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MENTALIZATION PREDICTS ADHERENCE TO PSYCHODYNAMIC PRINCIPLES IN CHILD PSYCHOTHERAPY

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Mentalization Predicts Adherence to Psychodynamic Principles in Child Psychotherapy

Zihinselleştirme Çocuk Psikoterapisindeki Psikodinamik Prensiplere Uyumu Yordar

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ABSTRACT

Mentalization can be defined as the ability to comprehend and express different mental states like emotions, beliefs, desires of self and others. It was found to be a protective factor for therapy processes and outcome. Initial mentalization capacity has been discovered to be associated with good outcomes in psychodynamic adult therapies. In child therapies, it was also found to be closely related to psychodynamic therapy process. Therefore, we aim to extend these findings and investigate different characteristics of initial mentalization and their relationship to adherence to principles of prototype psychodynamic child psychotherapy. The features of ideal psychodynamic child psychotherapy were determined by experts in Goodman and colleagues' study and the conformation of children's session characteristics to those features constituted the adherence scores for them. It was hypothesized that emotional, cognitive and opaqueness nature of the mentalization would be positively associated and predicted the psychodynamic adherences. Participants were 99 children who applied to get psychotherapy in the Istanbul Bilgi University Psychological Counseling Center. Children's mentalization capacities were conceptualized as mental state talk in this study and measured with The Coding System for Mental State Talk in Narratives (CS-MST) via Attachment Doll-Story Completion Task (ASCT). Their psychodynamic adherence scores were calculated through correlation with the factors of prototype psychodynamic child therapy determined by the experts. Child Psychotherapy Process Q-Set (CPQ) was used to measure psychodynamic adherence scores. Results of the study showed that children's total positive emotional, unique positive emotional, total emotional, self-oriented emotional, unique cognitive, self-oriented cognitive and unique opaqueness mental state talk were significantly and positively associated with average psychodynamic adherence scores. Also, there was a trend level significant association between total cognitive mental state word use and average psychodynamic adherence scores. Only unique positive emotional and unique

opaqueness mental state talk of children predicted their sessions' conformation to psychodynamic principles.

Key Words: Mentalization, Mental State Talk, Psychodynamic Psychotherapies, Child Psychotherapy, Process Research

ÖZET

Zihinselleştirme kişinin kendisinin ve diğerlerinin duygular, inançlar, arzular gibi farklı zihin durumlarını anlayabilme ve ifade edebilme becerisi olarak tanımlanabilir. Zihinselleştirmenin terapi süreçleri ve sonuçları için koruyucu faktör olduğu bulunmuştur. Yetişkin psikodinamik psikoterapilerde, terapinin öncesindeki zihinselleştirme kapasitesinin terapi sonundaki olumlu sonuçlarla bir ilişkisinin olduğu keşfedilmiştir. Ayrıca çocuk terapilerinde de zihinselleştirmenin psikodinamik prensiplerle yakından ilişkili olduğu bulunmuştur. Bu yüzden biz de bu çalışmaları daha da genişletmeyi ve çocukların terapi öncesi zihinselleştirmelerinin farklı karakterlerini ve bunların prototip psikodinamik çocuk terapisi prensiplerine uyumu ile ilişkisini araştırmayı hedefledik. İdeal psikodinamik çocuk terapisinin özellikleri Goodman ve iş arkadaşlarının çalışmasındaki uzmanlar tarafından belirlenmiş ve çocukların seans karakteristiklerinin bu özelliklere uygunluğu da uyum skorlarını oluşturmuştur. Çocukların duygusal, bilişsel ve opaklık zihinselleştirmelerinin, seanslarının psikodinamik uyumları ile ilişkili olacağı ve bu uyumu öngöreceği hipotez edilmiştir. Katılımcılar İstanbul Bilgi Üniversitesi Psikolojik Danışmanlık Merkezi'ne psikoterapi desteği için başvuran 99 çocuktan oluşmaktadır. Bu çalışmada çocukların zihinselleştirme kapasitesi zihin durumu konuşması olarak kavramsallaştırılmış ve Çocuklarda Güvenli Yer Senaryolarının Değerlendirilmesi (ASCT) aracılığıyla Anlatılardaki Zihin Durumlarını Kodlama Sistemi (CS-MST) kullanılarak kodlanmıştır. Çocukların psikodinamik uyum skorları ise uzmanlar tarafından belirlenmiş prototip psikodinamik çocuk terapisinin faktörleri ile korelasyona bakılarak hesaplanmıştır. Çocukların psikodinamik uyum skorlarının ölçülmesinde Çocuk Psikoterapi Süreçleri Q-set (CPQ) kullanılmıştır. Çalışmanın sonuçları çocukların toplam pozitif duygu, özgün pozitif duygu, toplam duygu, kendine yönelik duygu, özgün bilişsel, kendine yönelik bilişsel ve özgün opaklık zihin durumu konuşmalarının anlamlı ve pozitif şekilde ortalama psikodinamik uyum skorları ile ilişkili olduğunu göstermiştir. Ayrıca toplam bilişsel zihin durumu

kelime kullanımı ile ortalama psikodinamik uyum skorları arasında da pozitif ve anlamlı bir ilişki eğilimi vardır. Sadece özgün pozitif duygu ve özgün opaklık zihin durumu konuşması çocukların seanslarının psikodinamik prensiplere uyumunu yordamıştır.

Anahtar Kelimeler: Zihinselleştirme, Zihin Durumu Konuşması, Psikodinamik Psikoterapiler, Çocuk Psikoterapileri, Süreç Araştırması

CHAPTER 1

INTRODUCTION

One of the important things about human minds is thinking and being curious about why one's self or other people behave the way they do. How these behaviors occur, what are the underlying motives and mechanisms of these behaviors and how they differ from person to person are the questions that define the nature of human minds (Fonagy et. al., 1991a). This natural curiosity and the capacity to understand and interpret different mental states like beliefs, intentions, emotions, purposes, attitudes etc of self and others are defined as the mentalization (Fonagy et al., 2002). The capacity to mentalize is crucial for healthy development of children in many ways. It helps the child to develop an agentive self with ability to maintain regular social relationships as well as capacity to regulate negative affect in overwhelming situations (Fonagy et al., 2002; Scheemets, 2008). Lack of mentalization capacity on the other hand has been connected to both externalizing and internalizing behavioral problems in children (Allen et. al., 2008). Mentalization deficits are closely related to problems in affect regulation (Fonagy & Target, 1998) and symbolic play capacity of children (Sharp & Venta, 2012). Thus, it is also an important concept in psychotherapy research.

Psychodynamic psychotherapies with children aim to explore children's internal world, their unconscious conflicts and defenses in a safe therapeutic environment. Symbolic play is the tool for this exploration in these therapies. Symptom reduction through helping the children to gain affect regulation abilities with guiding them to recognize their own internal world is the ultimate goal in psychodynamic psychotherapies (Kegerreis & Midgley, 2014). Thus, mentalization has an important role in psychodynamic psychotherapies because it is closely related to these concepts as mentioned above. There are some empirical studies looking for the relationship between mentalization capacities and psychodynamic psychotherapies with children (Goodman & Athey-Lloyd, 2011; Goodman et al.,

2016; Halfon et al., 2017a; Halfon & Bulut, 2017; Halfon et al., 2019; Muñoz Specht et al., 2016).

Most of the research on these areas focus on the outcomes of therapies (Belvederi Murri et al., 2017; Ramires et al., 2012), specific mentalization techniques throughout psychodynamic psychotherapy process (Goodman et al., 2016; Muñoz Specht et al., 2016) or the relation of mentalization specifically with affect regulation and symbolic play in therapy (Halfon et al., 2017b; Halfon & Bulut, 2017; Halfon et al., 2019). However, the relation of initial mentalization of children with their process of psychodynamic psychotherapies were not explored detailly in the literature. Thus, we aim to contribute psychodynamic psychotherapy research literature by analyzing children's initial mental state talk in micro level with relation to their sessions' adherence to psychodynamic techniques. The purpose of this study is to examine how initial mentalization capacity of children is related to their sessions' adherence to psychodynamic principles. In other words, we would like to understand what different characteristics of mentalization capacity of children relate to and predict their therapy sessions' conformation to ideal prototype psychodynamic psychotherapy session with children.

In following pages, literature on mentalization and psychodynamic therapies with children will be reviewed. It starts with normal development of mentalization and its multidimensional construct in detailed and continues with culture and mentalization relationship, assessment of mentalization and mentalization deficits and empirical studies on behavioral problems and mentalization in children. Later, characteristics and effectiveness of psychodynamic therapies with children as well as process research will be reviewed. Finally, the relationship between mentalization and psychodynamic child therapies will be discussed in the light of empirical studies.

1.1. MENTALIZATION

Mentalization can be defined as the ability to comprehend the self and others in terms of different mental states. All people have their own emotions, intentions, beliefs, attitudes, perceptions in relation to others and all of these mental states constitute the core aspects of their existence. Mentalization capacity is closely associated with healthy development of self as an agent. (Fonagy et al., 2002). Even though theory of mind research has many contributions to the field, mentalization is a broader concept which covers more the emotional and interpersonal dynamics of the mental states while theory of mind mostly focuses on the cognitive dimensions (Allen, 2006, Allen et al., 2008).

People are social beings with necessity to make meaningful relationships and mentalization is a way to do this by making interpretations and predictions about other people's mental states and behaving according to that (Fonagy & Target, 1998). Not only understanding other people, mentalization also enables the person to understand own experiences and helps to comprehend an agent self with self-monitoring and affect regulation abilities (Fonagy et. al., 2002). On the other hand, developing a mentalizing agent self is possible with secure relationship with the caregiver and her ability to explore the child's mind (Schmeets, 2008). With a sensitive caregiver's marking the observed mental states of the child, she/he can find her/his image in another person's mind. (Winnicott, 1960). Finding his/her own representations with different mental states enables the child to build a self-organization who can understand the mental states of self and others (Fonagy et. al., 2002) with a more integrated perception of external world (Sharp et al., 2009).

1.1.1. Mentalization Development of Self as an Agent

1.1.1.1. Attachment and Mentalization

The emotional bond with the caregiver is essential and a common need for all human beings. This bond was defined as "*attachment*" by Bowlby (1971). Bowlby's basic theoretical contributions with Ainsworth's empirical work together comprehend the basis of the attachment theory (Ainsworth & Bowlby, 1991). Ainsworth (1970) designed a study called "*strange situation*" to assess infant's individual behaviors in the situations of separation from and reunion with the caregiver, their willingness to explore and their anxiety level with a stranger. As a result of the study, three attachment styles were defined: 1) Secure attachment where children securely explored the environment in mother's existence, showed distress when mother left but easily soothed when she returned and had a friendly attitude towards the stranger. 2) Anxious attachment where children showed extreme distress when mother left, could not leave the mother and explore the environment in her presence, showed ambiguous responses of clinging and pushing away the mother when she returned and did not interact with the stranger. 3) Avoidant attachment where children did not show any sign of distress in mother's leaving and did not show any interest to her coming back, they played normally in the presence of stranger and showed little emotional interaction with the mother (Ainsworth & Bell, 1970). Main & Solomon (1986) later discovered a fourth category of "*disorganized attachment*". Children with this kind of attachment style showed fear and confusion, disoriented or disorganized behaviors like sudden freezing moments and dissociations for a while with blank facial expressions. Disorganized attachment style was found to be strongly related with traumatic experiences (Main & Solomon, 1990).

For the representative mentalization development of a child, the secure relationship with the caregiver is one of the key factors. It is only possible for the

child go through all stages of mentalization development from infancy when she/he can find a secure place to explore the minds (Fonagy et al., 2002). Infants are not born with affect regulation capacities. In the times of distress and overwhelming situations, infant seeks the caregiver's help for comforting and soothing. With caregiver's attunement and responsiveness to his/her needs, she/he can turn to his/her affectively normal equilibrium. After a while, infant starts to learn the dynamic of the relationship and form some expectations based on past experiences with the caregiver (Sroufe, 1996). In other words, infant constitutes mental representations of interactions and consequences of that interactions with the caregiver and it is called "*Internal Working Models*" (Bowlby, 1973). In reflective self-development, infant's internal working model of his/her self as stable, valuable and reliant is possible with caregiver's right responsiveness when the infant needs comforting while respecting his/her autonomy at the same time. Otherwise in the situations of caregiver's rejection of infant's needs of both being soothed and exploring, his/her internal working models of self are developed as unworthy or incompetent (Bowlby, 1973).

For the caregiver to be contingently responsive to infant's needs, she herself should have a mentalizing ability and ability to reflect on infant's mind which in turn has an effect on infant's secure attachment development (Fonagy, et al., 1991a). The caregiver's ability to reflect upon her own mind brings more sensitivity and responsivity to her child's mind and needs and this promotes the secure relationship with the child and eventually helps the emergence of child's own mentalization abilities (Gocek et al., 2008). This reciprocal relationship between attachment security and mentalization is how infant feels to be seen and understood and develops an agentive self with a capacity to understand and reflect upon other's minds. (Fonagy et al., 1991b).

1.1.1.2. Social Bio-feedback and Representational Loop

If we look at the relationship between a caregiver and the infant in the scope of mentalization development more detailed, we see that caregiver responds to her child with the assumption of the infant as an intentional being. It is a natural human response to assume that human beings have mental states even in the earliest time of lives (Schmeets, 2008). With that assumption the caregiver starts to verbalize the assumed intentional mental states of the infant. Infants are not born with the capacity of knowing and understanding his/her experiences, it is developed and learnt with caregiver's affective mirroring. The attuned caregiver observes and makes deductions from the behaviors and mimics of the infant and realizes the different mental states of the infant (Fonagy et al., 2002). Then, she reflects what she observed to the infant which is called as mirroring or "*giving back to the baby the baby's own self"* by Winnicott (1967, p. 33). With that ongoing giving back to the infant what the caregiver sees, infant discovers his/her image in the mind of his/her caregiver and starts to understand, differentiate and make meaning of his/her own affective internal states which are the building blocks of self organization (Fonagy & Target, 1998). Infant gains the ability to represent other when she/he continuously sees representations of him/herself in the caregiver. This process is defined as "*social biofeedback*" by Gergely and Watson (1996).

Infants have an "*innate contingency detection mechanism*" which makes them able to make assumptions about the possible cause-effect relations between their behaviors and external clues. (Watson, 1994). In the earliest months, infant expects a perfect contingency between his/her affective states and the caregiver's reflections on that states but these expectations then transform into high but not perfect contingency later (Bahrick & Watson, 1985). In order for the infant to constitute a representative self by moving through the stages of physical and social being, the level of contingency as high but not perfect is important and the mirroring of the caregiver makes it possible.

This mirroring of affective mental states should be marked and re-presented to child with caregiver's processed and differentiated version (Gergely & Watson, 1996). This differentiated version of re-presenting also enables child to recognize what she/he is going through and to manage the mental states which are primarily not barrable (Fonagy & Target, 1997). Fonagy and his colleagues (2002) defined this cycle of processing affective states as "*representational loop*". In the representational loop, mother first perceives the infant's primary experiences and affect and then presents it to the infant as secondary representations (Schmeets, 2008). So, infant finds the representations of self in other's mind instead of the exact reality which enables the child to make differentiation between the minds of self and other. The difference between the original primary affective states of the infant and what mother perceives creates a space called as "*transitional space*" by Winnicott (1971) which is very important for mentalization development. If there is not any space or there is too much space between them, in other words if the experience of child and mother's perceptions and reflections of them are too similar or too different, child has mentalization deficit and affect regulation problems (Fonagy et al., 2002).

In the situation of too similar contingency with unmarked mirroring, child could not develop the ability to differentiate between the mental states of self and other and inner states become too real. Child perceives his/her affective states exactly same instead of the reflection in caregiver's mind and these states start to be external reality and universal for the child. As a result, the external world becomes threatening and overwhelming, child may not be able to regulate own affects (Fonagy et al., 2002). On the other hand, in the situation of too different contingency between child's experiences and the caregiver's perceptions of these experiences, the mirroring would be incongruent. Then, child could not find the accurate reflections of his/her internal states and gets confused. This confusion makes it difficult for the child to regulate affects in this situation too (Fonagy et al., 2002) and child may develop a "*false self*" (Winnicott, 1965).

1.1.1.3. Stages of Mentalization Development, Subjectivity before Mentalization and Mentalization Deficits

For a child to develop a comprehensive sense of self as an agent who has its own emotions, thoughts, beliefs, desires which are different from other people, there are many stages he/she should complete throughout the childhood years. Fonagy and his friends (2002) divided these stages of developing mentalization into five by age: "*physical, social, teleological, intentional and representational"*. In the first few months of the life, infant perceives the world through its body with sensory information. In other words, infant is a "physical" being in the beginning of its life. This physical interaction with environment through the infant's body constitutes the basis of the sense of self because infant begins to realize the differentiation of its body (self) and the surroundings (not self) (Scheemets, 2008). In this stage, infant also begins to realize its self as a body who starts an action and has an impact on the environment (Fonagy et. al, 2002) but it is still early in this stage for the infant to make distinction between purposes and the meaning of the behaviors (Piaget, 1936).

Throughout this interaction with the environment, infant is more attuned to people and discriminates the species-specific interactions (Stern, 1985). Especially the affective interaction with the caregiver is the building blocks of the developmental self of the infant and infant actively tries to interact with the caregiver. (Fonagy et. al, 2002, Beebe & Lachmann, 1988). For example, in the study of Murray (1985), it has been found that infants show distress and negative emotions when their interaction with mother was interrupted. Thus, infant's interaction with the surroundings turns into social interactions with human beings, especially with the caregiver (Scheemets, 2008).

Soon after, around the ninth month of age, these interactions become to create an "expectation" from the other subject and these expectations lead to

"predictions" about the possible reactions and behaviors of the other (Scheemets, 2008). These expectations and predictions on the other hand are based on purely physical (visible, audial or tactile) external features in this stage. Infant does not make inferences about intentions in teleological stage and it is still in a non-mentalizing mode. It understands and reasons the behaviors of others based on reality but not intentionality (Gergely & Csibra, 1997). Even though, in this stage of the age, it is developmentally normal for infants to do that, if child fails to make transition to the intentional stage of acknowledging the other has a mind additionally to the body; this becomes to be problematic for the child (Schmeets, 2008). These children only make inferences about other people's behaviors on what they see and they do not acknowledge any other explanation about that behavior. Especially in traumatic experiences, teleological mode of interpreting the behavior based on only physically observed and apparent material, is an important mentalization deficit (Fonagy & Target, 2006).

The mother-child dyadic relation is very important for the transition from teleological stage to intentional stage for children. In a normal development, when the child is around two years old, he/she begins to realize people have their own mind with desires, perceptions, beliefs, feelings etc. (Wellman, & Phillips, 2000). So, the child's interpretations go beyond what is physical and he/she starts to understand the actions in the scope of mental states of others (Schmeets, 2008). Joint attention is a good example for this stage because child expects the other person to change his/her attention which is a change in mind not only in body (Corkum & Moore, 1995). Also, this stage is important for mentalization development of the child because the infant clearly differentiates between the minds of self and other (Fonagy et. al, 2002).

Even though the child begins to make interpretations about mental states, these mental states are not represented in child's mind distinctively from the physical reality in intentional stage. Child still considers that the internal mental states exist when the external experiences exist (Flavell & Miller, 1998). Thus,

Fonagy & Target (1996b) came up with a model of thought from a developmental perspective based on the Freud's (1895) psychoanalytic notion of "*psychic reality*". The model states two modes of duality when experiencing this psychic reality which are "*pychic equivalence*" and "*pretend mode*". These two modes indicate the limitation for young children before they achieve to understand the ideas as representations of the reality (Schmeets, 2008).

In the psychic equivalence mode, which is also called as "*actual mode*", child experiences his/her internal world as equals to the external reality. In other words, the child cannot realize that reality is not same as she/he perceives and what she/he thinks, fantasizes, feelings are exactly same in outer world in child's experiences (Fonagy & Target, 2000). For example, when the child is asked what an object looks like and what it is, his/her answers for both questions would be the same (Flavell et al., 1986). This can become frightening for the child because all the powerful internal feelings he/she is experiencing are projected to reality and become real in the external world (Fonagy & Target, 1997). This situation turns into a mentalization deficit when it continues and the child fails to progress into representational stage of differentiating the inner and outer or re-emerges in later ages when it is not developmentally normal. In post-traumatic experiences, psychic equivalence mode makes the child to live the emotions like fear so real as in the forms of flashbacks and child fails to mentalize the notion and she/he perceives the external world dangerous. (Fonagy & Target, 2006).

There are also times that child is in the pretend mode. On the contrary to equivalence of inner and outer world in psychic equivalence, in pretend mode there is a sharp distinction between them (Fonagy & Target, 1996b). Through play, child's ability to attribute something as if it was something else and acting like that, in other words "pretending" develops and this is one of the major milestones for the developing capacity of representations (Leslie, 1987). In this mode, child represents the internal states in mind however they do not correspond with the reality this time. Internal and external have no link at all and child sticks what is in the inner world

and he/she cuts off the fantasy from the external reality (Allen et. al., 2008; Fonagy & Target, 2000). In the normal development, child should integrate these two modes and gains the ability to switch between fantasy world of the play and the reality (Schmeets, 2008). It becomes a mentalization deficit if child fails to do that and stays in the cut-offed fantasy world. For example, in traumatic experiences with dissociations, the experiences are reported as disconnected from reality (Fonagy & Target, 2006).

The final stage of the development of mentalization is the representational stage. Around the ages of three and four, child begins to integrate two modes of psychic equivalence and pretend mode and comes to representational mentalization mode of psychic reality. In this stage child acknowledges the differentiation of internal mental states and the reality but keeps in mind that they are related (Gopnik 1993). The integration becomes possible with the caregiver's ability to join pretending with the child while emphasizing the differentiation of the reality and fantasy world in play which is called as "*transitional space*" by Winnicott (1971) defining the space between the reality and imaginative world of the play. (Slade, 2005). With this integration, child can make various assumptions on the causes of actions because now understands that mental states are representational (Fonagy et. al, 2002). Just the concept of a mental state can exist in the child's mind instead of the real experience of it. Thus, the abstract thinking develops in the child and he/she understands the people as representational agents. For example, child can understand in this stage that people do not always feel the way they appear to feel (Flavell & Miller, 1998).

The reality and the concept of the mental states are differentiated by Fonagy and his colleagues (2002). They defined the experience of actual internal state (e.g., fear itself) as primary representations while the concept of that internal state (e.g., the concept of fear) as the secondary representations. With the conceptual understanding development, around the age of six, child now starts to remember the intentional behaviors and experiences in a causal temporal sequence which can

be defined as the development of autobiographical self (Povinelli & Eddy, 1995). Thus eventually, child becomes to comprehend an autobiographical representation of self and others as agents with different mental states and memories (Fonagy et. al, 2002).

1.1.2. Multi-Dimensional Concept of Mentalization

There is some criticism that mentalization is a very broad and complex term to be operationally defined (Choi-Kain & Gunderson, 2008). On the other hand, mentalization should be evaluated as a "*dynamic*" concept that can be affected by the circumstances like stress, arousal and even attachment relations. (Allen et al., 2008). In other words, mentalization should not be thought as "*static and unitary skill or trait*" (Fonagy et al., 2012, p.19). Recent research shows that mentalization can be conceptualized over four dimensions while each dimension includes two polarities. These dimensions are external versus internal, explicit versus implicit, affective versus cognitive and self versus other mentalizations. Problems in mentalization stem from the imbalance between these polarities when one polarity is dominant over the other one. (Fonagy et al., 2012). People may show differences on having problems in some of the polarities but not having problems in others. (Fonagy & Luyten, 2009)

1.1.2.1. External & Internal

While external mentalization is about focusing on one's or other's "*physical and visible features*" (Fonagy et al., 2012, p.22); internal mentalization is about to understand beneath these features. In other words, internal mentalization is about the inner states like emotions, thoughts, and intentions (Fonagy, & Luyten, 2009). For example, some patients with Borderline Personality Disorder (BPD) have difficulty to understand the inner thoughts and emotions of others (King-Casas et.

al., 2008) while they are highly sensitive to the physical cues like facial expressions (Domes et. al., 2008). As mentioned above, the balance between them is the key factor. Infants first learn to read the external features like the caregiver's eye-gaze direction, mymics etc. before they begin to understand their own internal mental states. With the mother's "marking" the feeling, infant matches the internal mental states based on the external signs as mentioned above (Fonagy et al., 2012).

1.1.2.2. Explicit & Implicit

Mentalization can be either automatically (implicitly) or controlled (explicitly). What differentiates those two processes is the consciousness level of the mentalization. Explicit mentalization is verbal and it includes "*attention, intention, awareness, and effort*" (Fonagy & Luyten, 2009, p.1358). A person should reflect upon the mental states of self or other consciously and deliberately for explicit mentalization. Expressing the emotions, desires and other mental states verbally in a narrative is an important implication for psychological wellbeing and it is encouraged in most of the therapy techniques (Allen et. al., 2008). Holmes (1999) emphasized the importance of explicit mentalization and its flexibility by pointing out the lack of comprehensive narratives in traumatic experiences and insecure attachments. On the other hand, implicit mentalization is an automatic process which requires intuition and proceeds in a low level of consciousness (Allen et. al., 2008). Most of the time, people make mental inferences without thinking about them deliberately. It provides them to maintain regular interpersonal relationships without consciously reflecting about them. (Fonagy et. al., 2012). In daily life, mentalizing is maintained by ongoing back and forth between these two dimensions and some pathologies stem from the impairments of these smooth ongoing process (Allen et. al., 2008).

1.1.2.3. Affective & Cognitive

Another dimension of mentalization is affective mentalization which focuses on emotional content, understanding and expressing affective states and cognitive mentalization which is more about cognitive components like believes, thoughts, desires. (Fonagy et al., 2012). Baron-Cohen et. al. (2008) talks about two different systems about affective and cognitive dimensions: The Empathizing System (TESS) and The Theory of Mind Mechanism (TOMM). While TOMM is helpful for understanding attitudes, false beliefs and other cognitive mental states and finally for predicting the behaviors; TESS is mostly helpful for processing and expressing the emotions and finally for empathy and sympathy. (Baron-Cohen et. al., 2008). In Borderline Personality Disorder (BPD), TESS is dominant to TOMM leading to hypersensitivity to emotional components but having difficulty to reason them by integrating with cognitive perspective (Blatt, 2008). On the other hand, in Antisocial Personality Disorder, cognitive components are predominant when they have impairment in getting in touch with the affective states (Blair, 2008). Similarly, in children, externalizing behavior problems were found to be related to deficits in understanding emotions while they performed better in cognitive tasks (Sharp, 2006).

In psychodynamic therapies, clinicians mostly focus on the affective dimension of mentalization because understanding, expressing and regulating the affect are very important to be protected from behavioral problems and psychopathology (Thompson, 1994; Aldao et al., 2010). Cognitions, perceptions, physical states also driven from different emotions thus mentalizing the emotions include both feeling them in affective level while understanding the emotions as underlying motivations of behaviors on cognitive level (Allen et al., 2008). Healthy emotional, social and cognitive development includes the interaction of these systems which Fonagy and his colleagues (2002) defines as *"mentalized*

affectivity" or *"the feeling of feeling"* and Allen and his colleagues defined as "*thinking and feeling about thinking and feeling*" (Allen et al., 2008, p.63).

1.1.2.4. Self & Other

Mentalization has two direction from the perspective of whom mind a person focuses: self or other. Both self-mind awareness and other-mind awareness are critical in mentalization. Stein (2003, p.143) stated that mentalization *"requires taking into account another persons' mental state through attunement."*. In order to make inferences about other's mind, a person should first recognize that other has its own feelings, wishes, thoughts etc and these are not the same with self. (Fonagy et al., 2012). In symbiotic state of development, infants in their first months of life lack the ability to differentiate the self and other and make splitting between good and bad qualities (both for self and other). With the successful development, infant comes to the stage of object constancy in which he/she starts to separate the minds of his/her and others while combining the good and bad qualities together in one human being (Mahler et al., 1975). This separation of minds helps the child to acknowledge his/her sense of selfhood while still considering another person's mind. (Brown, 2008). In some pathologies like borderline personality disorder this kind of self-other differentiation is severely impaired and they misread the intentions of others (Bender & Skodol, 2007).

1.1.3. Assessment of Mentalization in Children

Mentalization was thought to be related with many concepts like mind-mindedness, theory of mind, metacognition, perspective taking etc. for the history of mind research (Allen, 2003). On the other hand, most of these concepts could not catch multidimensional nature of the mentalization. Reflective functioning (RF)

which means capacity to reflect on minds of others and self has been commonly used to assess mentalization in adults (Vrouva et al., 2012). Adult Attachment Interview (AAI; George et al., 1985) was used to assess reflective functioning abilities through narratives of attachment relationships and early childhood memories of adults. Based on AAI, Fonagy and friends (1998) developed the Reflective Functioning Scale.

Even though it has been a useful way to assess mentalization in adults, it is hard to assess mentalization in children through own narratives of attachment and childhood relationships due to limited language capacities (Vrouva et al., 2012). Thus, other assessment tools were developed for children. For many years, theory of mind (TOM) research assessed cognitive side of the mentalization in children through different tasks (Baron-Cohen et al., 1985). For example, in order to assess children's realization of what appears to be true for other people may not match with the reality, false belief tasks were used (Astington et al., 1988). It was a useful tool to understand children's mentalization capacity and deficits in terms of pretend play and psychic equivalence (Fonagy& Target, 2000).

However, TOM research fell behind to capture affective side of the mentalization (Carpendale & Chandler, 1996). Therefore, other tools to assess affective mentalization was discovered. For instance, affective labeling tasks which requires children to label different affects through facial expressions or cartoons (Steele et al., 1999; Taumoepeau & Ruffman, 2008) or affective perspective taking tasks which requires children to predict the affective states of others through vignettes including emotion eliciting scenarios (Eisenberg at al., 1991) were used. Also, Fonagy and colleagues (2000) developed The Affect Task (AT) which is a semi-structured interview. Beyond to understand and label emotions, AT measures children's understanding of causal relations and several links between emotions and situations. Affective mentalization was found to be more related to prosocial behavior than cognitive mentalization (Denham, 1986) while cognitive

mentalization was found to be more associated with parents' educational and economic level (Cutting & Dunn, 1999).

Even though it is hard to assess younger children, for older children The Child Reflective Functioning Scale (CRFS; Target et al., 2001) was developed. Similar to adults, reflective functioning of children was assessed through interviewing about attachment relations and conflicting situations based on Child Attachment Interview (CAI; Target et al., 2000). It is a useful tool to assess mentalization because "working" mentalization abilities show up better in a narrative about interpersonal relationships (Ensink, 2003). On the other hand, application of CRFS to younger children is difficult because of the language limitations.

Another way to assess mentalization capacity of children is through mental state talk. It is not directly synonyms with mentalization but it is a good measure of explicit mentalization capacity (Fonagy et al., 1998). Meins (1999) proposed that children developed mentalization ability through mental state talk with significant others. Those interaction enables child to form representations of self and others. In theory of mind research, mental state talk was discovered to be related to successful outcomes in false belief and perspective taking tasks (Brown et al., 1996; Symons, 2004). Some studies looked for children's emotional and mental state talk in natural observation settings like play or snack times (Bretherton & Beeghly, 1982; Dunn et al., 1987). Also, children's emotional and cognitive mental state talk were found to be related to better socio-emotional comprehending (Youngblade & Dunn, 1995; Hughes & Dunn, 1998) and development of social understanding (Symons, 2004). In a similar vein, Jenskins and friends (2003) discovered that when cognitive and emotional mental state talk were more in family context, child's abilities on those aspects improved better in adulthood. Harris (1999) also emphasized that emotional mental state talk was an important indicator for children's understanding of emotional mental states.

One of the common ways to measure mental state talk of children is via creating narratives (Bamberg & Damrad-Frye, 1991; Bettmann & Lundahl, 2007; Dyer et al., 2000). This is helpful for children to discover own relational styles, meaning making ways and manners of affect regulation (Oppenheim, 2006). This narrative creating is mostly based on looking at pictures because it has two advantages. One of them is that child should use perspective taking because he/she makes attributions to the minds of story characters. The other one is that child also should use another level of perspective taking for the listener in order to evaluate the knowledge of the listener (Tager- Flusberg & Sullivan, 1995).

Coding System for Mental State Talk (CS-MST) was developed by Bekar and friends (2014) to assess different dimensions of mental state talk of children and parents through narratives. This coding system is originally based on a picture book with no words "Frog Where are You?" (Mayer, 1969). Children and parents create a story together and talk about mental states of story characters. It assesses different dimensions of mental state talk like emotional (e.g., happy, sad), cognitive (e.g., wish, think), perceptional (e.g., look, hear), physiological (e.g., hurt, hungry), and action-based (e.g., cry, hide). In addition to frequencies of mental state words, the causality, uniqueness and directions of attributions of mental states of self or other were also assessed. With adaptation of "self-oriented mental state talk" in the code into "play-oriented mental state talk", CS-MST was used in Turkish children and parents in play context (Halfon et al., 2017a; Halfon et al., 2017b).

1.1.4. Culture and Mentalization

Culture was found to be an important factor in mentalization ability. Developments in various domains of mentalization differed from cross cultural perspective (Aival-Naveh et al., 2019). Aivah-Naveh and friends (2019) reviewed different studies related to mentalization and culture. There are universalist

perspectives which think that culture has minor effect on psychological states including mentalization and it is mostly inherent or relativist approaches which claim that culture mostly shape the psychological concepts including mentalization. On the other hand, as the multiple constructive nature of mentalization, both of them could be evaluated as different polarities of a continuum thus, there is also a third perspective taking both of them into account (Berry et al., 2002).

Culture affects mentalization's different domains in different ways. For cognitive mentalization, theory of mind (TOM) tasks were used from cross cultural perspective. As a result of false belief task studies, in collectivist cultures like Japan (Naito & Koyama, 2006), China (Liu et al., 2008), Pakistan (Nawaz et al., 2015) and Philippines (Gracia et al., 2016) development of theory of mind abilities were found to be slower than the individualistic cultures. Thus, it was suggested that TOM capacity of collectivist cultures was relatively lower compare to individualistic cultures (Fiebich, 2016). However, some collectivist cultures including Turkish culture have more linguistic advantages in terms of having more words defining false belief thus, performances of children in these cultures were more enhanced than other collectivist cultures (Shatz et al., 2003). On the other hand, both Chinese (Wang et al., 2012) and Japanese (Moriguchi et al., 2010) children were found to be better in non-verbal false belief tasks than the verbal ones. Therefore, a difference between explicit and implicit mentalization can be considered from cross cultural perspective too (Aival-Naveh et al., 2019).

From the perspective of empathy which is closely related to both affective and other oriented mentalization, individualistic cultures showed more deficiency than collectivist cultures (Adams et al., 2010; Cheon et al., 2010; Chopik et al., 2016). Socialization, values and relatedness are important in collectivistic cultures more than individualistic ones. Thus, other oriented mentalization is higher in collectivist cultures when self-oriented metallization is higher in individualistic cultures (Bradford et al., 2018; Kessler et al., 2014; Valanides et al., 2017). For affective mentalization, cultural studies of alexithymia can be explored too.

Alexithymia is a disorder about failure in understanding, defining and expressing emotions (Taylor et al., 1991). Most of the cultural studies showed that collectivistic cultures indicated higher alexithymia scores than the individualistic cultures (Fukunishi et al., 1997; Lee et al., 1996; Loiselle & Cossette, 2001; Pandey et al., 1996; Zhu et al., 2007). It is also closely related to self-oriented mentalization too because alexithymia is difficulty to understand and express own emotions (Aival-Naveh et al., 2019).

In terms of children's emotional mentalization abilities, parenting styles are also important in cultural perspective. In collectivist cultures including Turkey, emotional bonding considered to be important. Parents in Turkey mostly encouraged their children to continue their emotional relationships with family (Kagitcibasi, 2007) and close bonding within family is emphasized (Corapci et al., 2012). Turkish children expected relational support when they expressed emotions (Okur & Corapci, 2015). However, parenting styles may show difference within Turkish culture too. Socioeconomic status (SES) and education level play important roles in here especially in the scope of emotion expression. Altan-Aytun and colleagues (2012) found that Turkish mothers with higher education used less minimization and more encouragement for expressing emotions. Education played an important role in the reduction of "*punitive emotion socialization*" while in the increase of "*problem-focused socialization*" (p. 441). In the study of Okur and Corapci (2015), children with middle-high SES were found to be more likely to express sadness and anger and to approve expression of shame than the children with low SES. It was considered by authors to be an important transition to expressing self in middle-high SES group because of emphasis on relatedness to other in Turkish sample. It also supported the theory of Kagitcibasi (2007) which suggested that Turkish culture includes both autonomous and relatedness features.

In the study of Baydar and Akcinar (2015), it was discovered that Turkish parents with higher education levels showed more sensitivity to their children's needs and enhances their cognitive capacity. However more punitive and less

tolerant attitudes towards children's expression of emotions were found to be related to lower SES than middle-high SES (Corapci et al., 2012; Nacak et al., 2011). Also, in the same study by Corapci and colleagues (2012), Turkish mothers were discovered to be more supportive for expressing sadness than the anger. For children with affect regulation problems, parent's lack of emotional support for their anger were associated with more aggressive behaviors.

Finally, in order to understand cultural diversities in responsiveness of mothers, data were collected from Turkey, Romania and United States (US) in the study by Corapci and colleagues (2017). As a response to anger, mothers from Turkey and Romania showed more comforting and reasoning conforming the relatedness characteristics of the cultures while mothers from US reacted with more behaviorally oriented disciplining methods. For sadness, all mothers showed reasoning and dismissive reactions as well as some emotion focused responses. It did not culturally differ. For fear on the other hand, mothers from Turkey and Romania used reasoning and problem-focused strategies equally while mothers from US exclusively used emotion-focused responses consistently with their autonomous orientations. Finally, for happiness, also mothers from US validated and encouraged the happiness in their toddlers more than Turkish and Romanian mothers. However, subtle regulative responses were observed by Turkish mothers like "dancing together". This is also parallel to the findings of nonverbal mentalization abilities in collectivist cultures as mentioned above (Moriguchi et al., 2010; Wang et al., 2012).

1.1.5. Mentalization and Behavioral Problems

Behavioral problems of children can be thought in two directions of internalizing and externalizing behaviors. Internalizing behavior problems include depression, anxiety, somatic and withdrawal symptoms (Achenbach & McConaughy, 1997) while externalizing behavior problems include aggressive and

impulsive behavior as well as disruptiveness and antisocial symptoms (Achenbach & Rescorla, 2001). On the other hand, there are some research showing comorbidity between internalizing and externalizing problems that children might have both of them (Weiss et al., 1998, Lilienfeld, 2003). For instance, a comorbidity between oppositional defiant disorder and anxiety disorders was found in one study (Martin et al., 2014) and an overlap between depression and attention deficit hyperactivity disorder was found in another study (Biederman et al., 1996). Internalizing and externalizing problems in children have common features like difficulties in negative emotionality (Eisenberg et al., 2005), self-regulation problems including regulating emotions (Eisenberg et al., 2010) and lower social competence and peer acceptance (Henricsson & Rydell, 2006).

Affect regulation and impulse control are closely related to mentalization abilities in children too (Fonagy & Target 1998). When children recognize and verbalize their inner states of self and others, it helps them to control these states as well as regulating their behaviors and emotions in a better way (Sharp, 2006). Mentalization also enables children to tolerate negative feelings like anger or anxiety (Leary, 2007) and enhance the social relationships because children with better mentalization abilities stay attuned and understand the affective states of others and as a result, social interactions and interpersonal relationships become better. (Allen et. al., 2008). Social competence is predicted by the ability to comprehend emotions of others (Denham, 1998). For example, a child show empathy and sympathy to his friend when he understands his friend's emotion of being sad when he is excluded from a group play (Trentacosta & Fine, 2010). Thus, it is inevitable that mentalization problems are in a relation with behavioral problems of children especially in the scope of interpersonal interactions (Allen et al., 2008, Sharp, 2006).

As mentioned in previous parts, parents own ability of mentalizing enables them to be more attuned to their child's minds which is helpful for child's mentalization development (Gocek et al., 2008). Thus, caregivers' mentalizing

abilities are also effective on child's psychosocial and socio-cognitive development which in turn is effective on the mental health of children in the scope of psychopathology (Sharp & Fonagy, 2008). There are many studies showing the relationship with caregiver's mentalizing abilities and psychopathology of children. For instance, in the study of Oppenheim and colleagues (2004), it was found that children's behavioral problems including both internalizing and externalizing problems were reduced when mother's insightfulness about their children's underlying motivations increased. Parent's mentalizing abilities were associated with fewer conduct problems in children in a follow up study of Ha and friends (2011). In another study with adopted children, longitudinal follow ups showed that parental mental state talk were effective on children's emotional understanding which was associated with lower externalizing and internalizing problems (Tarullo et. al., 2016). Children's ability to sooth themselves and regulate their emotions as well as healthy peer relations were developed better when parents were more aware of their own emotions and children's (Gottman et al., 1996).

In terms of behavioral problems of children, further more to caregivers' mental state talk, their accuracy of predicting their children's mental states was found to be important too. Sharp and colleagues (2006) found that when mother's accuracy about her child's mental states increased, children's psychopathology symptoms were reduced while when mothers failed to accurately guess children's mental states, children's attributions became overly positive and unrealistic. Also, mothers' appropriate attributions to children's internal states (mind-mindedness) were discovered to be in negative relationship with children's behavior problems including both internalizing and externalizing problems (Meins et al., 2013).

Due to the fact that mentalization is a broad concept, the relationship between behavioral problems and children's mentalization abilities can be thought in different dimensions. There are different studies including different dimensions of mentalization and its relation to internalizing and externalizing problems of children. In addition to examine just the presence or absence of mentalization, the

distortions and biases in different domains of mentalization and the imbalances between polarizations were searched (Sharp et al., 2007). First of all, the research on cognitive domain of mentalization is an important part of the mentalization literature. Social information processing theory is useful to understand deficits in cognitive mental state processing in interpersonal relationships and its relation to behavioral problems. It suggests that distortions in cognitive mental states lead to continuous maladaptive behaviors and psychopathology in terms of social relations (Dodge, 1993).

The nature of the cognitive mentalization deficits may differentiate between internalizing and externalizing problems. There are some studies showing that children with externalizing problems do not have difficulty in cognitive mentalization tasks like false-belief or theory of mind tasks and even they may excel in cognitive domains (Sharp, 2006). For example, Happ´e and Frith (1996) found that children with conduct disorder showed age appropriate performance on false belief task while Sutton and colleagues (2000) also found no relationship between conduct symptoms and mentalization abilities in theory of mind task. Furthermore, in the study of Griffin and Gross (2004), it was demonstrated that children who showed proactive bullying behavior excelled in mentalization and used it in a manipulative way. The problem with cognitive mentalization in externalizing behavior pathology stems from the distortions in mentalization in a biased way (Allen, 2006). In externalizing problems, in terms of aggression, children showed "*hostile attributional bias*" when inferring the social stimulus (Nasby et al., 1980). They showed attention more to hostile cues in social interactions and had difficulty to focus on other social cues which resulted in hostile attributions to the purposes of other's behaviors especially in the ambiguous circumstances (Dodge & Frame, 1982, Gouze, 1987). Their expectation of aggression from other people even though there are no indications for that leads to their acting aggressively to others (Sharp & Venta, 2012). Children with conduct symptoms showed mentalization superiority in terms of using mentalization skills as a manipulative way but their way of

mentalization included disruptions and Happe and Frith (1996) described this situation as "*intact but skewed theory of mind*" or "*theory of nasty minds*" (p. 395).

In internalizing problems, social cognitive biases, process in a different way than externalizing problems. Children with anxiety problems are hypervigilant to social cues and perceive threat due to the expectation of possible negative evaluations from other people (Banerjee, 2008). In social anxiety, they are afraid of failing and being criticized (Epkins, 1996) so they are motivated to impress other people because of the fear of negative reactions (Schlenker & Leary, 1982). In order to avoid these negative evaluations, they focus on their presentation of self more than other people's preferences thus they fail to modify their behavior according to interpersonal relationships dynamics (Banerjee & Watling, 2010). As a result, they actually having mentalization problems in a multi-level way because of their hyper arousal. They could not understand the links between different emotions, intentions, beliefs etc rather than simple deficit on cognitive mentalization. They fail to focus on different levels of mentalization thus fail to comprehend flexibility to adapt different social situations (Banerjee, 2008). Their hypervigilance also continuous in the absence of real social interaction which shows that cognitive biases are encoded (Banerjee & Watling, 2010). Even though research on depression in this context is limited compare to anxiety there are some studies showing similar kind of negative bias with depressive symptoms too. People with depressive symptoms showed tendency to perceive negative signals over the positive ones when processing the information (Beck, 1967). For instance, depressive children showed biased tendency to focus on and remember negative words related to self more than the positive ones (Hammen & Zupan 1984; Zupan et al 1987). Also, there are other studies showing theory of mind deficits in adults with major depression (Inoue et al., 2006; Montag et al., 2010).

Affective level of mentalization is another important dimension to be reviewed. Identifying, understanding and expressing the emotions as well as the regulation capacities play a crucial role in psychological wellbeing and preventing

behavioral problems (Thompson, 1994; Cicchetti et al., 1995; Allen et al., 2008). For instance, in the study of Hughes and friends (1988), children with behavioral problems showed worse performance on emotion understanding compare to control group of peers. Another study also showed emotion understanding was in a negative relation with behavioral problems while it was positively correlated with prosocial behavior (Cassidy et al., 2003). Cook and colleagues (1994) measured expressing and comprehending emotions by asking children to identify 10 emotions as well as 10 cues for recognizing those emotions. Results indicated that children with behavioral problems had more difficulty in emotion understanding than others.

Even though children with externalizing problems show successful performances on cognitive mentalization tasks, they have more difficulties in affective components of the mentalization ability (Sharp, 2006). Sharp (2008) found that children with conduct problems showed deficiency in identifying emotions from the eyes of others (Child's Eye Task; Baron-Cohen et al., 2001). In another study, it was demonstrated that children with externalizing behavioral problems performed badly in emotion understanding by failure in providing appropriate examples to specific emotions compare to their peers especially for their own emotions (Cook et al., 1994). Another level of affective mentalization is empathy and there are some studies showing the deficiency of empathy in children with externalizing behaviors too. Empathy was found to be a preventive factor for aggressive behavior (Feshbach, 1984; Parke & Slaby, 1983). Also, Miller and Eisenberg (1988) found a negative interaction between aggression, externalizing behaviors, antisocial symptoms and empathy, sympathy. The feelings of sadness and fear were found to be hard to empathized for children with externalizing behaviors in Blair's (2003) study.

Understanding emotional mentalization is hard for children with internalizing behaviors too. For example, children and adolescents with depressive symptoms recognized the negative emotions like fear and aggression less than non-depressed control group (Lenti et al., 2000). On the other hand, in Walker's (1981)

study, anxious-depressed children failed to identify positive and neutral emotions as their healthy peers. They labeled positive or neutral emotions like “curious” or “surprised” as negatives like “fear” or “sadness”. In another study, intensity perception was measured in adolescents with depression and higher levels of perceived intensity of anger were found to be related to the more depressing symptoms (van Beek & Dubas 2008).

Another distortion in mentalizing practices of children with behavioral problems is about the self and other perception. Children with externalizing problems tend to see themselves in a positive way while evaluating other’s intentions more hostile (Sharp, 2006). Sharp and colleagues (2007) looked for children’s responses to ambiguous social situations and evaluated the responses in three categories: overly positive attribution to self, overly negative attribution to self and rational attribution to self. They discovered that overly positive attribution is related to externalizing behaviors. In the study of Ha and colleagues (2011), it was also found that children with externalizing problems interpreted the intentions of other players as negative in a trust play designed to perceive other party’s perspectives and intentions. These children have a *“self-serving bias”* that while they think about themselves in an overly positive way, they also believe that others think about them positively too. This self-serving bias functions as a protective factor from possible negative evaluations from others but when they confront the reality, it leads them to act aggressively due to the feeling of being threatened (Ha et al., 2011).

On the other hand, the distortion in mentalizing of children with internalizing problems is more about focusing on other’s minds in order to detect possible negative evaluations (Banerjee, 2008). Recent research showed that children with internalizing problems have more difficulty to understand their own mental states even though they have a better understanding on other’s minds (Bizzi et al., 2019). But this focus on other’s minds are not in a balanced way; it is excessive and also harmful for social interactions (Banerjee & Waitling, 2010). On

the contrary to children's overly positive attributions to self in externalizing behavior problems; in internalizing behavior problems, children attend to negative features of situations and interprets the attributions in a negative way. This kind of *self-debasing cognitive distortions* lead children with internalizing problems to have irrational believes and blame themselves for negative things (Barriga et al., 2000).

Besides the dimensions of mentalization, intensity and level of mentalization are also indicators for psychopathology. Mentalization failures can be in three forms: no mentalization or under mentalization, hyper-mentalization and pseudo or distorted mentalization (Allen et al., 2008). Failing to mentalize or underdevelopment of mentalization attributes were found to be related to mostly autistic symptoms especially in theory of mind research (Sharp & Venta, 2012). Children with autism spectrum disorder have difficulty to understand mental states and behaviors in terms of mental states (Baron-Cohen et al., 1994). Recognizing emotions of others especially complex emotions in social situations is hard for them (Golan et al., 2008). So reduced level of mentalization is seen in individuals with autism (Sharp & Venta, 2012).

On the other hand, hyper mentalization or in other words mentalizing too much is a mentalization deficit because overly interpreting mental states actually results in reduced mentalization too (Sharp & Venta, 2012). This kind of mentalization deficit is mostly seen in internalizing behavior problems because of overly focusing other's mind due to the expectations of criticism and negative evaluations as mentioned above (Banerjee, 2008, Sharp et. al., 2011). Hyper mentalization is also a characteristic of borderline personality disorders (BPD). Individuals with BPD focus on social cues too much and overly interprets the signals resulting in excessive but inaccurate mentalization (Sharp et al., 2011). This kind of too much mentalization also found to be related to trauma because children are hypervigilant to mental states of others for possible danger coming from the other party (Allen et. al., 2008).

Finally distorted or pseudo mentalization refers to mental state assumptions that seem like mentalization but inaccurate and distorted thus it is lacking the main characteristics of real mentalization (Allen et. al., 2008). Pseudo mentalization includes inaccurate attributions (e.g. You are trying to kill me) and there is no room for the opaqueness nature of the mentalization in pseudo mentalization because genuine mentalization acknowledges the impossibility of knowing other's mind completely. In addition to the self-serving bias in externalizing behavior problems mentioned above, making certain assumptions about the minds of others are features of the pseudo mentalization (Fearon et al., 2006). The biased understanding of the minds of others in a distorted way with hostile attributions in externalizing behavioral problems (Nasby et al., 1980) is an indicator of pseudo mentalization. Children do not have the curiosity of minds in a genuine way but used the mentalization as a manipulative way in pseudo mentalization (Sharp & Venta, 2012). For example, in the study of Crick and Grotpeter (1996), girls got control over other children by building intimacy with them first and encouraging the disclosure before the bullying. This requires complex skills of mentalization but this kind of mentalization is not for building healthy social relations but is for social manipulation.

Assessing mentalization through mental state talk is another effective way to look for children's capacities to understand different internal states and explicitly express different dimensions of mentalization as mentioned above (Fonagy et al., 1998). Mental state talk gives opportunity to look different kinds of mental state words (emotion (e.g. sad), cognition (e.g. believe), perception (e.g. look), physiological (e.g. hungry) and action-based (e.g. hug, hide)) through narratives (Bekar et al., 2014). Though, there are also some research looking for the interaction between behavioral problems and mental state talk of the children. The less use of mental state talk was associated with behavioral problems in children. However, there are some studies looking for different kinds of mental state words and their relation to behavioral problems. For instance, Rumpf and colleagues (2012)

conducted a study with children with Asperger Syndrome (AS), children with Attention Deficit and Hyperactivity Disorder (ADHD) and healthy controls. They asked children to tell a story by looking a wordless picture and looked for the mental state talk of the children. Results indicated that children with AS and ADHD told shorter and less comprehensive stories with less use of mental state words especially in cognition category (Rumpf, et al., 2012). Understanding and explicitly expressing emotions are also hard for children with behavioral problems especially for externalizing behaviors. It has been found that these children used less emotional experience examples (Cook et al., 1994). Parallel to this finding, Bekar (2014) also discovered that preschool children who can easily understand and label emotions in a story narrative measured by CS-MST, have fewer behavioral problems. In the study of Gocek (2007), emotional availability and mental state talk of mothers were found be important in children's pathology too. Clinical and non-clinical group of children differed in terms of mother's cognitive mental state talk.

In addition to these studies, another perspective was suggested by Pinto and colleagues (2017) related to mental state talk and behavioral problems. Results of their study indicated that two main categories dominated the mental state talk of children: affective and perceptual. Perceptual states which include more action-based words, physiological and perception related states, refer to more superficial and shallow mental states and focus on rudimentary aspects of explaining a behavior. On the other hand, emotional states indicate deeper and more complex expressions of underlying mental states and explain the behaviors in causal relations to emotions (Pinto et al., 2017). Parallel to these findings, Halfon and colleagues (2017b) found that children with behavioral problems and their parents used more action-based and perception mental state words when compare to emotional mental state words.

In the same study by Halfon and colleagues (2017b), they looked for different mental state talks of children and their parents in relation to affect regulation, symbolic play and behavioral problems of children. They assessed

mental state talk in the context of play and categorized it as play related mental state talk which included the mental state talk of play characters by the child or parent, other related mental state talk which included attributions to listener and finally self related mental state talk which were the parents' and children's mental state words about themselves. In terms of symbolization and pretend play of children, play related mental state talks of children and mothers were found to be significant on children's capacity of symbolic play. From the perspective of behavioral problems, play related mental state talk of children and mothers was indicated to be related with lower levels of internalizing problems. On the other hand, higher levels of externalizing and total behavior problems were associated with self related mental state talk of children and other related mental state talk of both parents out of the play context (Halfon et al., 2017b). In another study, therapist's talk about mental states of children in play therapy context were examined in two single cases with symptoms of separation anxiety. Results of the study showed that in both cases therapists' mental state talk was predictive for affect regulation of both children. However, children's mental state talk was discovered to be supportive for affect regulation only for the child who showed clinical improvement in symptoms of anxiety (Halfon et al., 2017a).

1.2 PSYCHODYNAMIC PSYCHOTHERAPIES WITH CHILDREN

Psychodynamic technique in therapies of children has been commonly used in many years and supported to be effective (Midgley et al., 2017). It embraces psychoanalytic theories in integration with object relations, developmental psychology and attachment theory (Alvarez, 2012; Kegerreis & Midgley, 2014). Psychoanalysis has been used in many years with adults and it was applied to young people after 1920s with starting with Freud and later continued with other early psychoanalytic theorists like Anna Freud (1927), Melanie Klein (1933), Margaret

Mahler (1975) etc (Kegerreis & Midgley, 2014). Working with unconscious and defense mechanisms contributed to basis of psychoanalysis with children in the scope of play (Preter et al., 2018). Psychoanalysis has been still represented in psychodynamic psychotherapies as Preter and colleagues (2018, p.5) stated that psychodynamic psychotherapies "*continue to feature the aim of understanding the unconscious psychological meanings of symptoms and explication of narrative themes confounded by defensive avoidance*".

Attachment theory is also constituting an important aspect of psychodynamic psychotherapies with children. Main and colleagues (1985) included early attachment relation perspectives to representations of adults with developing Adult Attachment Interview (AAI). It contributed in research area as well as psychotherapy techniques (Obegi & Berant, 2010). In psychodynamic psychotherapies with children, attachment of the child could not be thought outside of the therapy (Levy et al., 2012). Bowlby (1973, p. 191) even defined the role of therapist as "*to provide the patient with a temporary attachment figure*". Therapist helps the child to explore his/her attachment relations and their effects on relations outside of the therapy thus works with child's internal working models (Levy et al., 2012).

Object relations theory also focus on the relational aspect of child's life. It embraces the concept of internalization of actual relationships beginning with mother-child dyads. Real objects (significant others) become internalized objects in child's inner life and child constitutes mental representations of self in relation to significant others (Hamilton & Hamilton, 1988). In psychodynamic psychotherapies, therapist takes the part of being the object child would internalize and helps the child with his/her difficulties in interpersonal relationship. Thus, the dyadic relationship between the therapist and the child is very important in this approach (Benedict, 2006).

Association of Child Psychotherapists (2016) defined the purpose of psychodynamic psychotherapy with children as "*The therapist can help the child*

make sense of their own experience and develop their own individuality and potential". Even though techniques and details of theory differentiated between early psychodynamic theorists, psychodynamic psychotherapy with children mainly focuses on the internal world of the child and its exploration in a safe therapeutic environment. Play is the key factor in this exploring process because children brings their internal world and communicates it with the therapist through play (Kegerreis & Midgley, 2014). Winnicott (1971) even thought that play itself is therapeutic and explained the psychotherapy in the scope of play: "*Psychotherapy takes place in the overlap of two areas of playing, that of the patient and that of the therapist. Psychotherapy has to do with two people playing together*" (p. 51). Thus, psychodynamic psychotherapies with children use symbolic play as a tool to discover child's unconscious fantasies, conflicts, wishes (Fonagy & Target, 1996b; Chazan, 2002). Throughout play, they aim to help affect regulation of children and enhance their symbolic play capacities which in turn brings reduction in symptoms. (Halfon et al., 2019; Kernberg & Chazan, 1991).

1.2.1. Attachment and Psychodynamic Psychotherapies with Children

As mentioned above, attachment plays a critical role in psychodynamic psychotherapies with children. When he constituted his attachment theory, Bowlby defined it in the scope of both normal and pathological development. He thought that early attachment relations in childhood may affect the later psychopathologies in adulthood (Bowlby, 1977). Thus, attachment theory is crucial for psychotherapy research too. It was integrated into psychodynamic principles with Main's Adult Attachment Interview (AAI) (Main et al., 1985). Main evaluated adults' representations and their mind states in terms of attachment relationships. Therefore, internal worlds of the patients were included in addition to behavioral observation side of the attachment research (Levy et al., 2012). It became to be used in the research of psychodynamic psychotherapies. For example, it was used in a

psychoanalytic therapy of a parent and infant in order to assess mental functioning of parents in terms of their early attachment relationships and its effect on their relationship with their babies (Steele & Baradon, 2004).

For many years, attachment theory was accepted as one of the most important things in psychoanalysis (Sandler, 2003). There are many common features between attachment theory and psychoanalytic theory (Fonagy et al., 2008). For example both of them emphasized that disorders have psychological meaning and they should be evaluated in terms of conscious and unconscious internal states of patients with an emphasis on understanding the unconscious; the primary caregiver of the patient and the relationship with her are central for healthy psychological functioning and these important relationships with significant others are internalized and constituted for later self and other representations (Holmes & Bateman, 2002; Person et al., 2005).

In therapy relationship therapists work on those aspects of attachment relations. Bowlby (1973, p. 191) himself defined the role of therapist as "*temporary attachment figure"* for the patient. In psychodynamic psychotherapies, the therapist investigates child's feelings, behaviors, wishes, ideas etc and their relations to child's attachment qualities before and throughout therapy. Eventually, therapist helps the child to explore his/her own attachment relations and experiences in outer world by using the interpersonal relation with the therapist in treatment process. Child gains awareness of how his/her relations with parents in the past may affect his/her relationships with other people including the therapist in present time. Therapist provides the child the secure platform for representational exploration of self thus child can become to internalize this new relation. The relation with the therapist enhances a new way of affectionate bonding and the new healthy bonding replaces the old insecure ones (Levy et al., 2012).

There is some empirical research on psychodynamic psychotherapies and attachment. For example, Fonagy and colleagues (1996a) looked for the outcomes of psychoanalytic psychotherapy of 85 nonpsychotic patients in relation to their

attachment qualities measured with AAI. They found that dismissing attachment style in adulthood was related to more improvements at the end of the therapy. On the other hand, 41% of patients with preoccupied attachment style also showed improvement but it was lesser than the dismissive group. Other studies also discovered that preoccupied attachment style was related to less improvements in outcome as a result of psychodynamic adult therapy (Reis & Grenyer, 2004; Strauss et al., 2006). Strauss and colleagues (2006) also found that securely attached patients mostly showed improvement. Also, Tasca and friends (2006) compared attachment styles and different psychotherapies of cognitive-behavioral and psychodynamic. They found that anxious attachment patterns were more related to gain greater successful outcomes in psychodynamic psychotherapies more than in cognitive behavioral psychotherapies.

There are less studies in child and adolescent psychodynamic psychotherapy research related to attachment. Pearce and Pezzot-Pearce (1994) emphasized to include attachment perspective in treatment of abused children. Stefini and colleagues (2013) looked for attachment styles and their effect on psychodynamic psychotherapy outcome of children and adolescent. They found that attachment style of children changed into security throughout therapy process. At first only 23% of children was classified as secure attachment while after therapy it raised into 63%. On the other hand, they could not find a relation between attachment styles and outcome. In another study, an improvement in outcome of short-term psychodynamic psychotherapy was observed in children with secure attachments (Stefini et al., 2008).

1.2.2. The Effectiveness of Psychodynamic Psychotherapies with Children

Shedler (2010) explained the effectiveness of psychodynamic psychotherapies with adults in his review paper of many empirical studies. Both short-term psychodynamic psychotherapies (STPP) and long-term psychodynamic

psychotherapies (LTPP) were found to be effective on symptom improvement in adult patients. In a meta-analysis by Abbass and colleagues (2006) STTP was discovered to be efficient on various common psychological disorders like anxiety, depression, somatic problems etc. Also follow ups were done in the study and it was observed that change continued even after therapies were ended. In addition to that, Abbass and colleagues (2009) looked for the effectiveness of STPP on various somatic disorders only in 23 studies and more than half of the patients showed improvement while nearly 79% of them reported reduction in using of healthcare systems due to somatic complaints after therapy. In another meta-analysis on STTP, it was demonstrated that 92% of the patients benefit from the psychodynamic therapy in terms of their target problems (Leichsenring et al., 2004). LTTP was also found to be effective on multiple complex disorders like personality disorders and chronic disorders with long term follow ups in the review of Leichsenring and Rabung (2008). Symptom improvement was observed in patients with various DSM diagnosis who were in a long-term psychodynamic psychotherapy and improvement increased even 3 years after therapies were ended (de Maat, et al., 2009). Lastly, two another meta-analysis showed psychodynamic psychotherapies are effective on treatments of anxiety (Keefe, et al., 2014) and depression (Driessen et al., 2010; 2015).

On the other hand, research on psychodynamic psychotherapies with children and adolescents are limited compare to adults (Midgley, 2009). There was a gap between the clinicians and researches in this area (Boston, 1989) but two reviews then examined the independent empirical research on psychodynamic psychotherapies with children and adolescents and filled that gap. The first review was conducted by Midgley and Kennedy (2011) and included studies until 2011 and second review by Midgley and colleagues (2017) investigated the studies after the first one until 2017. From the perspective of different diagnostic group and behavioral problems of children, children with internalizing behavior problems

were found to benefit from psychodynamic psychotherapies compare to children with externalizing behavior problems (Midgley & Kennedy, 2011).

In internalizing behavior problems, depression and anxiety are important diagnostic groups which were mostly studied. Psychodynamic psychotherapies were found to be effective on decrease of depression (Trowell et al., 2007; Weitkamp et al., 2014; Goodyer et al., 2017) and anxiety (Milrod et al., 2013; Göttken et al., 2014) in children and adolescents. Four cases of children were detailly analyzed by Haslam (2008) and significant change was observed in internalizing behavior problems which were measured by CBCL with a reduction of anxiety and depression symptoms. Also, Muratori and colleagues (2003) demonstrated that psychodynamic therapies with the focus of representations of child with emphasis on emotions and attachment relations were effective on improvement in internalizing disorders.

For externalizing problems, one study looked for the efficiency of psychoanalytic psychotherapies in addition to behavioral therapy with or without medication on oppositional defiant disorders and/or attention deficit hyperactivity disorders. Even though no significant differences were found between treatments, psychoanalytic treatment was discovered to be as effective as behavioral therapy and medication (Laezer, 2015). Winkelmann and colleagues (2005) looked for the difference between children with externalizing behavioral problems who did or did not have short-term psychodynamic psychotherapies. Results indicated that 31% of the children who got STTP showed improvement compare to controls. On the other hand, Eresund (2007) discovered that supportive therapies encouraging expression of emotions were more effective in children with externalizing problems. Expressing negative emotions and affect regulation in terms of aggression were mostly worked in psychodynamic psychotherapies with externalizing behavior problems (Kernberg & Chazan, 1991; Hoffman et al., 2016). Halfon and Bulut (2017) found significant improvements in regulating affects in children with behavioral problems who got psychodynamic play therapy.

A retrospective study from Anna Freud Center covered 763 cases of children between the ages of 3 to 18 with various disorders (Fonagy & Target, 1996a). Younger children were found to benefit more than older children. Results showed significant gains especially for children with emotional disorders. On the other hand, therapies with disruptive disorders especially conduct disorder were discovered to be more difficult to continue and dropout rates were more in these kinds of behavior problems. Although, when therapies were maintained for three years with intensive treatment, the significant difference between the success in outcomes of therapies with emotional disorders and disruptive disorders diminished.

1.2.3. Process Research

Even though researchers looked for the effectiveness of psychodynamic psychotherapies with various outcome studies, question of what ingredients of these therapies cause the effectiveness and successful outcomes remains unanswered (Diener et al., 2007). Process research aims to fill that gap and answer the question of why and how psychotherapies provide benefits and lead change (Goodman et al., 2016). In other words, it tries to figure out "*what works for whom*" as Fonagy and colleagues (2002) said. Thus, as a further step for effectiveness studies; process studies explored specific therapy techniques, interventions, therapist and client characteristics and features associated with the change (Jones et al., 1988; Kazdin, 2000).

There are some measures looking for different aspects of therapies (e.g. therapeutic alliance or interventions of therapists) separately but a measure which takes the whole single session into account and covers all the characteristics of therapist, clients and dyadic interaction between them was needed (Schneider et al., 2010). Psychotherapy Process Q-Set (PQS) was developed by Jones (1985) in order to assess these aspects in adult psychotherapy processes. There are 100 items in

PQS that covers all three aspects mentioned above. Coders q-sort all 100 items into nine piles in order to describe a single session according to degree of items being characteristic or uncharacteristic for that particular session. Limited number of items can be put into each category in order to constitute a normal distribution at the end of the coding. Thus, PQS provides a unique profile for a particular session as well as an opportunity to make comparisons with other therapy sessions (Jones, 2000). In studies used PQS for psychodynamic psychotherapy research, focusing on and emphasizing affects were found to be most important aspects in psychodynamic technique (Jones & Pulos, 1993; Ablon et al., 2006) especially when compared to cognitive behavioral therapies (Ablon & Jones, 1998).

In child psychotherapy process research, there has been some studies looking for the mechanisms of change and important elements in treatment too. For example; Kernberg and colleagues (1998) came up with an instrument to explore play detailly in child therapies or Foreman and colleagues adapted a measure to look for therapeutic alliance (2000). Estrada and Russell (1999) used Likert scale to assess therapy process by developing Child Psychotherapy Process Scale (CPPS). On the other hand, in order to assess the entire session objectively and to understand the therapy ingredients in terms of characteristics of therapist, child and the interaction between them, Schneider and Jones (2004) developed Child Psychotherapy Process Q-Set (CPQ) based on PQS. 100 items that cover the process in child therapies across different theoretical orientations were identified. Other than that, coding and methodology of CPQ is similar to PQS.

1.2.3.1. The Use of Child Psychotherapy Process Q-Set (CPQ) in Research

CPQ was used in many studies looking for basic factors differentiating theoretical approaches, main ingredients of therapy processes which are helpful in successful outcomes or identifying interaction structures which are group of items specifically determine interaction between therapist and the child. First of all, in the

study of Goodman and colleagues (2016), 31 experts on reflective functioning (RF), psychodynamic psychotherapy (PDT) and cognitive behavioral therapy (CBT) across the world rated CPQ in order to determine the ideal session for children according to their theoretical orientation. As a result, a prototype ideal session for each orientation was constructed. CBT and PDT were actively differentiated in their ideal session characteristics while RF was found to be the common factor in both orientations. 10 most characteristic and 10 most uncharacteristic items that define the prototype PDT session for children are listed in Table 1.1.

Table 1.1.

Most characteristic and uncharacteristic CPQ items of prototype PDT session

CPQ Number	CPQ Item
Most characteristic PDT items	
6	*T is sensitive to the C's feelings*
45	*T tolerates C's strong affect or impulses*
76	*T makes links between C's feelings and experience*
67	*T interprets warded-off or unconscious wishes, feelings, or ideas*
62	*T points out a recurrent theme in the C's experience or conduct*
65	*T clarifies, restates, or rephrases C's communication*
100	*T draws connections between the therapeutic relationship and other relationships*
36	*T points out C's use of defenses*
38	*T and C demonstrate a shared vocabulary or understanding when referring to events or feelings*
98	*The therapy relationship is discussed*
Most uncharacteristic PDT items	
24	*T's emotional conflicts intrude into the relationship*
18	*T is judgmental and conveys lack of acceptance*
17	*T actively exerts control over the interaction*
37	*T behaves in a didactic manner*
55	*T directly rewards desirable behaviors*
9	*T is nonresponsive (vs. affectively engaged)*
21	*T self-discloses*

66	*T is directly reassuring*
27	*There is a focus on helping C plan behavior outside the session*
95	*C's play lacks spontaneity*
41	*C does not feel understood by T*

Note. T = therapist; C = child.

Another recent study used CPQ to identify interaction structure (IS) in psychodynamic psychotherapy, other possible IS over the course of therapy process and their relationship with the outcomes (Halfon et al., 2018). Four IS were discovered as a result: a) *Therapeutic Alliance,* b) *Children's Emotion Expression,* c) *Child -Centered Technique* and d) *Psychodynamic Technique.* Among these four IS, only psychodynamic technique was found to be predictive on positive outcomes in total behavioral problems. Items load to this factor included therapist's interpretation of child's unconscious and unacceptable emotions, therapist's emphasizing affects and linking them to child's experiences, therapist's interpretation of the meaning in child's play and therapist's making comments on the defensive strategies of the child.

Goodman and Athey-Lloyd (2011) also looked for the interaction structures in their study. They compared the therapies of a boy with Asperger's disorder with two different therapists. Therapies were distinguished by using CPQ to detect different IS in both therapy processes. Four IS were identified and they were found to be fluctuated over the course of both treatment and their quantities differentiated between two therapists. Three of the factors cover positive aspects of therapist-child interactions. These are *"Helpful, mentalizing, confident therapist with expressive, comfortable, help-seeking child", "Reassuring, supportive, nondirective therapist with a compliant, curious child building insight and positive feelings"* and *"Accepting therapist with playful, competitive child".* Fourth IS was about negative aspect of transference relation. It was named as "*Judgmental, misattuned therapist with distant, emotionally disconnected, misunderstood child"*. This study

empirically supported that every child therapist dyad is unique and treatment should be shaped according to specific dyads.

Schneider and colleagues (2010) used CPQ to explore therapy process of a 11-year-old girl in psychodynamic treatment. She took intense psychoanalytic therapy for three years after coming with the complaints of extreme withdrawal, lack of feeling any emotion and difficulties in concentration. She got diagnosis of many disorders including *Major Depressive Disorder, Avoidant Disorder of Childhood, Panic Disorder* and *Generalized Anxiety Disorder*. Because her therapy process supplied successful outcomes, authors used CPQ to look for her psychotherapy process in detail. Three factors were discovered to be effective when factor analysis was conducted to identify which clusters of items load to which factors. First factor was about uncovering the withdrawal side of her with therapist's emphasizing unspoken emotions and making links with experiences of her. Second factor was about her resistance to explore her anxiety and therapist's interpretation of her play and drawing attention to unacceptable feelings. Finally, third factor was found to be related her coming out from her shell which means her being more active and expressive while therapist being nonjudgmental and sensitive to her feelings. These three factors were discovered to draw a portrait of her treatment process' early, middle and later phases in order and provided an important point of view to understand what promoted the change.

1.3. MENTALIZATION AND PSYCHODYNAMIC PSYCHOTHERAPIES WITH CHILDREN

Children with internalizing and externalizing problems have difficulties in symbolic play organization especially in the scope of regulating negative affects like anger and anxiety (Fonagy & Target, 1996b; Halfon et al., 2019; Kernberg & Chazan, 1991). In order to develop symbolic play capacity, children should stay distant in an adaptive way to overwhelming emotions and have the capability of

verbalizing and coherently reflecting on these emotions according to context (Fonagy et al., 2002). Children with behavioral problems show incapacity in this angle. Problems in regulating affects and organization in addition to higher levels of anger and hostility in play were observed in externalizing behaviors (Butcher & Niec, 2005). Children with internalizing problems also had difficulties in organization and coherent symbolic play (Christian et al., 2011; Lous et al., 2002).

Mentalization is closely related to symbolic play capacity and affect regulation in children (Fonagy et al., 2002). As mentioned in previous parts, children should develop capacity to pretend, to play with reality as if it was something else so they can represent internal states and develop agentive self. This is only possible with normally developed mentalization capacity (Fonagy & Target, 1996b). Symbolic play as well as mentalization also requires secure attachment relations. When mother is attentive and reflective on her child's mind, children internalize this ability and explore own mind and reflects it symbolically in play (Meins & Russell, 1997). For example, children's complex role play was found to be positively related to their dyadic mental state talk with their mothers in a study (Lillard & Kavanaugh, 2014).

Psychodynamic psychotherapies aim to re-establish these secure attachment relations with an attuned, reflective and holding attitude. Psychodynamic child therapies provide a safe environment for the child to explore his/her inner world and express emotions in a representative platform through pretend play (Fonagy & Target, 1996b). Thus, symbolic play capacity is crucial in psychodynamic child therapies too (Winnicott, 1971). Because children with behavioral problems have difficulties in these areas, one of the main therapeutic goal of psychodynamic child therapies is to enhance symbolic play capacity (Slade, 1994). Through safe therapeutic relation with a therapist who accepts, understands and reflects on child's mental states, child gains the ability to acknowledge own experiences which eventually help affect regulation (Fonagy & Target, 1998) and adaptive symbolic play (Halfon et al., 2019).

Mentalization principles were integrated into psychodynamic techniques in child therapy by Verheugt-Pleiter and colleagues (2008). Especially affective mentalization was emphasized in terms of psychodynamic treatment process (Verheugt-Pleiter, 2008) because when it comes to affects, regulating them requires being emotionally involved with feeling rather than cognitively embraces them (Blagys & Hilsenroth, 2000). Thus, first of all therapist him/herself should be at mentalizing stance, be there in a nonjudgmental way and accepts child's inner world without modification (Fonagy, 2000). In psychodynamic therapy with children, therapist emotionally engaged with the child and share child's unbearable experiences with him/her. So, these unbearable emotions become bearable and can be explored and reflected in symbolic world of the play (Fonagy & Target, 1998; Slade, 1994). Verheugt-Pleiter and colleagues (2008) suggest five mentalization criterion in therapy in terms of these principles:

1-) *Recognizing the child's level of mental functioning and meeting at the same level*: Therapist should be attuned to the child and understands his/her level of mentalization. Then he/she should adjust her/himself and his/her intervention techniques according to child's level.

2-) *Playing with reality*: Symbolic play is the key factor in therapy and therapist should encourage it.

3-) *Work in the here-and-now of the relationship*: As mentioned in previous parts, "marking" the mental states of children enhance the development of mentalization capacity. Thus, in therapeutic relation, therapist should mark the mental states of children in order to help his/her mentalization.

4-) *The process is more important than the technique*: The process itself implicitly be lived by child-therapist dyad and it is more important than the explicitly used techniques.

5-) *Giving reality value to inner experiences*: Embracing child's opinions and perspectives are important in therapy. Therapist should focus on and explicitly

states these by observing the child and her/his reality instead of making mere assumptions.

These criteria also show similarity with Blagys and Hilsenroth's (2000) principles for psychodynamic techniques especially the one about emphasizing affective states of patients. Psychodynamic play therapy manuals like Regulation-Focused Psychotherapy for Children (RFP-C; Hoffman et al., 2016) and Kernberg and Chazan's (1991) manual for children with conduct disorders, emphasize the significance of addressing the underlying avoided emotions of disruptive behavior of the child and supporting him/her to express negative affect in order to regulate them. Thus, throughout affect focus in psychodynamic child therapies, child's ability to comprehend a contact self narrative with a mentalization and affect regulation capacity improve (Ensink & Mayes, 2010; Fonagy et al., 2002).

So, in psychodynamic psychotherapies with mentalization principles, the dyad of therapist and child focus on mental states especially affective mental states of self and others. Therapist's mentalizing, empathic and reflective stance provides a secure base for the child to explore minds and replace his/her non-mentalistic modes of behavioral problems with the mentalizing stance. Becoming aware of mental states in here and now relationship of the dyad in therapy enables child to reconceptualize old traumas, insecure attachment patterns unconsciously in real dyadic secure relationship instead of focusing on these past experiences directly (Brent, 2009). One of the important things in psychodynamic psychotherapies with mentalization principles is therapist's role of being accompanying the child in his own adventure of discovering own mental states as reflection in therapist's mind. Thus, therapist's stance of "not knowing" but being curious about child's mind ("inquisitive stance") promotes this discovery and mentalization development of the child (Fonagy, 2000).

1.3.1. Empirical Evidence

Mentalization and psychodynamic psychotherapies with adults were found to be related in literature. Limited level of mentalization capacity may affect the outcome and process of therapy because these patients have difficulty to analyze their problems and understand the self and others in the scope of mental states. Thus, it may be harder and longer for them to improve (Fonagy et al., 2002). Mentalization was thought to be the common factor in many therapy techniques including psychodynamic psychotherapies (Allen et al., 2008). Freud (1933) defined the aim of psychoanalysis to gain "insight" about unconscious and increased level of "insight" was associated with better ego strength and good therapy outcomes. Reflective functioning is also closely related to "insight" because it also requires insight about inner states in terms of interpersonal relationships (Karlsson & Kermott, 2006).

Blagys and Hilsenroth' (2000) criteria defining the main components in psychodynamic psychotherapies include mentalization characteristics too. For example, one of the criteria was "*Focus on affect and the expression of patients' emotions*". Also, it was found that psychodynamic psychotherapies facilitated the mentalization abilities (Karlsson & Kermott, 2006) due to focusing on dyadic relationship between therapist and patient and the defense mechanisms (Bateman & Fonagy, 2004; Fonagy et al., 2002; Jones, 2000). Therefore, they facilitate the differentiation of representations of self and other (Jones, 2000). Thus, there is a mutual interaction between mentalization and psychodynamic psychotherapies (Muñoz Specht et al., 2016).

As mentioned above, mentalization was researched with different terms like reflective functioning or mind-mindedness. In the study of Müller and colleagues (2006), patients' "operationalized psychodynamic diagnostics" (OPD) which is a psychodynamic assessment way of psychic structure of patients, were found to be significantly associated with their reflective functioning capacity. Also, in the same

study, reflective functioning capacity of patients diagnosed as eating disorder or depressive disorders predicted the overall successful outcomes at the end of the therapy (Müller et al., 2006). In another study, authors compared reflective functioning improvement of patients who got transference-focused therapy which is a kind of psychodynamic therapy. They also compared the group with a control group of patients who got treatment by community therapists. After one year of treatment, significant improvement in mentalization capacity of patients was observed only for the group who got transference-focused therapy (Fischer-Kern et al., 2015). Also, in Goodman's (2013) study, mentalization was discovered to be the common factor between "*transference focused psychotherapy*" and the "*dialectical behavior therapy*".

Taubner and colleagues (2011) looked for the effect of mentalization assessed as reflective functioning on the psychoanalytic therapy of depression patients. Even though they did not find a prediction of mentalization on therapy outcome, they found that it predicted decrease in the general stress level of patients eight months after the therapy. In another study, Leweke and colleagues (2009) looked for alexithymia and its effects on psychodynamic treatment. Alexithmyia was defined as the inability to understand and express emotional states thus it is closely related to mentalization. They found that higher alexithymia negatively predicted the treatment outcome (Leweke et al., 2009). The results were parallel to the findings of Taylor and friends (1997) because they also found that deficits in mindedness and understanding the emotional cues decreased the chance of successful engagements in psychodynamic treatments. Finally, Brent (2009) found that mentalization based psychodynamic psychotherapies were effective on treatment of psychotic patients due to enhancing the awareness of self and others.

There are few studies looking for the direct relationship between mentalization in children and psychodynamic psychotherapies with them. One of the studies looking for the relationship between mentalization and psychodynamic treatment in child therapies is Goodman and colleagues (2016) study with expert

clinicians to identify ideal sessions according to psychodynamic, mentalization and cognitive behavioral theoretical approaches as mentioned above. After identifying most characteristic and uncharacteristic features of ideal sessions for each orientation, it was discovered that mentalization was a common factor for both psychodynamic and cognitive behavioral approach. Ideal sessions of mentalization based therapies and psychodynamic therapies with children shared many qualities. The common items which were determined by experts to describe both therapies' ideal sessions are displayed in Table 1.2.

Table 1.2.

Common characteristic and uncharacteristic CPQ items of prototype PDT and RF sessions

CPQ Number	CPQ Item
Common most characteristic PDT and RF items	
6	*T is sensitive to the C's feelings*
76	*T makes links between C's feelings and experience*
38	*T and C demonstrate a shared vocabulary or understanding when referring to events or feelings*
Common most uncharacteristic PDT and RF items	
24	*T's emotional conflicts intrude into the relationship*
18	*T is judgmental and conveys lack of acceptance*
55	*T directly rewards desirable behaviors*
9	*T is nonresponsive (vs. affectively engaged)*
66	*T is directly reassuring*
95	*C's play lacks spontaneity*
41	*C does not feel understood by T*

Note. T = therapist; C = child.

Another study by Halfon and Bulut (2017) looked directly to the relationship between mentalization, affect regulation and symbolic play improvement of children who were in psychodynamic play therapy. They looked for the change in symbolic play and affect regulation of children who showed success in symptom

reduction at the end of psychodynamic play therapy. They also compared these changes with Reflective Functioning (RF) adherence of the sessions by using CPQ. RF adherence of sessions were calculated as correlating each session with ideal RF session determined in Goodman and colleagues (2016) study. Results indicated that RF adherences of the sessions were significantly linked to affect regulation and symbolic play of children throughout their treatment process. The quadratic change in affect regulation was observed in sessions with high RF adherence while no change in affect regulation was observed in low RF adherence sessions.

RF adherence scores were used in another study to look for the relation between mentalization principles and children's expression of negative emotions like anger or dysphoric affects, affect regulation and symbolic play activity in children who got long term psychodynamic play therapy (Halfon et al., 2019). They found that expression of dysphoric negative emotions like anxiety, fear and sadness in sessions with high RF adherence was related to higher affect regulation abilities rather than low mentalization adherence sessions.

Muñoz Specht and colleagues (2016) used deduction method to identify mentalization techniques in 14 sessions of two experienced psychodynamically oriented child and adolescent therapists. Sessions were coded with CPQ and they identified 24 techniques which reflected mentalization principles under three categories: 1) "*Supporting mentalizing stance interventions"* (e.g. *Supportive and empathic interventions* technique like facilitating alliance), 2) "*Basic mentalizing techniques"* (e.g. *Exploring mental states* or *Mentalizing the transference technique*) and 3) "*Mentalizing the play context"* (e.g. *Mentalizing the play narrative* or *Mentalizing characters and relationships in the play context* or *Interpreting play context*) (p.p. 289-308). In conclusion, both psychodynamic therapists were found to be using mentalization based techniques in their treatments of children and adolescents.

Lastly, a single case study with two children diagnosed as separation anxiety who were in long term psychodynamic treatment were conducted to understand

how mental state words use of both therapists and children relate to their affect regulation capacities. One of the children showed symptomatic improvement at the end of the therapy while the other one did not. While therapists' mental state talk was discovered to be significantly predictive on affect regulation in both cases; children's mental state talk was supportive for affect regulation only for the child with symptomatic improvement. This study supports that children's mentalization can be effective on their psychodynamic psychotherapy process. When we looked detailly to the sessions of two patients, therapists' techniques of mentalizing differed for both cases. In the case of successful outcomes, child had more symbolic play capacity with solid organization skills. She was better in expressing her emotions thus, therapist could work with deeper underlying inner states of children, made more links with child's own affects and symbolic play characters and emphasize the conflicts related to child's life. On the other hand, other child had lower level of explicit mentalization capacity and less organized in her symbolic play capacity. Thus, therapist was using mentalization techniques according to child's level of mental functioning. Therapist focused on regulation of her arousal and attention and tried to take her to a more coherent symbolic play area (Halfon et al., 2017a).

1.4. CURRENT STUDY

There are few studies in child psychotherapy research looking for the relationship between mentalization and psychodynamic psychotherapy with children. These studies mostly aim to identify different mentalization techniques in psychodynamic therapies with children (Muñoz Specht et al., 2016) or common features of mentalization based sessions and psychodynamic sessions with children (Goodman et al., 2016) or how children's and their mothers' mental state talk affected the play context (Lillard & Kavanaugh, 2014). They also focus on to understand how in psychodynamic therapies, children's symbolic play and affect

regulation in the process of therapy related to ideal mentalization based techniques (Halfon & Bulut, 2017; Halfon et al., 2019) or how mentalization based techniques in therapy process are related to outcomes in terms of symptom reduction (Belvederi Murri et al., 2017; Ramires et al., 2012). Most of these studies looked for characteristics of mentalization and psychodynamic process throughout treatments or their relation to outcomes.

One study looked for how mentalization characteristics of children relate to psychodynamic characteristics of their treatment processes in the scope of affect regulation (Halfon et al., 2017a). Based on this study, we aimed to extend those results and explore how different characteristics of children's initial mentalization before therapy relate to their sessions' adherence to ideal psychodynamic psychotherapy session with children. Mentalization is conceptualized as mental state talk in this study. Even though they are not synonyms, mental state talk is an important indication for explicit mentalization (Fonagy et al., 1998).

There are different aspects of mental state words and Coding System for Mental State Talk in Narratives (CS-MST) **(**Bekar et al., 2014) was used to identify these aspects in this study. Different mental state talk variables like affective (two categories of positive and negative affective mental state words) and cognitive states as well as opaqueness nature of mentalization were measured through CS-MST for this study. These mental states were analyzed according to children's use of total words in each subcategory and variety among each mental state words as well as attribution of whom mind (self or other) the mental state words were stated.

In order to understand how these different aspects of mental state talk of children relate to their therapies' conformation to ideal psychodynamic techniques, CPQ was used to calculate adherence score of each session to prototype psychodynamic session determined by Goodman and colleagues (2016). An average psychodynamic adherence score was calculated for each child. Additionally, demographics like age and gender as well as attachment characteristics of children and their behavioral problems reported before their

therapy were also examined as control variables to understand their relation to average psychodynamic adherence scores. So, aim of the study was to understand if children's initial mental state word use characteristics associate and predict average psychodynamic adherence scores for their therapy process.

Thus we hypothesize that when children's attachment qualities, behavioral problems and demographics were controlled 1) Children's emotional mental state talk would be positively associated with and predict average psychodynamic adherence scores; 2) Children's cognitive mental state talk would be positively associated with and predict average psychodynamic adherence scores; 3) Children's opaqueness mental state talk would be positively associated with and predict average psychodynamic adherence scores.

CHAPTER 2

METHOD

2.1. DATA

The data of the study comes from the İstanbul Bilgi University Psychotherapy Research Laboratory. A research to understand the processes of psychotherapy sessions have been conducted in the laboratory. It takes part in İstanbul Bilgi University Psychological Counseling Center where psychodynamic psychotherapies are provided for people with low socioeconomic status. Psychotherapies are conducted by master level clinical psychology students who are either in their second or third years in master education. After the parents of children and adolescents apply for psychotherapy in the center, they are assessed by a licensed clinical psychologist to understand if they fit with the inclusion criteria. Children whose ages are between 3 and 11 years old are accepted for psychodynamic play therapy with the inclusion criteria of the child having no psychotic symptoms, no significant developmental delays, no drug abuse and no significant suicide risk. If they meet the inclusion criteria, parents are informed about the research and informed consent for participating for the research are taken from the parents who give permission. Participation for the research is voluntary and parents have the right to leave the research any time they want. Parents also give permission for either audio or video records for therapy sessions. For this study, data from children who got psychotherapy in 2015 Fall to 2019 Spring was used. The research where the data came from was approved by the İstanbul Bilgi University Ethics committee.

2.2. PARTICIPANTS

99 (58.6% male, 41.4% female) children who were referred to Psychological Counseling Center participated in this study. Children's ages ranged from 3 to 10 (*M* = 7.13, *SD* = 1.97). They were mostly going to elementary school (79.8%) while few of them were going to preschool (18.2%). Most of the children applied for psychotherapy due to the reasons of behavioral problems like rule breaking or being aggressive (37.4%) and anxiety (25.2%). There were also other application reasons like school/learning problems (23.2%) and somatic problems (7%). Most of the children had either one sibling (55.6%) or did not have any siblings at all (29.3%). Other children had either two (13.1%) or three (2%) siblings. Socioeconomic status (SES) of families of children ranged from low to high with most of the families' SES was in the middle range (40%). Ages of mothers were in between 24 and 53 (*M* = 36.21, *SD* = 4.98) while fathers' ages ranged from 25 to 62 (*M* = 40.23, *SD* = 6.27). While most of the fathers were working (89.9%), more than half of the mothers did not work (55.6%). Most of the parents of children were married (87.9%) while others were divorced (12.1%). Demographic information of participants is presented in Table 2.1. in detailed.

Table 2.1.

Demographic Information of the Participants (N = 99).

Variables	**Categories**	**Frequency (N)**	**Percentages (%)**
Children's Age	3-5 years old	21	21.3
	6-8 years old	52	52.6
	9-10 years old	26	26,2
Gender	Female	41	41.4
	Male	58	58.6
Children's Education Level	Preschool	18	18.2
	1st Grade	19	19.2

	2nd Grade	20	20.2
	3rd Grade	15	15.2
	4th Grade	14	14.1
	5th Grade	9	9.1
	6th Grade	2	2
Application Reasons	Aggressive Behaviors	37	37.4
	Anxiety	25	25.2
	School Problems	23	23.2
	Somatic Problems	7	7.1
	Other	7	7
Sibling	None	29	29.3
	1	55	55.6
	2	13	13.1
	3	2	2
Socioeconomic Level	Low	19	19.2
	Low-Middle	23	23.2
	Middle	40	40.4
	Middle-High	14	14.1
	High	3	3
Parents' Marital Status	Married	87	87.9
	Divorced	12	12.1
Mothers' Age	24-34 years old	35	35.3
	35-44 years old	60	60.7
	45-53 years old	4	4
Fathers' Age	25-36 years old	26	26.1
	37-48 years old	64	64.6
	49-62 years old	8	8
Mothers' Education Level	Elementary School	19	19.2
	Middle School	12	12.1
	High School	28	28.1
	University (2 years)	5	5.1
	University (4 years)	30	30.3
	Master/PhD	3	3
Fathers' Education Level	Elementary School	13	13.1
	Middle School	18	18.1

	High School	35	35.4
	University (2 years)	3	3
	University (4 years)	25	25.3
	Master/PhD	3	3
Mothers' Working Status	Working	44	44.4
	Not Working	55	55.6
Fathers' Working Status	Working	89	89.9
	Not Working	9	9.1

2.3. THERAPISTS

Therapists are clinicians who are clinical psychology master students in their internship years. There are 37 (5.4% male and 94.6% female) therapists in this study between the ages of 23 and 35 (M = 25.39, SD = 3.01). They all have the same education based on the theoretical background for psychodynamic play therapy with mentalization principles. All therapists get 1 hour of individual supervision in addition to 3 hours of group supervision per week in their first internship year and get 1 hour of individual supervision if they continue their internship in the second year. Supervisions are done by licensed therapists who are experienced at least 10 years. Number of children therapists treated ranged from 1 to 6 with an average of 3.

2.4. THERAPY SESSIONS

Each child therapy starts with at least 7 assessment sessions including intake session with parents, Parental Development Interview (Aber et. al., 1985) with each parent, parent-child dyadic and free play sessions with each parent, a free play session with child only and a feedback session with parents. Therapist makes formulation about the child before the feedback session and plans the therapy

process with parents in the feedback session. After the assessment sessions, therapy sessions with the child once a week begins and once a month, a session with parents is arranged for inclusion of parents to the process. In therapy sessions, even though they are not manualized, therapists follow psychodynamic principles with mentalization point of view (Verheugt-Pleiter et al., 2018). After setting rules about not physically harming each other and the room, therapist encourages child to express his/her feelings, interprets the play while using mentalization of the characters in the play and makes connections between experiences and feelings of the child etc. The length of the therapy is not determined and termination is mutually set by therapist and parents uniquely for each child.

2.5. MEASURES

2.5.1. Attachment Focused Coding System (AFCS)

Story stems are series of stories which a person tells the beginning of the story by using doll characters and the child completes it. There are many different coding systems by using story stems (Emde et al., 2003). As a story stem technique, Bretherton and friends (1990) developed the Attachment Doll Story Completion Task (ASCT) which is used in this study. In ASCT, there are five stories that begins with an attachment triggering situation with a conflict. The first story called "Spilled Juice" starts with a family of mother, father and child having dinner and child spills his/her juice. Then mother says slightly angrily "You spilled your juice" to the child. In the second story named "Monster in the Bedroom", child goes to his/her bedroom and screams that he/she saw a monster. Third story is "Hurt Knee" and the child climbs to a high rock and falls when the family is in a park. In the fourth story which is "Departure", mother and father go to a holiday without the

child and child stays with his/her grandmother. Finally, in the fifth story, "Reunion", mother and father come back from their holiday after one week.

Attachment Focused Coding System (Reiner & Splaun, 2008) is used for coding the attachment patterns of children by using the stories mentioned above. Different kinds of codes which are parent focused or child focused codes are used in this system. Parental codes include the supportiveness and rejecting patterns of the parents. Child focused codes assess child's avoidance attachment behavior towards his/her parents, child's emotional dysregulation, child's avoidance of negative feelings and the theme of the story and his/her resolution strategies for negative themes and emotions. The scoring system for the codes is Likert scale system of 1 as the lowest score and 5 as the highest score. Supportiveness of mother and father is about the level of the emotional (e.g., hugging, soothing) and instrumental (e.g., wiping the spilled juice or taking the child to hospital after his/her fall from the rock) supportive behavior of parents for the conflict in stories. If the parent does not supply any supportive behavior at all, they got the lowest score for this code while if they show a big deal of emotional and instrumental support, the highest score is given for this code. Parents' rejective behavior is coded as lowest if they do not show any rejecting and aggressive behavior towards the child at all and highest if they are extremely aggressive and get physically abusive to the child (e.g., they kill the child). Child's avoidance attachment behavior towards the parents and the communication with them is scored lowest when child physically goes and finds the parent for the resolution of the dilemma in the story (e.g., child says "Mommy, come here, I am scared of the monster"). For this code to get highest score, child indicates an obvious avoidance behavior from the parent even though he/she needs help (e.g., child runs away from the mother even his/her knee is bleeding). The code for assessing child's emotional dysregulation level explores how child manages with negative feelings and how comprehensive narratives she/he tells. Lowest score for this code includes story having no aggressive or bizarre theme at all while in the highest scoring, child's story should

include extremely violent and bizarre content with dysregulated behavior (e.g., brothers got in a fight and child kills his/her brother). In the code of child's avoidance from the story themes and negative feelings, child should indicate negative emotions related to the story and mention the primary story themes (e.g., For departure story, child should show distress like crying or saying "I am so sad and going to miss you" and address the issue of parents going away) for the lowest score. For getting the highest score for this code, child should not talk about anything related to the primary or secondary themes of the story without any negative emotions. Finally, in the last code of resolution, it is important how child ends the story. The lowest score indicates the negative emotions and conflicted themes in the story are never resolved at all (e.g., in Hurt Knee story, story ends like child's leg is broken but is not cared and he is crying). In the highest score, story should end in a positive or neutral emotional mode while the conflicts related to the primary story is resolved. (e.g., in Spilled Juice, child gets more juice and she/he happily continues his/her dinner at the end of the story).

10 master level clinical psychology students were trained by Allison Splaun, Ph.D., who is the second author of the AFCS manual. 15 sessions were coded in training to achieve interrater reliability (ICC) of .70 and interrater reliabilities of coders ranged from .76 to .86. After ICC reached to .70, coders interdependently coded the sessions from İstanbul Bilgi University Psychological Counseling Center. Only 6 of the 10 coders coded data used in this study. In the current study, the codes of Supportive Mother and Child's Emotional Dysregulation were used for attachment assessment.

2.5.2. The Coding System for Mental State Talk in Narratives (CS-MST)

In order to assess the mentalization capacity of children, Bekar and colleagues (2014) developed The Coding System for Mental State Talk in

Narratives (CS-MST). In this coding system, mental state word counting for different dimensions in narratives of children and parents is used for the assessment. The original use of the coding system was through a picture book without words "Frog, Where are You?" (Mayer, 1969). Parents and children look at the book together and construct a narrative which are recorded and transcribed into verbatim later. In the coding, identified mental state words are evaluated according to five types of mental state words: 1) *emotional* which are either positive (e.g., happy, love, proud) or negative (e.g., sad, angry, scared), 2) *cognitive* (e.g., think, want, know), 3) *perceptional* (e.g., look, smell, taste), 4) *physiological* (e.g., hungry, sleep, hurt) and 5) *action-based* which are actions inherently including mental states (e.g., hug, laugh, help). In each type of mental state words, diversity of the mental state word use is calculated by the uniqueness of mental state words. For example, if child uses the mental state word "angry" four times and "love" two times, the diversity of the emotional mental state words is counted as two because there are only two unique words child uses while total number of the emotional mental state words is counted as six. Also, each type is coded according to whether or not including causality (e.g., because, so, that is why) and the direction of the attribution to whom. These directions are 1) attributions to minds of story characters which is "story-oriented mental state talk", 2) attributions to the mind of narrator which is "self-oriented mental state talk" and 3) attributions to the mind of the listener which is "other-oriented mental state talk".

Addition to the codes mentioned above, there are also three other codes used in this system. These are "*opacity of mental states/reticence"* (e.g., perhaps, maybe, I guess) which is used to assess the opaqueness of the mind and narrator's ability to comprehend that a person cannot fully understand the other's mind, "*inappropriate/pseudo mental state comments"* (e.g., "*Are you crazy*?", "*He is a monster*" (mother talking about the child)) which are the inaccurate interpretations of mental states and "*the situational mental state words"* (e.g., *"The room is scary"*) which are the attributions to the context or situation by using mental state

word other than an agent's mind. The uniqueness of the mental state words in addition to total numbers is calculated in these codes too.

CS-MST is a validated coding system which has been used by a variety of researchers and it has high inter-rater reliability for all categories (.90; Bekar, 2014). The adaptation of the system to Turkish was done by Bekar and Çorapçı (2016) by using the narratives of Turkish children and their mothers.

2.5.2.1. Adaptation of CS-MST in This Study

CS-MST is used in this study through the five story stems of Attachment Doll Story Completion Task (ASCT) by Bretherton and colleagues (1990) mentioned above. The same stories used in the attachment coding are also used for CS-MST coding. The same five types of mental state words (emotional (negative or positive), cognitive, perceptional, physiological and action-based) with same causality and diversity principles in the original coding are used. On the other hand, the direction of the attributions coding is changed in our adaptation. Due to the use of story stems in our coding, most of the attributions of mental state words are done for the characters in the story. Thus, the direction of self-oriented mental state words is coded if child talks about the mind of the child character in the story while other-oriented mental state words are coded if child's attributions are towards to either mother, father or the grandmother in the stories. There is also a third direction of "merged/ambiguous" mental state words in which child either uses mental state words for more than one person (e.g., "*They hugged"*) or it is unclear whom mind the child is talking about.

Another adaptation is done for the use of CS-MST for this study because of the lack of taking organizational aspects of the mentalization into account in the original coding. This adaptation was done by Coskun (2018) with consultation of Özlem Bekar, Ph.D. who is one of the original writers of the coding system and

Sibel Halfon, Ph.D. for the inappropriate/pseudo mentalization category. The adaptation was done according to the principles of Reflective Functioning Scoring System (Fonagy et al., 1998) in which low level of reflective functioning (RF) includes unintegrated, bizarre and inappropriate mentalizing. First of all, if the used inappropriate word is not a mentalizing word, it is not included in the coding. A mentalizing word is coded as inappropriate/pseudo mentalization if the following criteria are met: 1) mentalization words including physical violence to another person (e.g., kicking, slapping, hitting), 2) extremely violent and aggressive mental state words towards others (e.g., killing, stabbing, beheading), 3) assaults ending with death (e.g., eaten by a zombie), 4) inappropriate attributions to mental states as if they are emotional states (e.g., feeling death) and 5) using a mental state words that are pointing out the shutdown of the mentalizing when child is supposed to continue the story (e.g., sleeping or dying suddenly).

For the current study, three mental state word (MSW) categories were used: Emotional MSW (positive and negative), Cognitive MSW and Opaqueness MSW. All three categories' total MSW use, variation (uniqueness) of MSW were included in analysis. For the first two, self or other orientation of MSW were also included.

Six master students in clinical psychology got the coding training from Özlem Bekar, Ph.D., who is the author of the CS-MST. After 5 hours training, interrater reliability of each coder was calculated with comparison to Bekar's own codings on six transcribed stories. Interclass Correlation Coefficient (ICC) was found to be in the range of .87 to .93. For pseudo category of CS-MST, Ayşenur Coskun trained same five master students and ten transcribed narratives were coded. ICC ranged from .74 to .95. Then, twenty five percent of the data were coded by pairs after the resolution of disagreements. Inter rater reliabilities of pairs was found between .83 to .99 in this time. Later, two other master level students received CS-MST coding training including the pseudo MST coding from Ayşenur Coşkun based on ten verbatim sessions and their ICC was calculated in the range of .78 to .98.

2.5.3. Child Psychotherapy Process Q-Set (CPQ)

Child Psychotherapy Process Q-Set (CPQ) was developed by Schneider and Jones (2004) in order to understand and describe psychotherapy process of children between the ages of 3 to 13. CPQ was adapted by Psychotherapy Process Q-Set (PQS; Jones, 1985) which is a process measure for adults and most of the items are similar to PQS except the items that are particular to child psychotherapy (Schneider, 2004; Goodman & Athey-Lloyd, 2011). It aims to bring a standardized language independent from the any specific theory and define the characteristics of child-therapist interaction (Schneider & Jones, 2004). CPQ includes 100 items which were designed to define the process based on a) characteristics of the child (e.g., Child's attitudes like feelings, experiences and behaviors (e.g., "Child is anxious and tense [vs. calm and relaxed]"); b) characteristics of the therapist (e.g., Therapist's attitudes and actions (e.g., "Therapist is sensitive to the child's feelings") and c) characteristics of the interaction between therapist and the child or the nature of the encounter (e.g., "Therapist and child demonstrate a shared vocabulary or understanding when referring to events or feelings").

After watching an entire session, coders q-sort 100 items according to characteristic and uncharacteristic nature of items for that particular session. There are nine piles from 1 to 9 where 1 indicates the most uncharacteristic pile and 9 indicates the most characteristic pile. While pile 1, 2 and 3 indicates uncharacteristic items for that session, piles 9, 8 and 7 indicates the characteristic items. Pile 5 covers the items which are neither characteristics nor uncharacteristic while piles 6 and 4 are similar with slight differences like slightly characteristic or uncharacteristic but still neutral. When placing items, there is a forced-choice ranging in order to make a perfectly normal distribution. In other words, every pile includes a fixed number of items and resemble a normal curve. Pile 9 and pile 1 includes 5, pile 2 and pile 8 includes 8, pile 3 and pile 7 includes 12, pile 4 and pile 6 includes 16 and pile 5

includes 18 items. As a result of forced sorting, each item's scores are related to other items which helps to capture the unique nature of the particular session (Goodman & Athey-Lloyd, 2011).

Different studies supported the validity and reliability of CPQ. In the study of Goodman and Athey-Lloyd (2011), interrater reliability (ICC) between coders reached to mean of .77 (ranging .55 to .89) and in the pilot study of Schneider (2004) ICC's ranged from .58 to .88. For the discriminant validity of CPQ, psychodynamic therapies and cognitive behavioral therapies were distinguished in the study of Schneider and colleagues (2009). Also, in the same study, therapies of two different children by same therapist were differentiated by CPQ (Schneider et. al., 2009). On the other hand, CPQ also distinguished the therapy process of the same child treated by two different therapists (Goodman, 2015; Goodman & Athey-Lloyd, 2011).

In this study, 10 master level clinical psychology students got the training by Geoffrey Goodman, Ph,D. and later, 6 master level clinical psychology students were trained by Sibel Halfon, Ph.D. All trainees coded training sessions until they reached the ICC of .70. After that, pair of reliable coders coded the sessions which were randomly assigned to each pair. Coders were blind to the aim of the study and the scores were calculated by averaging the two ratings of each session. Interrater reliabilities of CPQs used in this study ranged .70 to .98 (M = 0.82, SD = 0.07).

The prototype session for psychodynamic psychotherapies with children which was developed by Goodman and friends (2016) was used in this study. 31 therapists across the world who embraced the psychodynamic therapy (PDT) principles q-sorted the 100 items for an ideal hypothetical psychodynamic prototype session. Adherence score which means the conformation to the prototype session, was calculated through correlation with factor scores of ideal PDT session's 100 CPQ items for each session (Ablon & Jones, 1998). As a result, a PDT adherence score for each session was obtained. In this study, an average of PDT adherence scores was calculated for each child whose therapy process was ended.

2.5.4. The Child Behavior Checklist (CBCL)

Achenbach (1991) developed The Child Behavior Checklist (CBCL) in order to assess the behavioral problems of children from various perspectives. One of these perspectives is syndrome-based evaluation within three domains of "*Internalizing, Externalizing, Total Problems*". There are eight categories in syndrome scale which are "*Anxious/Depressed, Withdrawn/Depressed, Somatic Complaint*" under the domain of Internalizing Problems; "*Rule-Breaking Behavior and Aggressive Behavior"* under the domain of Externalizing Behaviors and Total Problems domain include "*Social Problems, Thought Problems and Attention Problems*" in addition to all five syndrome categories mentioned above. Another perspective CBCL takes into account is the competence of the children and it is scored under three dimensions: "*Activities, School, and Social*".

CBCL has two different versions for children at the ages of 1.5-5 years old and for children at the ages of 6 to 18 years old. Parents complete CBCL and rate 112 problem items according to severity of the problem in the last 6 months. Each item has three options in terms of severity: 0 indicates "not true", 1 indicates "somewhat or sometimes true" and 2 indicates "very often or often true". After that the scores are calculated via ASEBA Software Program. For the Internalizing, Externalizing and Total Problems, the severity of symptoms is determined according to criteria of clinical level for the scores above 63, borderline level for the scores between 60-63 and non-clinical level for the scores less than 60.

Achenbach & Rescorla (2001) found high test-retest reliability for Externalizing, Internalizing and Total Problems scales (alpha of .94, .90, and .97 relatively). Erol and colleagues (1995) adapted the CBCL to Turkish and conducted standardization study. The test-retest reliability is found to be high with the alpha

of .84. Also, internal consistencies of internalizing, externalizing and total problems scales are found to be with the alphas of .82, .81 and .88 in order.

2.6. PROCEDURE

After a consent form for participation in the research were taken from the parents, they were asked to come for a one to two hours of assessment session before the therapy process starts. One of the research assistants of İstanbul Bilgi University Psychotherapy Research Laboratory, conducted the assessment session with the child. Both parents fill out various scales including the Child Behavior Check List (CBCL). The assessment with the child included emotional cognitive assessment tools. In this study one of the emotional assessment tools, Attachment Doll Story Completion Task (ASCT) was used for coding mental state talk via CS-MST and attachment patterns via AFCS for the emotional assessment. Video and audio records were collected during the assessment. After the assessment session, transcription of video and audio records of the assessments were taken. Then, 8 coders who were trained for coding CS-MST, coded mental state talk and 6 coders who were trained for coding AFCS.

During the therapy sessions, video and audio records were taken in all sessions too and they were transcribed by research assistants. For the coding the dynamics of the session by Child Psychotherapy Q-Set (CPQ), one session in every 10 sessions (e.g., 1-10, 11-20, 21-30 etc.) of child were randomly chosen. After the double coding of the chosen session by two of 16 trained coders, the adherence score of the that session to a prototype session of different therapy techniques including psychodynamic psychotherapies was calculated. In this study, adherence score to a prototype session for a psychodynamic psychotherapy (PDT) were used as a variable and average PDT adherence score was calculated for each patient.

CHAPTER 3

RESULTS

3.1. Data Analyses

In our data, categories for mental state words (MSW) include emotional mental state words (EMSW) which were divided into positive EMSW and negative EMSTW, cognitive mental state words (CMSW) and opaqueness mental state words (OMSW). For each of these categories; total words and unique words were used for analysis. For the first two categories, self- and other-directed words were also included but the direction was not coded in opaqueness category. In addition to these, externalizing (CBCL-Ext) and internalizing (CBCL-Int) behavior problems, attachment qualities including supportive mother (SM) and child's emotional dysregulation (ED) and descriptive variables like gender and age were included as control variables. We also looked for if children's total number of sessions had any relation to psychodynamic adherence scores but there was not a significant association between them. Thus, they were not included in further analysis and average psychodynamic adherence score (PDT-Adh) was calculated for each child as dependent variable. First of all, bivariate correlation was conducted for all variables. Later, with significantly correlated variables, hierarchical linear regression was used in order to understand which of MSW variables were predictive in explaining PDT-Adh of children's sessions.

3.2. Results

3.2.1. Associations Between Control Variables and PDT Adherences

The means, standard deviations, and bivariate-correlations of the control variables and PDT adherence scores were displayed in Table 3.1. Zero-order correlations indicated that gender of children was significantly associated while age was not significantly correlated with PDT-Adh. Gender was dummy coded in analysis and results showed that girls had higher PDT-Adh scores than boys. From behavioral problem categories, a significant negative association between externalizing problems and PDT-Adh was found. On the other hand, the association between internalizing behavioral problems and PDT-Adh was not significant. The correlation also was not significant for attachment subcategories supportive mother and emotional dysregulation and PDT-Adh.

Table 3.1.

Descriptive Statistics and Bivariate Correlations Between Average Psychodynamic Adherence Scores (PDT-Adh) and Control Variables

Variables	*M*	*SD*	1	2	3	4	5	6
(1)Age	7.11	1.99	-					
(2)Gender	0.60	0.49	-0.02	-				
(3)CBCL Internalizing	62.88	9.56	0.01	-0.07	-			
(4)CBCL Externalizing	61.37	10.86	-0.11	0.10	0.57**	-		
(5)Supportive Mother	2.15	0.68	0.31**	-0.32**	-0.03	-0.14	-	
(6)Emotion Dysregulation	1.74	0.98	-0.28**	0.42**	0.02	0.22*	-0.38**	-
(7)PDT-Adh	0.48	0.11	-0.05	-0.27**	-0.02	-0.23*	0.07	-0.14

Notes. Gender was dummy coded as "0" = female, "1" = male. CBCL = Child Behavior Checklist, PDT-Adh = Average Psychodynamic Adherence Scores. *$p \leq .05$. **$p \leq .01$.

3.2.2. Associations Between Mental State Talk Variables and PDT Adherences

The descriptive statistics and bivariate-correlations of the mental state talk variables and PDT adherence scores could be seen in Table 3.2. and 3.3. For emotional mental state word (EMSW) subcategories, positive significant associations between total EMSW, self-oriented EMSW, positive EMSW, unique positive EMWS and PDT-Adh were found. On the other hand, other-oriented EMSW, negative EMSW and unique negative EMSW were not significantly correlated with PDT-Adh.

In cognitive mental state word (CMSW) subcategories on the other hand, self-oriented CMSW and unique CMSW were positively and significantly associated with PDT-Adh while other subcategory of other-oriented CMSW was not significantly correlated with PDT-Adh. A trend level significant association was found between total CMSW and average psychodynamic adherence scores. For subcategories of opaqueness mental state words (OMSW), there was a positive significant association between unique opaqueness mental state words and PDT adherence scores while total OMSW was not significantly correlated with PDT-Adh.

Table 3.2.

Descriptive Statistics and Bivariate Correlations Between Average Psychodynamic Adherence Scores (PDT-Adh) and Emotional Mental State Words (EMSW) Subcategories

Variables	*M*	*SD*	1	2	3	4	5	6	7
(1)Total EMSW	7.31	6.67	-						
(2)Total Positive EMSW	2.18	2.93	0.76**	-					
(3)Total Negative EMSW	4.91	4.66	0.91**	0.43**	-				
(4)Unique Positive EMSW	1.27	1.25	0.63**	0.78**	0.36**	-			
(5)Unique Negative EMSW	2.15	1.42	0.61**	0.25*	0.69**	0.15	-		
(6)Self-oriented EMSW	5.80	5.93	0.97**	0.75**	0.86**	0.64**	0.56**	-	
(7)Other-oriented EMSW	1.33	1.72	0.55**	0.37**	0.55**	0.25*	0.44**	0.34**	-
(8)PDT-Adh	0.48	0.11	0.22*	0.21*	0.18	0.32**	0.13	0.20*	0.12

Notes. EMSW = Emotional Mental State Words, PDT-Adh = Average Psychodynamic Adherence Scores. *$p \leq .05$. **$p \leq .01$.

Table 3.3.

Descriptive Statistics and Bivariate Correlations Between Average Psychodynamic Adherence Scores (PDT-Adh) and Cognitive Mental State Words (CMSW) Subcategories and Opaqueness Mental State Words (OMSW) Subcategories

Variables	*M*	*SD*	1	2	3	4	5	6
(1)Total CMSW	6.57	7.25	-					
(2)Unique CMSW	3.32	3.19	0.89**	-				
(3)Self-oriented CMSW	5.12	5.52	0.97**	0.88**	-			
(4)Other-oriented CMSW	1.35	2.35	0.80**	0.68**	0.62**	-		
(5)Total OMSW	0.72	1.46	0.19	0.31**	0.205	0.12	-	
(6)Unique OMSW	0.48	0.91	0.20*	0.35**	0.21*	0.13	0.84**	-
(7)PDT-Adh	0.48	0.11	0.20*	0.21*	0.22*	0.09	0.18	0.26*

Notes. CMSW = Cognitive Mental State Words, OMSW = Opaqueness Mental State Words, PDT-Adh = Average Psychodynamic Adherence Scores. *$p \leq .06$. **$p \leq .01$

3.2.3. Hierarchical Linear Regression

In order to understand which of the significantly associated mental state word (MSW) variables predicted children's average psychodynamic adherence scores (PDT-Adh), hierarchical regression analysis was conducted. Gender and CBCL-Externalizing were used as control variables because they indicated a significant association with PDT-Adh. Gender was dummy coded so girls had higher PDT-Adh scores according to correlation analysis. In the first model, using the enter method, gender was added as a variable. It accounted for 8% of the PDT-Adh. In the second block analysis, CBCL-Externalizing was added to the model. Second model explained the 12% of the PDT-Adh. Finally, in the third model, unique OMSW, total EMSW, total positive EMSW, unique positive EMSW, self-oriented EMSW, total CMSW, unique CMSW and self-oriented CMSW were included as predictor variables. Hierarchical linear regression analysis revealed that third model explained 26% of the PDT-Adh. In this model, gender, unique positive EMSW and unique OMSW significantly predicted the PDT-Adh. Results of the analysis were displayed in detailed in Table 3.4.

Table 3.4.

Summary of Hierarchical Linear Regression Analysis Predicting Average Psychodynamic Adherence

	Model 1			Model 2			Model 3		
Variables	*B*	SE	*β*	*B*	SE	*β*	*B*	SE	*β*
Gender	-0.062	0.022	-0.274**	-0.058	0.022	-0.253**	-0.056	0.022	-0.246*
CBCL Externalizing				-0.002	0.001	-0.200*	-0.002	0.001	-0.176
Total EMSW							0.010	0.007	0.579
Self-oriented EMSW							-0.009	0.007	-0.453
Positive EMSW							-0.012	0.007	-0.324
Unique Positive EMSW							0.035	0.014	0.389*
Total CMSW							-0.002	0.007	-0.112
Self-oriented CMSW							0.007	0.008	0.339
Unique CMWS							-0.009	0.009	-0.251
Unique OMSW							0.029	0.013	0.234*
R^2 change		0.075			0.039			0.147	
F change		7.874**			4.282*			2.194*	

Note. B = unstandardized coefficient of the effect, *β* = standardized coefficient of the effect, SE = standard error, CBCL = Child Behavior Checklist, EMSW = Emotional Mental State Words, CMSW = Cognitive Mental State Words, OMSW = Opaqueness Mental State Words. *$p \leq .05$. **$p \leq .01$.

CHAPTER 4

DISCUSSION

Children's initial mental state talk were found to be related to their therapy processes in previous research (Halfon et al., 2017a). In micro level analysis, we aimed to extend these findings and explore how children's different characteristics of mental state talk would be associated with and predict their sessions' average psychodynamic adherence scores. Based on the literature, we hypothesized that when children's attachment qualities, behavioral problems and demographics were controlled, 1) Children's emotional mental state talk would be positively associated with and predict average psychodynamic adherence scores; 2) Children's cognitive mental state talk would be positively associated with and predict average psychodynamic adherence scores; 3) Children's opaqueness mental state talk would be positively associated with and predict average psychodynamic adherence scores.

Our first hypothesis was partially supported by the results. The more children used emotional mental state words the more their sessions adhered to psychodynamic principles. On the other hand, total emotional mental state word use did not predict the adherence scores. In micro level analysis of subcategories of emotional mental state words; total and unique positive emotional mental state word use and self-oriented emotional mental state talk were significantly and positively associated with psychodynamic adherence scores. There was not a significant association between unique and total negative as well as other-oriented emotional mental state words and the psychodynamic adherence scores. In further analysis, only unique positive emotional mental state talk significantly predicted the psychodynamic adherence. Children's use of different positive emotion words predicted their sessions' adherence to psychodynamic principles.

The second hypothesis was not supported. Total cognitive mental state talk was not significantly correlated with average psychodynamic adherence scores as

we hypothesized but a trend level significant positive association between them was found. On the other hand, in micro level analysis of cognitive mental state words, the more children used unique cognitive mental state words and self-oriented cognitive mental state words, their sessions significantly adhered to psychodynamic principles more. Other-oriented cognitive mental state word use did not indicate significant association with psychodynamic adherence scores. In further analysis, none of them predicted the adherence scores.

Our third hypothesis was not supported either. Total opaqueness mental state words were not significantly correlated with psychodynamic adherence scores as we hypothesized. On the other hand, unique opaqueness mental state talk was both significantly associated with psychodynamic adherence scores and predicted the scores in further analysis. Children's use of different opaqueness words predicted their sessions' adherence to psychodynamic principles.

The demographic variables like age and gender as well as children's attachment qualities and behavioral problems before therapy were controlled for further analysis. Attachment qualities were examined as supportive mother and emotion dysregulation in children and no significant association were found between them and psychodynamic adherence scores. Children's behavioral problems were also examined as internalizing and externalizing behavior problems. Only externalizing problems were found to be significantly associated with psychodynamic adherence scores. It even predicted the psychodynamic adherence scores until mental state talk variables were added to the model but it lost its significance in the third model. There was no significant correlation between internalizing behavior problems and psychodynamic adherences. Lastly, while age did not indicate any significant correlation with psychodynamic adherence scores, gender of children was found to be significantly associated with and predicted the psychodynamic adherence scores. Girls' psychodynamic adherence scores were significantly higher than the boys'.

4.1. Associations between Children's Attachment, Behavioral Problems, Demographics and Psychodynamic Adherence Scores

In order to control variables that might be associated with psychodynamic adherences; gender, age, behavioral problems and attachment qualities were included in analysis. For demographic variables, age was not significantly associated with psychodynamic adherence scores. Previous research showed contradictory results about the age of children. It was found that younger children benefit from psychodynamic psychotherapy more than older children (Edlund et al., 2014; Fonagy & Target, 1996a; Midgley & Kennedy, 2011). Also, in a study from psychodynamically oriented day care program, teacher reported more improvement for younger boys compare to older ones (Grizenko & Sayegh, 1990). On the other hand, from the perspective of mentalization development, children's understanding expressing different components of emotional mental state words as well as cognitive mental state words significantly increased by age (Bamberg & Damrad-Frye, 1991; Pons et al., 2004; Pons et al., 2003). Even though they are either outcome efficiency studies or related mental state talk development rather than psychodynamic adherences, we included age as a control variable. In current study, it did not indicate any significant association with psychodynamic adherence scores.

Second demographic variable we controlled was gender. Gender was significantly associated with psychodynamic adherence scores and girls' scores were higher than boys'. Gender also significantly predicted the variance in psychodynamic adherence scores even after mental state talk variables were included to the model. From the perspective of emotion expression, Brody (1999) suggested in her theory, gender plays a differentiative role in emotion expression. She combined the perspectives of biological temperament and gender-related emotion display principles. According to gender-related display studies, girls express their emotions better than the boys (Brody, 1999; Kring & Gordon, 1998)

while boys are expected not to express their emotions, especially fragile ones (Brody & Hall, 2008). Some studies looked specifically to which emotions boys and girls differed in their expression. In a meta-analysis, it was found that girls use more positive emotion words like “happiness” as well as more internalizing emotions like “anxiety” or “sadness”. On the other hand, boys expressed more externalizing emotions like “anger” (Chaplin & Aldao, 2013).

These are also parallel to the gender expectations in society. Girls are expected to be more nurturing and easy-going while they expect boys to be stronger and show anger if necessary (Barrett & Campos, 1987; Izard & Ackerman, 2000; Zahn-Waxler & Robinson, 1995). Also, in the study with adults about defense mechanisms and gender, senior boys were found be using projection more than girls. Girls mostly turned anger inwards but when they expressed their anger, it was more stable and mature (Cramer, 2002). It was indicated that in Weinberg and colleagues’ (1999) study, boys were more impulsive and their arousal level was higher than the girls. Their language abilities were less developed than girls either. So, their affect regulation abilities were lesser than the girls. Since expression of emotions and regulating affects are key factors in psychodynamic therapies, our results supported the literature. Also, Child and Adolescent Ambulatory Psychiatric Clinic (1994) discovered that girls benefited from intensive psychodynamic therapy more than boys.

Another explanation for girls’ sessions to be more conformed to ideal psychodynamic principles in our study can be explained through therapist and client gender match because in our study, most of the therapists were female. It was suggested that gender match of therapist and patients revealed more positive therapeutic alliance and lower dropout rates (Winterseen et al., 2005). Also, patients reported more satisfaction with therapeutic relationships when the dyad has the same gender (Johnson & Caldwell, 2011). Female patients were discovered to form bonding with female therapists more easily than male therapists (Werner-Wilson et

al., 2003). Thus, gender match of the patient therapist dyad in our study may be an important factor to be worked more easily in the sessions.

Attachment is also closely related to both mentalization development and psychodynamic psychotherapies (Fonagy et al., 1996). Thus, children's attachment qualities were controlled in the analysis. It was measured through Attachment Focused Coding System (Reiner & Splaun, 2008) through narratives of children as mentioned above. Supportive mother and emotion dysregulation codes were used for attachment assessment. Neither of the codes indicated a significant association with psychodynamic adherences as expected.

Previous literature showed that initial attachment qualities of patients have an effect on psychodynamic psychotherapy processes and outcome (Fonagy et al., 1996; Levy et al., 2012; Stefini et al., 2008). Our results failed to support previous literature on this side. Some studies looked for the attachment of patients and their psychotherapy process more detailly. For example, Levy and colleagues (2011) found that the anxious attachment of patients predicted the worst outcome but avoidant attachment did not have an effect on the therapy outcome. On the other hand, Wiseman and Tishby (2014) discovered that effects of anxiety and avoidance of initial attachments of patients differed in their effect on their stress level in psychodynamic therapy process. Their results indicated that avoidance affected the beginning and termination phases of therapy while anxious attachment had an impact on the middle phases of psychotherapy. Security on the other hand, was related to lower stress level throughout therapy regardless of the phase. Thus, patients' attachment levels can differ in their relation to therapy process. In current study, attachment of children was not categorized according to security. Only supportiveness level of mothers and children's level of emotion dysregulation was measured for attachment indication. These were also assessed through narratives of children. In future research, another measure that can assess children's attachment directly with acknowledging different security and insecurity levels would be better indicators.

Another reason why our results did not indicate significant associations with psychodynamic adherences may be that children's attachment to therapist play a significant role in terms of therapy techniques. In the study mentioned above, Wiseman and Tishby (2014) also looked for client attachments to therapist and their therapy process. They found that patients with high anxious attachment before treatment showed avoidant attachment characteristics to their therapists in the treatment phase of the therapy. They evaluated differences between attachment styles throughout therapy and before therapy due to the different demands of therapy and changing levels of intimacy throughout therapy process. They also looked for the attachment characteristics of therapist ant the match between attachments of clients and the therapists. Results showed that therapists' higher level of anxious attachment were related to patients with less secure attachments in beginnings of therapy. Also, the match of attachment styles was only predictive on beneficial outcomes when both therapist and patient had low levels of avoidance. Therefore, attachment qualities in terms of psychodynamic psychotherapy processes might be more complicated and indirectly related to the process. It is also possible that the characteristics of child and therapist dyad including attachment relationship may be indicative for conformation to psychodynamic principles because one of most significant items of prototype psychodynamic session is "*The therapy relationship is discussed*" (Goodman et al., 2016, p.595).

Mentalization capacity is closely related to attachment of children (Fonagy et al., 2002). In current study, even though attachment qualities were not significantly correlated with psychodynamic adherence scores, they indicated significant correlations with mental state talk of children. Supportive mother code was positively and significantly associated with total and self-oriented emotional mental state words and total and unique positive emotional mental state words. Also, emotion dysregulation of children had a significant negative association with total positive, unique positive and self-oriented emotional mental state words. Thus,

children's attachment qualities may be associated indirectly with their psychodynamic adherences with mediation of their emotional mental state talk.

Lastly, children's behavioral problems were examined under two categories of internalizing and externalizing behavior problems. While internalizing behavior problems was not significantly correlated with psychodynamic adherence scores, externalizing problems were negatively and significantly associated with them. The more externalizing problems children had, their sessions adhered to psychodynamic principles less. They even predicted the psychodynamic adherence scores until mental state talk variables were added to the model. Thus, there may a moderative or mediator effect on mentalization between externalizing behavior problems and psychodynamic adherence scores.

It supported the previous research indicating that children with externalizing problems were more resistant to psychodynamic techniques in therapy (Midgley & Kennedy, 2011) and supportive techniques were more useful for treatment of these children (Eresund, 2007). Also, Halfon and colleagues (2018) reported that before coming to psychodynamic techniques, child-centered techniques were more effective in the beginnings of therapy with children with externalizing behavior problems. Previous research also indicated that children with externalizing problems had difficulties in mentalization abilities especially for expressing and regulating emotions (Fonagy et al., 2002). Thus, in therapy process before coming to psychodynamic techniques like interpreting the child's inner conflicts or underlying mental states, therapists were more likely to be supportive like staying empathic, trying to sooth children and setting rules first (Eresund, 2007). From the light of symbolic play capacity research reviewed above, it is also meaningful that these children had less psychodynamic adherence scores because one of the least characteristic items defining the ideal psychodynamic therapy was "*Child's play lacks spontaneity*" (Goodman et al., 2016). Children with behavioral problems show incapacity in this angle. They had difficulties in organization of symbolic play

and had higher levels of anger and hostility in play (Butcher & Niec, 2005). Thus, it may be harder for the dyad to work therapeutically in psychodynamic settings.

For internalizing behavior problems, psychodynamic psychotherapies were found to be more effective (Fonagy & Target, 1996a; Midgley & Kennedy, 2011). Their affect regulation and symbolic play capacities were higher than children with externalizing problems (Eisenberg et al., 2010; Halfon et al., 2019). On the other hand, they are still having problems on these areas even though not as much as children with externalizing problems. Internalizing problems were also found to be related some mentalization deficits (Banerjee, 2008) and coherent symbolic play organization (Christian et al., 2011; Lous et al., 2002). Their mentalization deficit on the other hand is different than externalizing behavior problems, they had difficulty in multi-level mentalization. They had difficulty to understand the connections between different mental states like emotions, intentions, beliefs etc rather than simple deficit on mentalization. They failed to focus on different levels of mentalization thus fail to comprehend flexibility to adapt different social situations (Banerjee, 2008). Thus, it is possible that there was not a direct relationship between conforming to psychodynamic scores and internalizing behavior problems as it was in externalizing problems.

4.2. Hypothesis

4.2.1. Associations between Children's Emotional Mental State Talk and Psychodynamic Adherence Scores

Talking about emotions is one of the key factors of psychodynamic child therapies. It is important for child to express emotions in order to gain affect regulation abilities in psychodynamic psychotherapies (Fonagy & Target, 1996a; Verheugt-Pleiter et al., 2008). Thus, we hypothesized that children's initial emotional mental state walk would be positively associated with their sessions'

conformation to psychodynamic principles and eventually predict the adherence. Different subcategories of emotional mental state talk were examined. Results showed that children's higher use of emotional mental state words were significantly correlated with higher psychodynamic adherence scores as hypothesized. Also, in micro level analysis of subcategories, total and unique positive emotional mental state word use were indicated a significant positive association with psychodynamic adherence scores. On the other hand, neither total nor unique negative emotional mental state words were significantly associated with psychodynamic adherences. Also, the more self oriented emotional word children used, their sessions adhered to psychodynamic principles more. Other oriented emotion word use did not indicate significant association. After all, only unique positive emotional mental state talk significantly predicted the psychodynamic adherence.

Expressing more and different positive emotional mental states can be considered as a protective factor for children. The stories used to assess mental state talk of children were based on attachment triggering situations. They provoked negative emotions like anxiety or fear. Thus, using different positive emotion words related to those stories can be interpreted as more positive representations in attachment relations in terms of internal working models (Bowlby, 1969). Even though attachment qualities were not significantly correlated with psychodynamic adherence score in our data, supportive mother were positively and significantly associated with total, unique and self-oriented emotional mental state words as well as total and unique positive emotional mental state words. On the other hand, the more emotionally dysregulated children in their attachment relationships, the less they produced total positive, unique positive and self-oriented emotional mental state words. Thus, children's attachment qualities may be associated indirectly with their psychodynamic adherences with mediation of their emotional mental state talk.

Children who were more securely attached had a more tendency to produce comprehensive narratives with positive attributions. They could bring more adaptive resolutions to conflicts in situations and produce more positive emotions regarding to their interpersonal relationships. Bringing positive emotions in negative situations is an important coping mechanism. Children who see their parents as a secure and holding agent can use them to resolve and regulate negative emotions and eventually produce more positive emotions in stories (Splaun et al., 2010). Parents own mentalization capacities and holding the child as a mental agent in their mind are important for children's healthy mentalization development as well as attachment security and affect regulation capacity (Fonagy et al., 2002; Sharp et al., 2006). Fonagy and colleagues (1991a) found that parents mentalization also predicts the secure attachment of children and secure attachment is important for children's mentalization capacity (Fonagy et al., 1997; Meins et al., 1998).

In psychodynamic psychotherapies with children, therapists play the role of holding and attuned parent and provide a secure base for children to encourage expressions of emotional mental states (Bretherton,1984; Fonagy & Target, 1996a). For instance, in ideal psychodynamic session used in this study to calculate adherence scores, "*Therapists' being sensitive to children's feelings*" is one of the most characteristics items while "*Children's feeling not understood by therapist*" is one of the least characteristic items (Goodman et al., 2016). So, in therapy, therapist takes the place of significant other in child's life and accompanies the child through his/her gaining abilities to discover own internal life (Shirk & Burwell, 2010). Thus, children's using more and different positively attributed emotional words can be considered as an important factor in child-therapist dyad in psychodynamic therapies.

In prediction analysis, only unique positive emotion word use predicted the adherence scores. Emotional mental state talk was considered as deeper and more complicated when compared to other categories of mental state talk, (Pinto et al., 2017). Positive emotion word use may indicate a developed mentalization capacity

as mentioned above. On the other hand, variance may point out to a higher level of mentalization capacity because it includes not only verbalizing positive emotion words but also expressing a variety of different positive emotion words. Using variety of inner state talk played the role of fostering factor in development of mentalization skills (Hughes et al., 2010).

The following examples present a section from the stories of one child with one of the highest psychodynamic adherence scores while another child with one of the lowest psychodynamic adherence scores. Different positive emotional mental state words were highlighted.

Monster in the Bedroom:

1. Child with Average PDT Adherence Score of 0.66

T: "Now it is night time. Mom says "It's night time, it is time to sleep." and dad says "Yes. Go to your bed and sleep." And the child says "Ok" and she goes to her bedroom. Then she screams as "Mom, dad, there is a monster in my room, there is a monster!" Then what happened?"

Ç: Then, that monster was a bad doctor who pretended like the monster. The bad doctor pretended like a monster in order to scare me but I only pretended as scared. But in reality, I was not scared.

T: You were not actually scared

Ç: And mother and father whispered, whispered and questioned if their daughter were scared. Maybe she was really scared (mother and father said). They whispered and eventually they understood that bad doctor was pretending to be the monster. Then all of them ıı both of them fired the bad doctor from there to the other side of the world. Then they high-fived.

T: Mom and dad high-fived.

Ç: And then they went to look for their daughter and controlled if she went to sleep. I ıı I mean the child was asleep and parents went to their beds too. End of the story.

T: Ok, how dis the child feel?

Ç: She was so **excited**, **surprised** and felt that she was **happy** in that day

T: And what did she think?

Ç: She thought she was very **lucky**.

T: Why lucky?

Ç: Because she has a mother and father whom she had a lot of **fun**.

2.Child with Average PDT Adherence Score of 0.12

T: "Now it is night time. Mom says "It's time to sleep." and dad says "Yes. Go to your bed and sleep." Then the child goes to his bedroom and screams as "Mom, dad, there is a monster in my room, there is a monster!" Then what happened?

C: And the dad punched the child from the head!

T: The dad punched the child.

Ç: The child slept. Then his father and mother came. Then father pretended like the monster and said "Greee" (scary noises). "Mooom wake up someone ate my dad!" (child said). "What! What is happening tonight? Run son run." (mom said) We ran away.

T: Then what happened?

Ç: Then his father scratched his legs and he suddenly ate his son. Then he ate the mother. Then he died. Then the dad turned into real and sat down.

T: Ok. How did child feel?

Ç: Vey bad.

T: Ok. What did he think?

Ç: He felt very bad things

Note. T = Therapist, C = Child

As it can be seen from the examples, the child with one of the highest PDT adherence scores, produced a story with different positive emotional words related to parents. Parents were supportive to the child to resolve conflicting situation with monster and they were curious about the child's feelings. Story ended with a very positive notion and child's feelings were resolved with the help of attuned patents. On the other hand, the second child with one of the lowest psychodynamic adherence scores did not bring any positive emotions to the story and the story ended with a very negative notion. His story was very disorganized with insecure attachment patterns.

As mentioned in the literature review, symbolic play is the tool for psychodynamic child therapies. Therapists use play space to explore children's inner world in psychodynamic therapies. Children's mentalization capacity were closely related to symbolic capacity too because pretend play is one of the important developmental milestones of mentalization development (Fonagy et al., 2002; Fonagy & Target, 1996b). Expressing different positive emotions can be considered as a complex, developed mentalization ability as mentioned above. Children who had the basic level of security in a positive environment can develop the full mentalization ability and positive coping skills. Thus, it would be easier to work psychodynamically for those children and therapist dyads in therapy. For example, in the study of Halfon and colleagues (2017a), two children's sessions were detailly examined in terms of their expression of mental states and affect regulation. Both

children's and therapists' mental state talk was measured. One of the children showed symptomatic improvement at the end of the therapy while other one did not. The children's expression of mental state words was found to be significantly predicted affect regulation only in the case with successful outcomes. On the other hand, both therapists' mental state talk significantly predicted the affect regulation in both cases. The child with significant improvement had more solid ability in her organization skills, symbolic play capacity and expression of internal states thus therapist could find a place to work with the child's inner conflicts and interpret the underlying mental contents linking with child's subjective experiences. This "mentalized affectivity" (Fonagy et al., 2002) helped her to discover her own inner world and brought the improvement at the end of the therapy. On the other hand, in the case of other child with no significant improvement, her level of mentalization abilities were not as developed as the previous child. Thus, the dyad worked on more understanding and seeing the child with helping her to regulate overwhelming emotions before focusing on more psychodynamic interpretations of conflicts and defenses.

It can also be evaluated from the perspective of behavioral problems. Externalizing and internalizing behavioral problems of children were used as control variables in this study as mentioned above. Even though internalizing problems did not indicate any significant relation with psychodynamic adherence score, externalizing behavior problems were found to be negatively associated in a significant level. They even predicted the psychodynamic adherence scores until mental state talk variables were added to the model. The more externalizing problems children had, their sessions adhered to psychodynamic principles less.

It supported the previous research indicating that children with externalizing problems were more resistant to psychodynamic techniques in therapy (Midgley & Kennedy, 2011) and supportive and child-centered techniques were more useful for treatment of these children (Eresund, 2007; Halfon et al., 2018). Previous research also indicated that children with externalizing problems had difficulties in

mentalization abilities especially for expressing emotions. For example, children with externalizing problems used less emotional experience examples in the study of Cook and friends (1994). Also, Bekar (2014) found that easily understanding and labeling emotions associated with fewer externalizing behavioral problems.

Even though we did not find a positive association between externalizing behavior problems and positivity and negativity of emotion word use; positive and negative emotion word use was differentiated in externalizing behavior problems in literature. For example, Kim and colleagues (2007) found that children with externalizing problems used more negative emotion words (especially anger) and less positive emotion words. "Anger" was associated with externalizing behavior problems and these children were more disorganized (Eisenberg et al., 2001), had difficulties in affect regulation and symbolic play capacity and they were more impulsive (Eisenberg et al., 2010). Thus, in therapy process before coming to psychodynamic techniques like interpreting the child's inner conflicts or underlying mental states, sessions were more likely to be in a supportive manner like empathic stance, soothing children and setting rules first (Eresund, 2007).

Another perspective to evaluate children's different positive emotional word use predicting while negative emotion word use did not significantly correlate with the sessions' adherence to psychodynamic principles is therapeutic alliance. Alliance is a core factor in all kind of therapeutic orientations including psychodynamic therapies (Horvath & Luborsky, 1993) because a strong alliance between therapist and the child provides the secure environment for child to express him/herself (Shirk & Burwell, 2010). For instance, in the study of Pos and colleagues (2003), emotional expression and therapeutic alliance were found be strongly associated. While alliance predicted the expression of emotions, emotion expression predicted the successful outcomes at the end of therapy.

One of the ways to measure therapeutic alliance between child and therapist is Therapy Process Observational Coding System-Alliance scale (TPOCS-A; McLeod & Weisz, 2005). It was used in psychodynamic child therapy process with

Turkish sample before (Özsoy, 2018). One of the items used in this scale to assess the positive alliance in the dyad is child's expression of positive feelings towards the therapist. It includes explicitly expressing feelings with different positive emotional words like love, admire etc. On the other hand, child's expression of negative feelings towards the therapist by using negative emotional words like hate, angry etc. were considered to be negative in terms of therapeutic alliance. So, it may be possible that children's use of positive emotional mental state words affects the psychodynamic process through alliance. It can be studied in the future research.

When we looked for the other subcategory of emotional mental state talk, the orientation of emotional mental state words was found to be the important variable. When the orientation was examined, the more children used self oriented emotional mental state words, their sessions adherence to psychodynamic principles significantly increased. However, other oriented emotional mental state talk was not correlated with psychodynamic adherence. None of them predicted the psychodynamic adherence scores.

In psychodynamic therapies aim is to help the child to find the subjective meanings of his/her own experiences. Therapist guides the child his/her own adventure of discovering her/his self (Verheugt-Pleiter et al., 2008). In order to gain affect regulation abilities, child should discover and label own underlying subjective meanings of his/her psychic experiences. Even though, focusing on others mind is crucial, ultimate aim is for child to develop an agentive self and monitor the self (Fonagy & Target, 1998). In psychodynamic therapy, at the end of the treatment, child can come to a position to identify and express own mental states and link them to own behaviors (Verheugt-Pleiter et al., 2008). Therapist encourages child to think about his/her mental states by standing in a "not knowing" stance. While interpreting child's play and trying to make inferences about his/her inner life, therapist acknowledges the fact that child has separate individual mind therapist cannot fully know (Zevalkink et al., 2012). Thus, it is possible that focus and sensitivity for child's inner world in sessions are defining psychodynamic

principles in child therapies. Thus, child becomes to be able to make sense of own internal states especially own emotions rather than others. This was defined as "mentalized affectivity" by Fonagy and colleagues (2002) as reviewed above.

4.2.2. Associations between Children's Cognitive Mental State Talk and Psychodynamic Adherence Scores

Cognitive mentalization is another important aspect of mentalization abilities. Theory of mind research has been focused on the understanding and expressing cognitive side of internal states for many years. Gocek (2007) discovered that mothers' cognitive mental state talk was related to mothers' emotional availability and children's pathology. Even though in psychodynamic psychotherapies, emotions were emphasized more, cognitive mentalization abilities are also important (Allen et al., 2008). Thus, we hypothesized that children's cognitive mental state word use would be positively associated with and predicted the psychodynamic adherence scores. Total cognitive mental state talk was almost significantly correlated with average psychodynamic adherence scores as we hypothesized; a trend level positive association between them was discovered. On the other hand, the more children used unique cognitive mental state words and self-oriented cognitive mental state words, their sessions significantly adhered to psychodynamic principles more. None of them predicted the adherence scores.

In psychodynamic therapies, emotional expressions are more important than other categories of mental state talk. On the other hand, expressing those emotions in a healthy way requires to be in a representational distance to them. A healthy developed mentalization ability includes to be thinking about those inner states and verbally expressing them. Cognitively thinking upon the affective and cognitive mental states is important for affect regulation. (Allen et al., 2008) "Metacognition" was used in mentalization literature and it was defined as "*any knowledge or cognitive process that is involved in the appraisal, monitoring or control of*

cognition" (Wells, 2000; p. 6). It includes both awareness and regulation abilities (Allen et al., 2008). Thus, cognitive abilities also constitute an important aspect of healthy mentalization and affect regulation. After all, the balance between emotions and cognitions is important for healthy emotional and cognitive development and mentalization abilities (Fonagy et al., 2002). Allen and his colleagues (2008, p.63) defined it as "*thinking and feeling about thinking and feeling*". As supporting the literature, both cognitive and emotional characteristics of mentalization were found to be important in adherence to psychodynamic principles in therapies of children. Even though total cognitive mental state talk remained at the trend level of significance both of them positively associated with adherence characteristics.

On the other hand, when we looked for the subcategory of orientation of cognitive mental state words, it was found to be the important. When the orientation was examined, the more children used self oriented cognitive mental state words, their sessions adherence to psychodynamic principles significantly increased as it was like with the orientation of emotional mental states. Similarly, other oriented cognitive mental state talk was not correlated with psychodynamic adherence too. None of them predicted the psychodynamic adherence scores.

Thus, as it was stated in the previous section, it can be again said that self oriented talk was more important in psychodynamic therapies because the ultimate aim is for children to understand, express and regulate own mental states including both emotions and cognitions. Child should gain the ability to express own inner states and to understand their link to own behaviors as a result of the psychodynamic psychotherapies (Verheugt-Pleiter et al., 2008). Thus, self-oriented talk was more associated with psychodynamic adherences in both categories. On the other hand, the self orientation of cognitive mental state use lost its significance in prediction of the adherence scores.

The uniqueness of the cognitive mental state words was significantly and positively associated with psychodynamic adherence scores even though it did not predict them in further analysis. The importance of variation will be discussed

separately in another section. As a result, none of the characteristics of cognitive mental state predicted the psychodynamic adherence scores so our hypothesis on prediction was not supported. Even though, some characteristics indicated a positive association, it was not enough to predict them. When other aspects of mentalization like emotional or opaqueness mental state talk were included, cognitive side of the mentalization lost its significance. From psychodynamic perspective; understanding, expressing and regulating the affect considered to be most important factors to be protected from behavioral problems and psychopathology (Thompson, 1994, Aldao et al., 2010). The results are also parallel to the literature because psychodynamic psychotherapies emphasized those aspects more (Verheugt-Pleiter et al., 2008). Cognitive awareness was not sufficient for change in psychodynamic psychotherapies (Blagys & Hilsenroth, 2000).

4.2.3. Associations between Children's Opaqueness Mental State Talk and Psychodynamic Adherence Scores

Embracing the opaqueness nature of minds is critical for development of representational mentalization (Fonagy et al., 2002) In psychodynamic therapies, therapist behaves according to that principle and stayed in "not knowing" position (Zevalkink et al., 2012). Thus, we hypothesized that children's opaqueness mental state word use would be positively associated with and predict their psychodynamic adherence scores. Total opaqueness mental state word use did not significantly correlate with psychodynamic adherence score as we hypothesized. However, for the subcategory of unique opaqueness mental state words, the more children used them, the more their sessions adhered to psychodynamic principles. Also, children's unique opaqueness mental state word use significantly predicted the psychodynamic adherence scores.

As mentioned in introduction section, children born with innate contingency detection mechanism so they could make inferences about causes and effects of

own actions and external stimuli (Watson, 1994). At first, they expect a perfect contingency between their own mental states and caregiver's reflection about those states. Then it turns into high but not perfect contingency expectation with mentalization development because the space between the high and perfect is important for child to comprehend a representative self (Bahrick & Watson, 1985). If there is not any space between them and the experience of child and mother's perceptions and reflections of them are too similar, child would have mentalization deficit and affect regulation problems (Fonagy et al., 2002). For instance, in psychic equivalence mode, child experiences his/her inner world as equals to the outer reality and cannot realize that reality is not exactly same as s/he perceives and what (Fonagy & Target, 2000). Thus, child fails to differentiate the mind of self and other in this mode.

On the other hand, genuine mentalization requires the understanding of people are different and have own mental states which another person cannot fully recognize (Schmeets, 2008). We cannot know exactly what another person thinks, feels etc and we can only make assumptions. The ability to comprehend this "not fully knowing" another's mind developed in children through primary caregiver's re-presenting the child's mind to the child. (Fonagy & Target,1997) Through this representational loop, child understand that what mother gives him back is not exactly what he feels but instead representation of his/her mental states in mother's mind (Fonagy et al., 2002). So, the transitional space (Winnicott, 1971) between the primary mental states of children and representations of these states as mother perceived enables child to develop complex representational mentalization ability (Schmeets, 2008).

The authors of CS-MST used in this study, Bekar and colleagues (2014, p.19) defined the opaqueness of mental states as "*One of the basic premises of mentalization is that others' mental states can be "predicted/guessed" but not "determined by" or "fully known" to others. A mentalizing stance requires a certain amount of uncertainty regarding other people's mental states, and openness*

to be mistaken about predictions or comments about others' mental states. This stance helps the child appreciate the separateness and -at the same time connectedness- of the minds, and facilitates the development of "agency".".

In psychodynamic therapies, it is important for therapist to embrace opaqueness of mental states too. While trying to understand and label child's mental states and making connections between observable behaviors and those underlying mental states, therapist should stay in a representational distance to child's absolute and not fully knowable inner world. By this way, therapist can also give opportunity to the child to make changes and corrections and enable child to develop own mentalization abilities in the long term (Fonagy & Target, 1997; Sharp, 2008; Steele & Steele, 2008). Bateman and Fonagy (2006, pp. 197) defined this as "*mentalizing stance of not knowing*" of therapist. Therapist's approaching to child with curiosity and talk with him/her in the scope of possibilities rather than certainties also help the child to understand the unknowability of other minds. It also enables child to deal with uncertain situations because children may think that adults may know the exact things in his/her mind (Zevalkink et al., 2012).

In current study on the other hand, only total use of opaqueness words did not associate and predict with psychodynamic adherences. It may stem from some linguistic complication in Turkish language too. Turkish language is very different than the English thus there might be slight differences in expressing some mental states. For instance, Aksu-Koç and colleagues (2005) suggested the use of "guess or suppose" (sanmak) instead of "think" (düşünmek) in theory of mind tasks like false belief. The word "think" is coded as a cognitive mental state talk in our coding system. On the other hand, it might reflect opaqueness nature of mental states if it indicates the guessing or predicting. For example, if child says "I think he can do this" (Bunu yapabileceğini düşünüyorum) the word "thinking" indicates an opinion like words "in my opinion" "according to me". In other words, it captures the opaqueness nature but it is not coded as opaqueness but coded as cognitive word in CS-MST. Thus, the use of opaqueness mental state might be underestimated

because of linguistic complications but when child used very different opaqueness words, it cannot be gone unnoticed because different words capture the quality in anyway. Also, variation in using mental state words can be considered as a more complex and developed mentalization ability (Hughes et al., 2010). It will be discussed in later section more detailed.

Below, there is a section from one of the children's stories which was used to code mental state talk in the study. Her average psychodynamic adherence score was one of the highest and different opaqueness mental state words she used in the story were highlighted.

Monster in the Bedroom:

Child with Average PDT Adherence Score of 0.62

T: Let's see what happens in our new story. Listen carefully now. It is time to sleep. "Come on go to your bedroom and sleep" (mother said). "Yes. Go to your bed" (dad said)

Ç: Ok dad I am going

T: Wait for me to finish then you maintain the story. And the child says "Ok mom Ok dad. I am going" and she goes to her bedroom in upstairs. "Mom, dad, there is a monster in my room, there is a monster!" (she screams) Now tell me what happened.

Ç: Honey, Ç is calling us (dad talks). "What happened Ç, why did you scream?" (mother said) "There is a monster in my bed!" "How so? You and your dad stay far and I would check" (mother said). "Mom don't go, it would eat you" (child said). "Don't worry, I am a mother, it cannot eat me. Hmm but there is not a monster in here". "But I saw a monster". "**Maybe,** ıı**, is it possible that** you saw hallucination because you are sleepy?" (mom said). "No" (child said). "**In my opinion,** you sleep now then we will see later. If

there is a noise, we will notice it, we won't miss it okay my daughter?" (dad said). "Okay dad, I am going to sleep then. Good night mom good night dad." (child said). "How many times she called us?" (dad said). "I don't know but it would be better if we sleep too." (mom said) "What was that noise? What was it? Mom! Dad! Mom!" "What happened my daughter?" "Mom, I am hearing strange noises, monster noise" "My daughter, why would it be a monster, I checked it before. Your dad and I told you that if something happens, we immediately come. Look nothing happens but if you are scared you can sleep with us." "Okay mom. But I am not comfortable here I am going to my bed." "Okay my daughter, good night." "Good night mom". "I am going to check it, there is nothing. **I wonder why** I heard that noises" (child spoke to herself). That is all.

Note. T = Therapist, Ç = Child

As it is seen in the example, the child with one of the highest PDT adherence scores, came up with a story including different opaqueness words. In the story, both parents and the child were curious about the mind of the children. Mother also acknowledged the fact that child may have different opinions and she stated her opinions by using different opaqueness statements like "maybe" or "is it possible that" or "in my opinion". Also, the mother was supportive in the story and trying to sooth the child. They helped the child to resolve conflicting situation with monster and they were curious about her feelings.

4.2.4. Variation

For both emotional mental state words and opaqueness mental state words, only variation was found to be predictive in explaining the average psychodynamic scores. Also, for cognitive mental state words, variation was positively and

significantly correlated with psychodynamic adherence even though it did not predict them. Both emotional and opaqueness mental state talk can be considered as indicators of developed mentalization ability. As mentioned above, many children with behavioral problems and mentalization deficits failed in understanding, expressing and regulating emotions. They also had difficulties in embracing the "not fully known" nature of minds (Fonagy et al., 2002). Affect regulation abilities require for child to stay in a representational distance to overwhelming negative affects so child can think upon and verbalize those affects. All of these requires a complex developed mentalization capacity (Fonagy et al., 2002). Emotional mental state talk was considered as deeper and more complex (Pinto et al., 2017) as well as opaqueness mental state talk (Bateman & Fonagy, 2006) when compared to other kinds of mental state talk categories,

On the other hand, even though these two aspects of mentalization (affective and opacity) requires a developed level of mentalization, variance in those aspects required a higher level of mentalization ability. For instance, in the study of Hutchins and colleagues (2009), when mother's mental state talk and epistemological beliefs get complexed and more, children's mental state talk significantly increased in terms of both frequency and variety. Thus, a complex developed mental state talk abilities of mothers predicted to variance in mental state talk of children and their mentalization and theory of mind capacities. Other studies also emphasized the importance on variety in mental state talk. The variation in mental state talk of children (Hughes & Dunn, 1998) and parents (Ruffman et al., 2002) predicted children's developmental level of theory of mind abilities in later times.

Ability to express and verbalize different mental states bring child to ability to control those processes in both emotional and behavioral way (Sharp, 2006). A developed mentalization ability enables child to handle with problematic situations and cope with them in a healthy way (Fonagy & Luyten, 2009). Eventually, children with a fully developed mentalization ability can be in an adaptive distance to

overwhelming situations and reflect their conflicts through coherent, organized as if platforms (Fonagy & Target, 1996b). Throughout psychodynamic psychotherapy process, patients who have lower mentalization capacities are easily fell apart, confused and get disorganized in intense and overwhelming arousal times, in attachment triggering situations and in overwhelming negative affect. Thus, it becomes more difficult for therapist and patient dyad to work in a psychodynamic setting because changing the automatic arousal reactions and progressing in therapy are harder. (Arntz et al., 2006). On the other hand, working with patients who have a solid organization and mentalization ability is easier. Because they can express their inner states, powerful emotions and acknowledge the flexibility of different minds; stressful and overwhelming situations become less threatening and can be dealt with more easily (Allen et al., 2008). Thus, child can bring the reality to his/her symbolic play and deal with them in a transitional space and progress in therapy with successful outcomes in terms of affect regulation and symptomatic improvement (Fonagy & Target, 1996b; Winnicott, 1971). It was supported in Halfon and colleagues (2017a) study with two cases of separation anxiety. A symptomatic improvement was observed for only one child who had a more solid mentalization capacity.

Many psychodynamic theorists including Glenn (1978); Hoffman (1993) and Kernberg (1995) defined certain criteria for children who can be included in psychoanalytic psychotherapies (Fonagy & Target, 1998; p.88):

> *1) "Superior intelligence, particularly verbal skills, and psychological mindedness."*
>
> *2) "A supportive and stable environment, including parents who can form an alliance with the analyst, respect the boundaries of the treatment, and support their child's participation in it."*
>
> *3) "Internal conflict, judged to be the primary cause of the child's symptoms."*

4) "An absence of major ego deviations—that is, developmental "deficits" that are not the result of unconscious conflict and thus cannot be "resolved" by insight."

5) "Motivation to engage in a lengthy and sometimes difficult therapy, stemming from anxiety, guilt, or shame."

6) "A capacity to form relationships and trust that help can be found in relationships with others."

As it can be seen from the criteria, children with higher developmental capacities in areas like language, strength of ego, capacities to form interpersonal relationships and certain level of mentalization development are important for therapy process to be effective (Fonagy & Target, 1998). They also found that children with emotional disorders benefit from those therapies better than children with disruptive disorders (Fonagy & Target, 1996a). Thus, the variation in opaqueness and positive emotional mental state talk of children can be evaluated as a higher level in mentalization development as mentioned above. Thus, they are predictive in the session's conformation to psychodynamic principles.

4.3. Clinical Implications

Previous research showed that children's initial mentalization is related to their therapy process (Halfon et al., 2017b). Our study also supported that by extending the mentalization assessment. Assessing different and specific aspects of mentalization in detailed provided a more comprehensive frame to understand mentalization capacities of children and its relation to their psychodynamic therapy processes. Specifically, the complexity of mentalization abilities was found to be predictive in psychodynamic adherences. Children's use of variety of positive emotion words and opaqueness words can be thought as strengths and protective factors in terms their therapy processes.

Many children applied for getting therapy support due to various problems. Therapists mostly focus on children's referral reasons and their behavioral problems. Most of the time, specific characteristics of child and protective factors are ignored. On the other hand, a child with a developed mentalization capacity before therapy process may be better in affect regulation and dealing with negative affects thus sessions can be done better psychodynamically. They can even develop better affect regulation abilities and enhance their understanding of own inner states with relation to significant others in their life. Our study supported the positive impact of children's initial mentalization abilities especially with focus on different opaqueness and positive emotion states, on their therapy processes by predicting better psychodynamic adherences. Thus, it would be beneficial for clinician who is working with children and embrace the psychodynamic orientation, to focus on children's pretreatment mentalization abilities.

The intervention techniques may be adapted to the child's developmental level of mentalization. So, their therapy process can be more effective. For instance, in the study by Halfon and colleagues (2017b), results showed that the child with better mentalization ability could benefit from psychodynamic child therapy better than the other child with lower mentalization abilities. Also, for behavioral problems perspective, children with externalizing problems were found to be more disorganized in terms of their affect regulation and symbolic play capacities (Butcher & Niec, 2005; Halfon et al., 2019; Kernberg & Chazan, 1991). Thus, supportive and child-centered techniques were found to be more effective for those children before psychodynamic techniques (Eresund, 2007; Halfon et al., 2018; Midgley & Kennedy, 2011).

Therapy is a dynamic process which is shaped upon the therapist and child dyad (Schneider et al., 2010). Every child has different characteristics and lives. Thus, it is also useful for therapist to acknowledge those subjective characteristics before treatment. So, sessions can be accommodated according to what would be more effective for that particular child and therapist dyad. It is important to

determine which technique would be better and beneficial for the child and compensate his/her actual needs (Zevalnik, 2008). If child is not ready for psychodynamic interventions and mirroring of mental states, she/he can close her/himself or interpret these as an attack (Verheugt-Pleiter, 2008). For children with limited mentalization capacities, it would be better to create that space for child to come to developmentally appropriate level in mentalization before psychodynamic interpretations (Halfon et al., 2017b; Verheugt-Pleiter, 2008).

Expression of negative affect is mostly emphasized in psychodynamic therapies. On the other hand, different positive emotion and opaqueness expressions were found to be predictive in sessions adherence to psychodynamic principles in our study. Maybe, clinicians can focus on increasing expressions of these aspects in therapy sessions. Also due to fact that variation is the predictive in both categories, it may be useful to mirror different kinds of mental states with emphasis on uncertainty of mental states of other people. Parents can also be encouraged to do mentalization based talks with children in sessions with parents. Especially focusing on different positive emotions of children and emphasizing differences and unknowability of minds can enhance children mentalization abilities and provide a benefit for their therapy process.

From the cultural perspective, cultural sensitivity is necessary for successful outcomes in psychotherapies (Roysircar, 2009). Considering patients cultural backgrounds would be beneficial for clinician to understand the patient, his/her mentalization capacity and psychopathology (Aival-Naveh et al., 2019). Also, establishment of initial relationship between patient and therapist, cultural knowledge related to mentalization was useful. Fonagy and Allison (2014) defined this as “epistemic trust”. Mental state talk which is culturally insensitive may harm the epistemic trust thus, awareness of cultural side of the mentalization is important in clinical practices (Aival-Naveh et al., 2019).

Literature supported that collectivistic cultures are better in other oriented mentalization while individualistic cultures are mostly more self-oriented (Aival-

Naveh et al., 2019). Self-oriented mental state talk in both emotions and cognitions were found to be positively correlated with psychodynamic adherences of sessions in our study. Considering these aspects, self-oriented mental state talk of children can be encouraged in collectivist cultures including Turkish culture. Relatedness and autonomy are both important factors in family contexts with the balance between them is the key (Kagitcibasi, 2007). Thus, therapists in Turkey should keep in mind the both aspects and cultural characteristics of Turkish children. Especially in families with low socioeconomic status, autonomy aspect may be underestimated (Corapci et al., 2012; Nacak et al., 2011). Therefore, it would be beneficial to work with parents in parent sessions to reflect upon their self and encouragement of self reflection in their child.

Another important aspect of mentalization was positive emotion expression in our study. Expression of positive affect are more encouraged than negative ones in all cultures. In individualistic cultures like European Americans, positive affect was evaluated as ideal state and seen as an achievement (Tsai, 2007). In the study of Corapci and colleagues (2017), it was also supported that mothers from America encouraged their children's happiness more. In Turkish culture positive affect was also encouraged (Corapci et al., 2017) and expression of them was more tolerated by parents than negative affect (Sunar, 2002). Our findings are parallel to literature that positive emotion expression was found to be associated with sessions psychodynamic adherences. However, the encouragement of positive affect was subtle in Turkish population while it was more directive in European American mothers (e.g. Turkish mothers danced with their children while European American mothers verbally said that "*I would also smile*"; Corapci et al., 2017; p. 275). Nonverbal theory of mind abilities were discovered in some other collectivist cultures too (Moriguchi et al., 2010; Wang et al., 2012). Thus, implicit mentalization should be taken into consideration in therapies with children in our culture and therapists can focus on nonverbal cues during sessions. Since verbal expression of emotions in narratives are important in most of therapy techniques

(Allen et. al., 2008), explicit emotional mentalization can also be encouraged in sessions without underestimating the implicit mentalization. Parents can also be encouraged to talk about own emotions and children's emotions.

4.4. Limitations and Directions for Future Research

One of the limitations of the current study is a relatively small sample size. Because of that, some variables had lower variances. It would be better to have larger sample sizes for further analysis and for better generalization of the results. Also, therapy techniques were not standardized and manualized even though therapists were educated with certain orientation so it can also be a limitation in terms of generalization of results. Due to the fact that we worked with clinical sample and certain psychotherapy orientation, it is not possible to do comparisons with control groups outside of the therapy settings with non-clinical sample. Thus, internal validity of the study is low. On the other hand, it reflects the nature of real psychotherapy processes so the study has an external validity.

Another limitation is that our data included children with different number of sessions. Psychodynamic adherence scores were averaged for each child but the adherence scores may show differences in different time points of therapy. Even though we could not find a significant association between number of sessions and psychodynamic adherence scores, in further research, it would be beneficial to look the adherence scores' tendencies over to course of treatment in different therapy phases and its relation to mental state talk of children. Different characteristics of psychodynamic psychotherapies can be examined qualitatively to understand which specific interventions were used in sessions of children with more developed mentalization abilities. Also, both pre and post mentalization assessment would be useful to observe the change in mediation with psychodynamic adherence scores.

In terms of externalizing behavior problems of children, results showed that externalizing behavior problems of children significantly and negatively predicted the average psychodynamic adherence scores until mental state talk variables were added to the model. Thus, there may a moderative or mediator effect on mentalization between externalizing behavior problems and psychodynamic adherence scores. So in future studies, it would be beneficial to look for further moderation and mediation analysis in terms of children's externalizing behavior problems and their sessions' conformation to psychodynamic principles through mentalization capacities.

We assessed children's mentalization abilities with CS-MST. Even though it is a valid research to assess children's explicit mentalization, some mental state words (especially emotional mental state words) were elicited due to the themes of the stories because stories are based on attachment triggering situations with conflicts. It may also force children to reflect fully their mentalization abilities because of stressful topics (Gocek et al., 2008). Thus, in future research mentalization assessments can be conducted in more comfortable contexts for children.

Also, even though, current study included various aspects of mental state talk, there are still other categories which were not included in this study. It would be useful to examine those categories like action-based mental state words, perception mental state words or pseudo/inappropriate mental state words and their relation to adherences to psychodynamic principles. Also, an assessment for nonverbal relationship between therapist and children in terms of implicit mentalization would be beneficial to understand therapy process in future research. Since collectivist cultures including Turkey showed better performances in implicit mentalization as mentioned above, it would be meaningful from cultural perspective too.

Since language is an important indicator for verbal expressions and understanding the mental states (Astington & Baird, 2005; Gocek et al., 2008),

future research can control language capacities of children. Even though variables like age, gender, behavioral problems and attachment securities were controlled, other control variables like language or characteristics of parents might be included to provide a more informative and comprehensive research. None of the parent variables were included in this study but parents own mentalization abilities were also closely related to children's mentalization abilities, affect regulation and symbolic play capacities (Fonagy et al., 2002; Gocek, 2007). Thus, it would be useful to look for parent characteristics especially their mentalization abilities and its relation to psychodynamic adherences of children's therapies.

4.5. Conclusions

The aim of the study was to investigate if children's initial mentalization capacities associate with and predict their session' adherence to psychodynamic principles. A micro level analysis of mental state talk of children was conducted. Also, children's age, gender, behavioral problems and attachment qualities were controlled. Findings showed that different mental state talk qualities are predictive on psychodynamic adherences.

Firstly, association of variables was assessed. A positive significant association was found between total emotional, total positive emotional, unique positive emotional, self-oriented emotional, unique cognitive, self-oriented cognitive, unique opaqueness mental state talk and average psychodynamic adherence scores of children. Also, a trend level positive significant association was discovered for total cognitive mental state word use and average psychodynamic adherence scores. In addition, gender and externalizing behavior problems were negatively and significantly correlated with average psychodynamic adherence scores. In other words, boys had significantly less psychodynamic adherence scores than girls and the more children had externalizing problems, the less their sessions conformed to psychodynamic principles.

In further analysis, prediction of significantly correlated mental state talk variables on psychodynamic adherences was examined. Results demonstrated that unique positive emotional mental state talk and unique opaqueness mental state talk of children as well as gender significantly predicted the average psychodynamic adherence scores.

These findings supported that a developed level of mentalization has a positive effect on children's psychodynamic therapy process. The more expression of different positive emotional words as well as acknowledging the "not fully known" nature of minds with different mental state words can be a protective factor for children's therapy progress according to psychodynamic principles. Therefore, it is crucial to acknowledge children's different initial mentalization capacities and its effect over the course of treatment. Also, preliminary assessments with cultural sensitivity before therapy are important in order to understand protective factors in children's lives and their effects on the successful progress throughout the therapy process.

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APPENDICES

APPENDİX A: Attachment Doll Story Completion Task (ASCT)

Yönerge: “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.”

Doğum Günü Öyküsü (ısınma oyunu) (Birthday-Warm Up Story):

Uygulayıcı: 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. Şimdi de 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.

1) Kazara Dökülen Meyve Suyu Öyküsü (Spilled Juice):

Araçlar: Çocuk, anne, baba, masa, tabaklar

Uygulayıcı: 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.

2) Yatak Odasındaki Canavar Öyküsü (Monster in the Bedroom):

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

Uygulayıcı: Ailemizi yeni oyun için hazırlayabilir misin? "Şimdi neler 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.

3) Yaralı Diz Öyküsü (Hurt Knee):

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

Uygulayıcı: Tamam, Şimdi başka bir öyküm var. Ben bunları toplarken, sen ailemizi oraya koy ve yeni öykü için hazırla. 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.

4) Ayrılık Öyküsü (Separation):

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

Uygulayıcı: 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.

5) Yeniden Bir Araya Gelme Öyküsü (Reunion):

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

Uygulayıcı: 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.

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

ÇOCUĞUN;

Cinsiyeti: ___ ERKEK ___ KIZ

Yaşı:

Doğum Tarihi: GÜN___AY___YIL_____

Kreşe, anaokuluna gidiyor mu? ___ HAYIR ___EVET

(Okulun adı: _____)

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

BABANIN İŞİ: _____ EĞİTİMİ: _____ YAŞI: ____

ANNENİN İŞİ: _____ EĞİTİMİ: _____ YAŞI: ____

FORMU DOLDURAN:

___ Anne

___ Baba

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

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

0 1 2 66. Çok bağırır, çağırır, çığlık atar.
0 1 2 67. Sevgiye, şefkate tepkisiz görünür.
0 1 2 68. Sıkılgan ve utangaçtır.
0 1 2 69. Bencildir, paylaşmaz.
0 1 2 70. İnsanlara karşı çok az sevgi, şefkat gösterir.

0 1 2 71. Çevresindeki şeylere çok az ilgi gösterir.
0 1 2 72. Canının yanmasından, incinmekten pek az korkar.
0 1 2 73. Çekingen ve ürkektir.
0 1 2 74. Gece ve gündüz çocukların çoğundan daha az uyur. (açıklayınız):

_____

0 1 2 75. Kakasıyla oynar ve onu etrafa bulaştırır.
0 1 2 76. Konuşma sorunu vardır. (açıklayınız):

_____

0 1 2 77. Bir yere boş gözlerle uzun süre bakar ve dalgın görünür.
0 1 2 78. Mide-karın ağrısı ve krampları vardır (tıbbi nedeni olmayan).
0 1 2 79. Üzgünken birden neşeli, neşeli iken birden üzgün olabilir.
0 1 2 80. Yadırganan, tuhaf davranışları vardır. (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 _____

LÜTFEN TÜM MADDELERİ YANITLAYINIZ.

SİZİ KAYGILANDIRAN MADDELERİN ALTINI ÇİZİNİZ

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

ÇOCUĞUN;

Cinsiyeti: ___ ERKEK ___ KIZ

Yaşı:

Doğum Tarihi: GÜN___AY___YIL_____

Sınıfı: _____ Okula devam etmiyor ____

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

BABANIN İŞİ: _____ EĞİTİMİ: _____ YAŞI: ____

ANNENİN İŞİ: _____ EĞİTİMİ: _____ YAŞI: ____

FORMU DOLDURAN:

___ Anne

___ Baba

___ Diğer (Çocukla olan ilişkisi: _____)

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

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

0 1 2 73. Cinsel sorunları vardır. (açıklayınız):
_____
0 1 2 74. Gösteriş meraklısıdır, maskaralık yapar.
0 1 2 75. Çok utangaç ve çekingendir.
0 1 2 76. Diğer çocuklardan daha az uyur.
0 1 2 77. Gece ve/veya gündüz diğer çocuklardan daha çok uyur. (açıklayınız):
_____
0 1 2 78. Dikkati kolayca dağılır.
0 1 2 79. Konuşma problemi vardır. (açıklayınız):
_____
0 1 2 80. Boş gözlerle bakar.
0 1 2 81. Evden bir şeyler çalar.
0 1 2 82. Ev dışındaki başka yerlerden bir şeyler çalar.
0 1 2 83. İhtiyacı olmadığı halde birçok şey biriktirir. (açıklayınız):
_____
0 1 2 84. Tuhaf, alışılmadık davranışları vardır (eşyaların belli bir düzende ve sırada olmasını isteme gibi). (açıklayınız):
_____
0 1 2 85. Tuhaf, alışılmadık düşünceleri vardır (bazı sayıları, sözcükleri tekrarlama ve bunları zihninden atamama gibi). (açıklayınız):
_____
0 1 2 86. İnatçı ve huysuzdur.

0 1 2 87. Ruhsal durumu ya da duyguları çabuk değişir.
0 1 2 88. Çok sık küser.
0 1 2 89. 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 _____