır.

0 1 2 76. Konuşma sorunu vardır. (açıklayınız): _____

0 1 2 77. Bir yere boş gözlerle uzun süre bakar ve dalgın görünür.

0 1 2 78. Mide-karın ağrısı ve krampları vardır (tıbbi nedeni olmayan).

0 1 2 79. Üzgünken birden neşeli, neşeli iken birden üzgün olabilir.

0 1 2 80. Yadırganan, tuhaf davranışları vardır. (açıklayınız): _____

0 1 2 81. İnatçı, somurtkan ve rahatsız edicidir.

0 1 2 82. Duyguları değişkendir, bir anı bir anını tutmaz.

0 1 2 83. Çok sık küser, surat asar, somurtur.

0 1 2 84. Uykusunda konuşur, ağlar, bağırır.

0 1 2 85. Öfke nöbetleri vardır, çok çabuk öfkelenir.

0 1 2 86. Temiz, titiz ve düzenlidir.

0 1 2 87. Çok korkak ve kaygılıdır.

0 1 2 88. İşbirliği yapmaz.

0 1 2 89. Hareketsiz ve yavaştır, enerjik değildir.

0 1 2 90. Mutsuz, üzgün, çökkün ve keyifsizdir.

0 1 2 91. Çok gürültücüdür.

0 1 2 92. Yeni tanıdığı insanlardan ve durumlardan çok tedirgin olur.

(açıklayınız): _____

0 1 2 93. Kusmaları vardır (tıbbi nedeni olmayan).

0 1 2 94. Geceleri sık sık uyanır.

0 1 2 95. Alıp başını gider.

0 1 2 96. Çok ilgi ve dikkat ister.

0 1 2 97. Sızlanır, mızırdanır.

0 1 2 98. İçe kapanıktır, başkalarıyla birlikte olmak istemez.

0 1 2 99. Evhamlıdır.

0 1 2 100. Çocuğunuzun burada değinilmeyen başka sorunu varsa lütfen yazınız:

0 1 2 _____

0 1 2 _____

0 1 2 _____

Appendix G: Child Behavior Checklist for 6-18 Years

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

ANNE BABANIN İŞİ (Ayrıntılı bir biçimde yazınız, örneğin emekli, ilkokul 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?

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

Çocuğunuz her birinde ne kadar başarılıdır?

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

b. _____	O	O	O	O
c. _____	O	O	O	O

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

___ **Hiç yok.**

Çocuğunuz her birine ne kadar zaman ayırır?

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

Çocuğunuz her birinde ne kadar başarılıdır?

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

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

___ **Hiç yok.**

Çocuğunuz her birinde ne kadar başarılıdır?

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

IV. Çocuğunuzun evde ya da ev dışında yaptığı işleri a, b, c şıklarına yazınız. Örneğin: Gazete alma, bakkala gitme, pazara gitme, bahçe-tarla işleri,

hayvancılık, elektrik-su faturası yatırma, çocuk bakımı, sofra kurma-kaldırma, bir dükkanda çalışma gibi ödeme yapılan ve yapılmayan her şeyi katınız.

___ **Hiç yok.**

Çocuğunuz her birinde ne kadar başarılıdır?

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

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

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

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

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

VI. Yaşıtlarıyla karşılaştırıldığında çocuğunuzun:

a. Kardeşleriyle arası nasıldır?

Kötü	Normal Sayılır	Oldukça İyidir	Kardeşi Yoktur
O	O	O	O

b. Diğer çocuklarla arası nasıldır?

Kötü	Normal Sayılır	Oldukça İyidir	Kardeşi Yoktur
O	O	O	O

c. Size karşı davranışları nasıldır?

Kötü	Normal Sayılır	Oldukça İyidir	Kardeşi Yoktur
O	O	O	O

d. Kendi başına oyun oynaması ve iş yapması nasıldır?

Kötü	Normal Sayılır	Oldukça İyidir	Kardeşi Yoktur
O	O	O	O

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

_____

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

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 – Kaçıncı sınıfta ve nedeni

_____

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

O Hayır O Evet – açıklayınız

_____

Bu sorunlar ne zaman başladı?

_____

Sorunlar bitti mi?

O Hayır O Evet – Ne zaman?

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

O Hayır O Evet – açıklayınız

_____

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

Çocuğunuzun en beğendiğiniz özellikleri nelerdir?

Aşağıda çocukların özelliklerini tanımlayan bir dizi madde bulunmaktadır. Her bir madde çocuğunuzun **şu andaki ya da son 6 ay** içindeki durumunu belirtmektedir. Bir madde çocuğunuz için **çok ya da sıklıkla doğru ise 2, bazen ya da biraz doğru ise 1, hiç doğru değilse 0** sayılarını yuvarlak içine alınız. Lütfen tüm maddeleri işaretlemeye çalışınız.

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

0 1 2 1. Yaşından çok çocuksu davranır.

0 1 2 2. Anne babanın izni olmadan içki içer.

0 1 2 3. Çok tartışan bir çocuktur.

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

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

0 1 2 6. Kakasını tuvaletten başka yerlere yapar.

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

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

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

_____

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

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

0 1 2 12. Yalnızlıktan şikayet eder.

0 1 2 13. Kafası karışık, zihni bulanıktır.

0 1 2 14. Çok ağlar.

0 1 2 15. Hayvanlara eziyet eder.

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

0 1 2 17. Hayal kurar, hayallere dalıp gider.

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

0 1 2 19. Hep dikkat çekmeye çalışır.

0 1 2 20. Eşyalarına zarar verir.

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

0 1 2 22. Evde söz dinlemez.

0 1 2 23. Okulda söz dinlemez.

0 1 2 24. İştahsızdır.

0 1 2 25. Başka çocuklarla geçinemez.

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

0 1 2 27. Kolay kıskanır.

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

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

_____

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

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

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

0 1 2 33. Kimsenin onu sevmediğinden yakınır.

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

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

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

0 1 2 37. Çok kavga çıkarır, kavgaya karışır.

0 1 2 38. Çok fazla sataşılır, dalga geçilir.

0 1 2 39. Başı belada olan kişilerle dolaşır.

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

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

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

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

0 1 2 44. Tırnaklarını yer.

0 1 2 45. Sinirli ve gergindir.

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

0 1 2 47. Geceleri kabus görür.

0 1 2 48. Başka çocuklar tarafından sevilmez.

0 1 2 49. Kabızlık çeker.

0 1 2 50: Çok korkak ve kaygılıdır.

0 1 2 51. Başı döner, gözleri kararır.

0 1 2 52. Kendini çok suçlu hisseder.

0 1 2 53. Aşırı yer.

0 1 2 54. Sebepsiz yere çok yorgun hissettiği olur.

0 1 2 55. Fazla kiloludur.

56. **Sağlık sorunu olmadığı halde;**

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

0 1 2 b. Baş ağrılarından yakınır (şikayet eder)

0 1 2 c. Bulantı, kusma duygusu olur

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

(açıklayınız): _____

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

0 1 2 f. Mide-karın ağrısından şikayet eder

0 1 2 g. Kusmaları olur

0 1 2 h. Diğer (açıklayınız):_____

0 1 2 57. İnsanlara vurur, fiziksel saldırıda bulunur.

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

0 1 2 59. Herkesin içinde cinsel organıyla oynar.

0 1 2 60. Cinsel organıyla çok fazla oynar.

0 1 2 61. Okul ödevlerini tam ve iyi yapamaz.

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

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

0 1 2 64. Kendinden küçüklerle vakit geçirmeyi tercih eder.

0 1 2 65. Konuşmayı reddeder.

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

0 1 2 67. Evden kaçar.

0 1 2 68. Çok bağırır.

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

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

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

0 1 2 72. Yangın çıkartır.

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

0 1 2 74. Gösteriş meraklısıdır, maskaralık yapar.

0 1 2 75. Çok utangaç ve çekingendir.

0 1 2 76. Diğer çocuklardan daha az uyur.

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

0 1 2 78. Dikkati kolayca dağılır.

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

0 1 2 80. Boş gözlerle bakar.

0 1 2 81. Evden bir şeyler çalar.

0 1 2 82. Ev dışındaki başka yerlerden bir şeyler çalar.

0 1 2 83. İhtiyacı olmadığı halde birçok şey biriktirir. (açıklayınız): _____

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

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

0 1 2 86. İnatçı ve huysuzdur.

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

0 1 2 88. Çok sık küser.

0 1 2 89. Şüphecidir, kuşku duyar.

0 1 2 90. Küfürlü ve açık saçık konuşur.

0 1 2 91. Kendini öldürmekten söz eder.

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

0 1 2 93. Çok konuşur.

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

0 1 2 95. Öfke nöbetleri vardır, çabuk öfkelenir.

0 1 2 96. Cinsel konuları fazlaca düşünür.

0 1 2 97. İnsanları tehdit eder.

0 1 2 98. Parmak emer.

0 1 2 99. Sigara içer, tütün çiğner.

0 1 2 100. Uyumakta zorlanır. (açıklayınız): _____

0 1 2 101. Okuldan kaçar, dersini asar.

0 1 2 102. Hareketleri yavaştır, enerjik değildir.

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

0 1 2 104. Çok gürültücüdür.

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

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

0 1 2 107. Gündüz altını ıslatır.

0 1 2 108. Gece yatağını ıslatır.

0 1 2 109. Mızırdanır, sızlanır.

0 1 2 110. Karşı cinsiyetten biri olmayı ister.

0 1 2 111. İçine kapanıktır, başkalarıyla kaynaşmaz.

0 1 2 112. Evhamlıdır, her şeyi dert eder.

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

0 1 2 _____

0 1 2 _____

0 1 2 _____

Appendix H: Kerns Security Scale

Şimdi sana seninle ve annenle ilgili bazı sorular soracağız. Her bir cümle için **sadece bir tane kutucuğu işaretleyeceksin. Ancak bu anketin biraz farklı bir yolla doldurulması gerekiyor. Aşağıdaki sorularda, "AMA" yazan kutunun hemen sağında ve solunda iki çocuk tanımlanmaktadır. Önce bunları oku ve hangisine daha çok benzediğine karar ver. Sonra da seçtiğin tarafa git. Bu çocuğa çok benziyorsan "Bana çok benziyor" kutucuğunu", biraz benziyorsan "Bana biraz benziyor" kutucuğunu işaretle.**

1.

Bana çok benziyor ☐	Bana biraz benziyor ☐	Bazı çocuklar annelerine **kolayca güvenirler**.	**AMA**	Bazı çocuklar annelerine **güvenip güvenemeye-cekleri konusunda emin değildirler.**	Bana biraz benziyor ☐	Bana çok benziyor ☐

2.

Bana çok benziyor ☐	Bana biraz benziyor ☐	Bazı çocuklar **yaptıkları her şeye annelerinin çok karıştığını düşünürler.**	**AMA**	Bazı çocuklar **kendi başlarına bir şeyler yapmalarına annelerinin izin verdiğini düşünürler.**	Bana biraz benziyor ☐	Bana çok benziyor ☐

3.

Bana çok benziyor ☐	Bana biraz benziyor ☐	Bazı çocuklar için annelerinin yardım edeceğine inanmak **kolaydır**.	**AMA**	Bazı çocuklar için annelerinin yardım edeceğine inanmak **zordur.**	Bana biraz benziyor ☐	Bana çok benziyor ☐

4.

Bana çok benziyor ☐	Bana biraz benziyor ☐	Bazı çocuklar annelerinin onlarla yeterince zaman **geçirdiğini** düşünürler.	**AMA**	Bazı çocuklar annelerinin onlarla yeterince zaman **geçirmediğini** düşünürler.	Bana biraz benziyor ☐	Bana çok benziyor ☐

5.

Bana çok benziyor ☐	Bana biraz benziyor ☐	Bazı çocuklar annelerine ne düşündüklerini veya hissettiklerini söylemekten **pek hoşlanmazlar.**	**AMA**	Bazı çocuklar annelerine ne düşündüklerini veya hissettiklerini söylemekten **hoşlanırlar**.	Bana biraz benziyor ☐	Bana çok benziyor ☐

6.

Bana çok benziyor	Bana biraz benziyor	Bazı çocuklar her şeyde annelerine	**AMA**	Bazı çocuklar hemen hemen her şey için	Bana biraz benziyor	Bana çok benziyor

☐	☐	**ihtiyaç duymaz**.		annelerine **ihtiyaç duyar.**	☐	☐

7.

Bana çok benziyor ☐	Bana biraz benziyor ☐	Bazı çocuklar **"Keşke anneme daha yakın olabilseydim"** derler.	**AMA**	Bazı çocuklar **annelerine olan yakınlıklarıyla mutludurlar.**	Bana biraz benziyor ☐	Bana çok benziyor ☐

8.

Bana çok benziyor ☐	Bana biraz benziyor ☐	Bazı çocuklar **annelerinin onları gerçekten sevmediğinden** endişe duyarlar.	**AMA**	Bazı çocuklar **annelerinin onları sevdiğinden emindirler.**	Bana biraz benziyor ☐	Bana çok benziyor ☐

9.

Bana çok benziyor ☐	Bana biraz benziyor ☐	Bazı çocuklar annelerinin onları **anladığını** hissederler.	**AMA**	Bazı çocuklar annelerinin onları **anlamadığını** hissederler.	Bana biraz benziyor ☐	Bana çok benziyor ☐

10.

Bana çok benziyor ☐	Bana biraz benziyor ☐	Bazı çocuklar annelerinin onları terk etmeyeceğinden	**AMA**	Bazı çocuklar annelerinin onları terk edebileceğinden	Bana biraz benziyor ☐	Bana çok benziyor ☐

		gerçekten emindirler.		**bazen endişelenirler.**		

11.

Bana çok benziyor ☐	Bana biraz benziyor ☐	Bazı çocuklar ihtiyaç duyduklarında annelerinin **yanlarında olamayacağını düşünerek endişelenirler.**	**AMA**	Bazı çocuklar ihtiyaç duyduklarında annelerinin **yanlarında olacağından emindirler.**	Bana biraz benziyor ☐	Bana çok benziyor ☐

12.

Bana çok benziyor ☐	Bana biraz benziyor ☐	Bazı çocuklar annelerinin kendilerini **dinlemediğini** düşünürler.	**AMA**	Bazı çocuklar annelerinin onları **gerçekten dinlediğini** düşünürler.	Bana biraz benziyor ☐	Bana çok benziyor ☐

13.

Bana çok benziyor ☐	Bana biraz benziyor ☐	Bazı çocuklar üzgün olduklarında annelerinin **yanına giderler.**	**AMA**	Bazı çocuklar üzgün olduklarında annelerinin **yanına pek gitmezler.**	Bana biraz benziyor ☐	Bana çok benziyor ☐

14.

Bana çok benziyor ☐	Bana biraz benziyor ☐	Bazı çocuklar **“Keşke annem sorunlarımla daha çok ilgilense”** derler.	**AMA**	Bazı çocuklar **annelerinin onlara yeterince yardım ettiğini** düşünürler.	Bana biraz benziyor ☐	Bana çok benziyor ☐

15.

Bana çok benziyor ☐	Bana biraz benziyor ☐	Bazı çocuklar anneleri etrafta olduğunda **kendilerini daha iyi hissederler.**	**AMA**	Bazı çocuklar anneleri etrafta olduğunda **kendilerini daha iyi hissetmezler.**	Bana biraz benziyor ☐	Bana çok benziyor ☐

Appendix I: Expressive Language Subtest of the Turkish Expressive and Receptive Language Test (TİFALDİ)

"Şimdi seninle daha farklı bir oyun oynayacağız. Burada ben sana resimler göstereceğim, sende bana her resmin ne olduğunu söyleyeceksin, tamam mı? Bazı resimler zor gelebilir, ama bu hiç önemli değil. Neye benzetiyorsan, ne olduğunu düşünüyorsan onu söyle."

"Haydi şimdi ilk resmimizle başlayalım." *(Sayfa 1'i açın.)* "Sence bu ne resmi?" "Şimdi diğer resimlere bakalım." Eğer sesletim hataları yaparsa (örn., anahtar için anahtay vs. ahdar) veya elle ne olduğunu tasvir ederse, soruyu tekrar edin: "Bir daha söyler misin, bu ne resmi?" deyin. Eğer hala aynı şeyi yapıyorsa "Peki bu ne işe yarıyor, söyler misin?" diye sorun. Eğer "kapı açar" vb. gibi cevaplar veriyorsa doğru kabul edin. Ancak, hala söyleyemiyor veya elle anlatıyorsa doğru kabul etmeyin. Çocuğun ne söylediğini muhakkak puanlama kağıdına yazın.

(Test sonunda) "Aferin çok güzel yaptın. Teşekkür ederim."

Appendix J: Attachment Doll Story Completion Task

"Şimdi, nelerimiz var bir bakalım." *(Aile figürlerini çıkarın)*.

"Bak bu bizim ailemiz. Bu annesi, bu babası, bu büyükannesi, bu da çocuk *(Çocukla aynı cinsiyette olan oyuncağı gösterin)*. Hadi çocuğa isim verelim. Çocuğun ismi ne olsun istersin?"

"Şimdi ailemizle ilgili bazı öyküler uydurup oynatacağız. Ben bu aile ile ilgili öyküler anlatmaya başlayacağım, sen de bu öykülerin sonunu anlatacaksın."

Her hikaye anlatımı sonunda, "X (çocuğun verdiği isim) ne düşündü?", "X ne hissetti?" diye sorun.

Doğum Günü Öyküsü (Isınma Oyunu)

"Bu bir masa. Bakalım üzerinde ne varmış?" *(Katılımcı pastayı görüp isimlendirene kadar beklenir.)*

"Bu ne pastası? Evet, bir doğum günü pastası. Şimdi öyküyü dikkatlice dinle."

"Anne çok güzel bir doğum günü pastası yapmış. Şimdide herkesi masaya çağırıyor." *(Anne figürü oynatılarak)*

Anne: "Büyükanne, baba, X *(çocuğun verdiği isim)*. Hadi gelin. Doğum günü partisi yapalım."

"Hadi bakalım sen bu öykünün gerisini oynat."

Kazara Dökülen Meyve Suyu Öyküsü

Araçlar: Çocuk, anne, baba, masa, tabaklar

"Tamam, aklıma yeni bir hikaye geldi." *(Büyükanneyi alın ve yeni figürleri aşağıda*

gösterildiği gibi yerleştirin, masadan uzaklaştırın.)

(İçinde sofra malzemelerinin olduğu kutuyu sallayın.) "Akşam yemeği için sofrayı hazırlamamda bana yardım eder misin?" *(Kutu katılımcıya verilir, katılımcı sofrayı hazırlayana kadar beklenir, eğer yardım isterse yardımcı olunur.)*

"Şimdi aileyi yemek masasının etrafına oturtalım, böylece yemeğe hazır olsunlar." *(Katılımcı figürleri yerleştirene kadar beklenir.)*

"Burada ailemiz akşam yemeği yiyor. X ayağa kalktı, uzandı ve meyve suyunu kazara devirdi." *(Çocuk figürünü meyve suyu kabını devirecek şekilde hareket ettirin, çocuğun kabı açıkça görmesini sağlayın.)*

Anne: "X, meyve suyunu döktün." *(Sitemli ama aşırıya kaçmayan bir ses tonuyla; anneyi X'e çevirin ve konuştuğu sırada hareket ettirin.)*

"Şimdi ne olduğunu bana göster."

(Hikaye bittikten sonra, sırasıyla) "Çocuk ne düşünmüş?", "Çocuk nasıl hissetmiş?"

<u>Yardımlar</u>

(Katılımcı kendiliğinden söze başlamazsa) "Meyve suyu dökülünce neler yapmışlar?"

(Katılımcı sadece tek bir tepki verirse) "Sonra ne olmuş?"; "Başka bir şey?"

(Katılımcı figürlerle belirsiz hareketler yapıyorsa) "Ne yapıyorlar?"

(Katılımcı figürler hakkında konuşurken hangi figürü kastettiği belirsizse) "Kim yapıyordu?"

(Katılımcı büyükanneye ne olduğunu sorarsa) "Bu öyküde o yok, daha sonra onunla tekrar oynayacağız."

Terapist katılımcının söylediklerini tasdik etmek için, katılımcının cümlelerini soru formunda tekrar edebilir. Örn: “Anne meyve suyunu silmiş, ve sonra ne olmuş?”

NOT: Bu yardımlar katılımcının aklına belli fikirleri getirmek için hazırlanmamıştır. Bu konuda tek istisna, eğer katılımcı asıl konudan söz etmiyorsa, katılımcının dikkatini asıl konuya (dökülen meyve suyuna) odaklamak için yapılan yardımlardır.

Yatak Odasındaki Canavar Öyküsü

Araçlar: Çocuk, anne, baba, üzerinde battaniyesi olan bir yatak

“Ailemizi yeni oyun için hazırlayabilir misin?” *(Eğer katılımcı bu şekilde düzenlemezse, oyuncakları aşağıda görüldüğü gibi yerleştirin. Ailenin geri kalanının yatak odasındaki yataktan en az 30 cm uzak olması oldukça önemlidir.)*

“Şimdineler olduğuna bak. Dikkatlice dinle.”

Anne: *(Annenin yüzü öyküdeki çocuğa çevrilir ve konuşurken hafifçe hareket ettirilir.)* “Yatma vakti. Hadi bakalım, odana git ve uyu.”

Baba: *(Yüzü çocuğa dönerek, bir parça hareket verip ve sesi kalınlaştırarak)* “Şimdi yatağına git”

Çocuk: “Tamam anne baba gidiyorum.” *(Çocuk figürünü yatağa doğru yürütün.)*

“X üst kattaki odasına gidiyor, gidiyor.”

Çocuk: *(Korkmuş bir ses tonuyla)* “Anne! Baba! Odamda bir canavar var! Odamda canavar var!

“Şimdi ne olduğunu bana göster.”

(Hikaye bittikten sonra, sırasıyla) "Çocuk ne düşünmüş?", "Çocuk nasıl hissetmiş?"

Yardımlar

(Katılımcı kendiliğinden söze başlamazsa) "Çocuk seslenince neler yapmışlar?"

(Katılımcı bitirmiş gibi görünüyorsa ya da öyküyü tekrar etmeye başlamışsa) "Hazırsan yeni bir tanesine geçelim."

Diğer yardımlar için 'Kazara dökülen meyve suyu öyküsü'ne bakılabilir.

Yaralı Diz Öyküsü

Araçlar: Çocuk, anne, baba, kayalık için sünger, çimen için keçe

"Tamam, Şimdi başka bir öyküm var. Ben bunları toplarken, sen ailemizi oraya koy ve yeni öykü için hazırla." *(Uygulamacı masanın köşesini gösterir. Öyküde kayalığa tırmanan çocuk dışında ailenin geri kalanının kayalıktan en az 30 cm uzak olması önemlidir.)*

"Bak. Şimdi elimde neler var! *(Bir parça yeşil alan ve kayalık yerleştirilir.)* Bu bir park."

"Bunlar bizim ailemiz, parkta dolaşmaya çıkmışlar ve bu parkta yüksek, oldukça yüksek bir kayalık var."

Çocuk: "Anne, baba bakın. Bu yüksek, çok yüksek kayalığa nasıl da tırmandığımı seyredin." *(Çocuk figürünü kayalığa tırmandırılmaya başlanır, daha sonra düşer.)*

"Off! Dizim acıyor." *(Ağlamaklı bir sesle)*

"Şimdi ne olduğunu bana göster."

(Hikaye bittikten sonra, sırasıyla) "Çocuk ne düşünmüş?", "Çocuk nasıl hissetmiş ?"

Yardımlar

(Katılımcı kendiliğinden söze başlamazsa) "Dizi yaralanınca neler yapmışlar?"

(Katılımcı bitirmiş gibi görünüyorsa ya da öyküyü tekrar etmeye başlamışsa) "Hepsi bu kadar. Hadi gel Şimdi bunları kaldıralım ve başka bir tanesini yapalım."

Diğer yardımlar için 'Kazara dökülen meyve suyu öyküsü'ne bakılabilir.

Ayrılık Öyküsü

Araçlar: Çocuk, anne, baba, büyükanne, çimen ve araba için bir kutu

"Hadi bu sefer büyükanneyi kullanalım." *(Yeşil alan ve arabayla birlikte, aile ve büyükanneyi masaya aşağıdaki gibi yerleştirilir. Arabanın katılımcının önünde olması ve her iki ebeveynin çocuklara ve büyükanneye bakıyor olası önemlidir.)*

"Burası onların ön bahçesi ve bu onların arabası. Bu ailenin arabası." *(Araba katılımcının önünde durduğu sırada anne ve babanın yüzlerini çocuk ve büyükanneye çevrilir.)*

"Sanırım, anne ve baba tatile gidiyorlar."

Anne: *(Anne hafifçe hareket ettirilerek çocukla konuşturulur.)* "Evet, X. Baban ve ben bir tatile gidiyoruz. Şimdi senden ayrılıp, tatile çıkıyoruz."

Baba: *(Baba hafifçe hareket ettirilerek çocukla konuşturulur.)* "Bir hafta sonra görüşürüz. Büyükannen seninle kalacak."

"Şimdi ne olduğunu bana göster."

ÖNEMLİ NOT: Uygulamacı, katılımcının figürleri arabaya yerleştirmesine ve arabayla uzaklaştırmasına izin vermelidir. Eğer katılımcı arabayla uzaklaşmalarını sağlayamazsa, sadece bu durumda uygulamacı karışır. Eğer katılımcı çocukları da arabaya yerleştirirse, "Hayır, sadece anne ve baba gidiyorlar." denir. Çocuk arabayı uzaklaştırdıktan sonra (zorunlu olduğu taktirde), uygulamacı arabayı masanın altına alır ve gözden uzaklaştırır. Eğer katılımcı arabayı bulup getirmek isterse, "Hayır, onlar henüz geri gelmediler." denir.

"Ve uzaklara gittiler." *(Araba masanın altına alınır.)*

"Şimdi ne olduğunu bana göster."

(Hikaye bittikten sonra, sırasıyla) "Çocuk ne düşünmüş?", "Çocuk nasıl hissetmiş?"

Yardımlar

(Katılımcı kendiliğinden söze başlamazsa) "Anne ve babası gidince çocuk ne yapmış?"

Yeniden Bir Araya Gelme Öyküsü

Araçlar: Çocuk, anne, baba, büyükanne, çimen ve araba için bir kutu

Araba içindeki iki ebeveynle beraber masanın altından geri getirilir. Çocuktan uzak olacak şekilde masanın üzerine yerleştirilir. (Örneğin, katılımcının ulaşmasını ve arabayı sürmesini engelleyecek şekilde uygulamacının yakınına konulur.) Eğer bir önceki oyunda katılımcı çocuklar ve büyükanneyi masanın ortasına yaklaştırmışsa geri gelen araba ve çocuk figürleri arasında mesafe oluşturacak şekilde bu figürler katılımcıya yakın bir yere geri koyulur.

"Tamam, Ne oldu biliyor musun? Bir hafta geçti ve büyükanne pencereden dışarı bakıyor." *(Büyükannenin yüzü arabaya doğru çevrilir ve konuşurken biraz hareket ettirilir.)*

Büyükanne: “Bak X, annen ve baban geri geldi. Tatilden eve geri döndüler.”

“Şimdi ne olduğunu bana göster.” *(Katılımcının arabayı eve yaklaştırmasına izin verilir ve gerekiyorsa yardımcı olunur.)*

(Hikaye bittikten sonra, sırasıyla) “Çocuk ne düşünmüş?”, “Çocuk nasıl hissetmiş?”

Yardımlar

(Katılımcı kendiliğinden söze başlamazsa) “Anne ve baba eve döndüklerinde neler olmuş?”

Appendix K: Parental Distress Subscale of the Parenting Stress Index-Short Form

Lütfen her bir ifadeyi dikkatlice okuyunuz ve her birini her birini çocuğunuzu düşünerek ve bütün soruları aynı çocuğunuz için cevaplayınız.

Eğer duygu ve düşüncelerinize tam olarak uyan bir ifade bulamazsanız lütfen size en yakın gelen ifadeyi işaretleyiniz. Sorulara, üzerinde uzun süre düşünmeden, sizde uyandırdığı ilk tepki ile cevap veriniz.

Her bir ifade için sadece bir cevabı işaretleyin ve **lütfen tüm ölçek maddelerini cevapladığınızdan emin olunuz**. Lütfen verilecek olan ifadelere ne derecede katılıp, katılmadığınız hakkındaki duygularınızı en çok yansıtan numarayı bir çembere alınız. Eğer cevabınızdan emin değilseniz üç numarasını işaretleyiniz.

1	2	3	4	5
Hiçbir şekilde katılmıyorum	Katılmıyorum	Emin değilim	Katılıyorum	Tamamen katılıyorum

1. Çoğunlukla sorunlarla iyi baş edemediğimi düşünüyorum	**1**	**2**	**3**	**4**	**5**
2. Çocuklarımın ihtiyaçlarını karşılamak için hayatımda beklediğimden çok daha fazla fedakârlık yapıyorum.	**1**	**2**	**3**	**4**	**5**
3. Bir anne-baba olarak kendimi sorumluluklarımdan dolayı kısıtlanmış ve mecbur hissediyorum.	**1**	**2**	**3**	**4**	**5**
4. Bu çocuk dünyaya geldiğinden beri yeni ve farklı şeyler yapamıyorum.	**1**	**2**	**3**	**4**	**5**

5. Çocuk sahibi olduğumdan beri istediğim şeyleri hiçbir zaman yapamayacağımı düşünüyorum.	**1**	**2**	**3**	**4**	**5**
6. En son kendim için bir şeyler aldığımda kendimi mutsuz hissettim.	**1**	**2**	**3**	**4**	**5**
7. Hayatımla ilgili pek çok şey beni rahatsız eder.	**1**	**2**	**3**	**4**	**5**
8. Çocuk sahibi olmak eşimle olan ilişkimde beklediğimden daha fazla soruna yol açtı.	**1**	**2**	**3**	**4**	**5**
9. Kendimi yalnız hissediyorum ve hiç arkadaşım yok.	**1**	**2**	**3**	**4**	**5**
10. Bir eğlenceye gittiğimde eğlenemeyeceğimi düşünüyorum	**1**	**2**	**3**	**4**	**5**
11. İnsanlarla eskisi kadar ilgilenmiyorum.	**1**	**2**	**3**	**4**	**5**
12. Eskisi kadar bazı şeylerden zevk almıyorum.	**1**	**2**	**3**	**4**	**5**

Appendix L: Brief Problem Monitor

Bugünün tarihi: _ _ / _ _ / _ _ _ _ (*gün/ay/yıl olarak yazınız)*

Çocuğunuzun

Adı ve soyadı: Cinsiyeti: **O** Erkek **O** Kız

Yaşı:

Doğum tarihi: _ _ / _ _ / _ _ _ _ (*gün/ay/yıl olarak yazınız)*

Formu dolduran kişinin:

Adı ve soyadı:

Çocukla olan ilişkisi: O Annesi O Babası O Diğer (*lütfen belirtiniz*): _____

Aşağıda, çocuk ve gençleri tanımlayan maddelerin bir listesi bulunmaktadır. Lütfen her maddeyi, çocuğunuzu şu anda ya da geçmiş,____ gün içerisinde tanımlayan haline göre değerlendirin. Eğer bir madde, çocuğunuz için **çok ya da sıklıkla doğru** ise **2**, bazen ya da **biraz doğru** ise **1**, **hiç doğru değil** ise **0** sayılarını yuvarlak içine alınız. Lütfen tüm maddeleri, bildiğiniz kadarıyla, eksiksiz olarak işaretleyiniz.

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

		Yorumlar
0 1 2	1. Yaşından çok daha çocuksu davranır.	_____
0 1 2	2. Çok tartışan bir çocuktur.	_____
0 1 2	3. Başladığı etkinlikleri (oyun, dersler vb.) bitiremez.	_____
0 1 2	4. Bir konuya odaklanamaz, dikkatini uzun süre toplayamaz.	_____
0 1 2	5. Yerinde sakince oturamaz, çok hareketli ve huzursuzdur.	_____
0 1 2	6. Ailesine ya da başkalarına ait eşyalara zarar verir.	_____
0 1 2	7. Evde söz dinlemez.	_____

0 1 2 8. Okulda söz dinlemez. _____

0 1 2 9. Kendini önemsiz ya da yetersiz hisseder. _____

0 1 2 10. Düşünmeden hareket eder, aklına eseni yapar. _____

0 1 2 11. Çok korkulu ve kaygılıdır. _____

0 1 2 12. Kendini çok suçlu hisseder. _____

0 1 2 13. Çekingen ve utangaçtır. _____

0 1 2 14. Dalgındır, dikkati kolayca dağılır. _____

0 1 2 15. İnatçı, huysuz ya da huzursuzdur. _____

0 1 2 16. Kolay öfkelenir, öfke nöbetleri geçirir. _____

0 1 2 17. İnsanları tehdit eder. _____

0 1 2 18. Mutsuz, üzgün ya da çökkündür. _____

0 1 2 19. Kaygılıdır. _____

Çocuğunuzla ilgili, yukarıdaki listede belirtilmeyen başka bir durum *varsa*, lütfen yazınız:

0 1 2 _____ _____

0 1 2 _____ _____

0 1 2 _____ _____

Lütfen tüm maddeleri yanıtladığınızdan emin olunuz. Teşekkür ederiz.