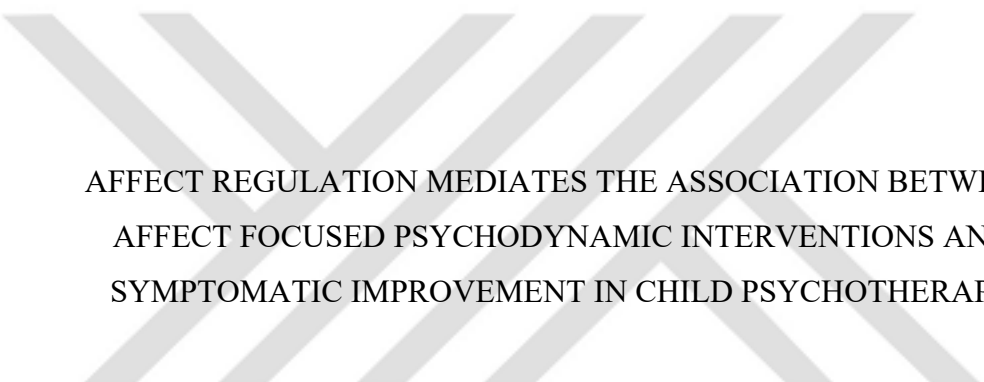


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AFFECT REGULATION MEDIATES THE ASSOCIATION BETWEEN
AFFECT FOCUSED PSYCHODYNAMIC INTERVENTIONS AND
SYMPTOMATIC IMPROVEMENT IN CHILD PSYCHOTHERAPY

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Affect Regulation Mediates the Association between Affect Focused
Psychodynamic Interventions and Symptomatic Improvement in Child
Psychotherapy

Çocuk Psikoterapisinde Duygu Düzenlemenin Duygu Odaklı Psikodinamik
Müdahaleler ve Semptomatik Gelişim Arasındaki İlişkide Aracı Rolü

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ABSTRACT

The importance of the therapists' affect focus, such as labeling, linking and interpreting patient's affect, as well as interventions aimed to evoke affective experience have strongly differentiated adult psychodynamic psychotherapy from other frameworks and been associated with symptomatic outcome. In psychodynamic psychotherapy for children, although there is recent evidence on the effectiveness of psychodynamic interventions, the specific affect focus and its associations with the outcome have not been empirically investigated. Psychodynamic child psychotherapy uses play activity as a medium to improve affect regulation (AR) to bring symptomatic remission. Following these premises, this study investigated the mediating role of AR on the association between affect focused psychodynamic interventions (AFPI) and symptomatic improvement in psychodynamic child psychotherapy. Participants were 70 children who underwent psychodynamic child psychotherapy. 132 sessions were coded with the Child Psychotherapy Process Q-set for AFPI and the Children's Play Therapy Instrument for the assessment of AR by trained outside raters. For the assessment of the symptoms, The Child Behavior Checklist parent-form; and child reports of The Children's Depression Inventory, and The Screen for Child Anxiety Related Emotional Disorders were used at intake and termination. Path analyses provided good model fit, and significant indirect effects indicated that changes in AR, mediated the relation between AFPI in the first phase of the psychotherapy and symptomatic outcome in depression and anxiety symptoms. AR also mediated the associations between AFPI in the middle phase of the treatment and outcome in externalizing, depression, and anxiety symptoms. There exists no other research on the psychotherapist's AFPI and symptomatic outcome with a mediator in psychodynamic child psychotherapy. Therefore, findings of this study contribute to the literature in mechanisms of changes in psychodynamic child psychotherapy.

Keywords: Child Psychotherapy, Psychodynamic Psychotherapy, Affect Focused Interventions, Affect Regulation, Symptomatic Improvement

ÖZET

Danışanın duygularını adlandırmak, duygular hakkında yorum yapmak ve hatta duygusal deneyimi güçlendirecek müdahalelerde bulunmak gibi, psikoterapistin duygu odaklı tutumlarının psikodinamik psikoterapiyi diğer kuramsal yaklaşımlardan ayırdığı ve bunların semptomlardaki azalma ile ilişkide olduğu gösterilmiştir. Psikodinamik çocuk psikoterapisinin etkinliğine dair kanıtlar olsa da duygu odağı ve bunun semptomlarla ilişkisi henüz ampirik olarak incelenmemiştir. Psikodinamik çocuk psikoterapisi, oyun aktivitesini kullanarak çocuğun duygu düzenleme (DD) kapasitesini güçlendirmeyi ve dolayısıyla sağaltım sağlamayı amaçlar. Bu önermelerden yola çıkarak, bu araştırma, DD'nin duygu odaklı psikodinamik müdahaleler (DOPM) ve semptomlardaki azalma arasındaki ilişkide aracı değişken rolünü incelemiştir. Psikodinamik psikoterapiden geçen 70 çocuğun katılımcı olduğu bu çalışmada, toplam yüz otuz iki psikoterapi seansı, DD için the Children's Play Therapy Instrument ile; DOPM için de the Child Psychotherapy Process Q-set ile kodlanmıştır. Dışsallaştırma semptomları için Çocuk Davranış Değerlendirme Ölçeği, depresyon semptomları için Çocuklar İçin Depresyon Ölçeği, anksiyete semptomları için de Çocuklarda Anksiyete Bozukluklarını Tarama Ölçeği psikoterapi sürecinden önce ve sonra doldurulmuştur. Yapısal eşitlik modellemesi kabul edilebilir model uyum sonuçları göstermiştir. Sonuçlara göre DD'nin psikoterapinin ilk aşamasındaki DOPM ile depresyon ve anksiyete semptomlarındaki azalma arasında aracı görevi gösterdiği bulunmuştur. Ayrıca DD'nin, orta dönemdeki DOPM ile dışsallaştırma, depresyon ve anksiyete semptomlarındaki azalma arasındaki ilişkiyi aracı ettiği de bulunmuştur. DD'nin DOPM ve semptomatik gelişim arasındaki ilişkide aracı rolünü inceleyen başka bir araştırma bulunmamaktadır. Bu sonuçlar psikodinamik çocuk psikoterapisinde değişim mekanizmalarını inceleyen araştırmalara katkıda bulunmaktadır.

Anahtar Kelimeler: Çocuk Psikoterapisi, Psikodinamik Psikoterapi, Duygu Odaklı Müdahaleler, Duygu Düzenleme, Semptomatik Gelişim

CHAPTER 1

INTRODUCTION

The increasing number of studies have been providing evidence for the effectiveness and efficacy of psychodynamic psychotherapy for adults, adolescents and children (Shedler, 2010; Midgley & Kennedy, 2011; Midgley, O’Keeffe, French, & Kennedy, 2017). However, the study of whether the psychodynamic psychotherapy works, that is outcome study, does not yield detailed information that would enhance the evolution of clinical practice (Shedler, 2010). A further level in psychotherapy studies is the process research that studies the reasons accounting for the change by investigating the specific factor in the sessions and outcome (Diener, Hilsenroth, & Weinberger, 2007; Midgley, 2009; Levy, Ehrenthal, Yeomans, & Caligor 2014). As there are a few process studies in child psychotherapy research, the main purpose of the present study is to contribute to the literature by examining the associations between main constructs that are highlighted in psychodynamic child psychotherapy, such as therapist’s affective interventions, affect regulation; and treatment outcome. Therapists’ affect focused interventions, such as verbalizing, relating and interpreting patient’s affective experience, as well as interventions aimed to evoke affect have strongly differentiated adult psychodynamic psychotherapy from other frameworks and been associated with outcome (Blagys & Hilsenroth, 2000; Diener & Hilsenroth, 2009). In psychodynamic child psychotherapy, the central goal is to promote affect regulatory capacities of the children by affective intervention, which is expected to bring change in psychotherapy (e.g., Hoffman, Rice & Prout, 2016; Kernberg & Chazan, 1991; Muratori, Picchi, Bruni, Patarnello & Romagnoli, 2003). In the following literature review, the place of affect focused interventions in psychodynamic psychotherapy; and its links between AR and behavior problems will be discussed in order to support a model in which AR is expected to operate as a mediator in the AFPI’s prediction of symptomatic outcome.

1.1. EMPIRICAL STUDIES ON EFFICACY AND EFFECTIVENESS OF PSYCHODYNAMIC PSYCHOTHERAPY

There has been a conjecture that psychodynamic frameworks of treatment lacked empirical support, or even they were not as effective as cognitive behavioral therapy (CBT) or pharmacotherapy (Fonagy & Target, 1997; Shedler, 2010, Levy et al., 2014). Shedler (2010) remarked that antipathy to dismissing attitude of former psychoanalytic circles towards the training of non-medical students and empirical research might have been a reason for this supposition. Nevertheless, Shedler successfully demonstrated in his article the efficacy and effectiveness of psychodynamic psychotherapy by reviewing the empirical studies, yet, he emphasized the limited number of empirical research conducted with scientific rigor in psychodynamic research compared to other psychotherapy schools.

Studies reviewed by Shedler (2010) constitute the cornerstones of empirical support for psychodynamic adult psychotherapy. One meta-analysis on randomized control trials (RCTs) showed that short-term psychodynamic psychotherapy (STPP) was efficacious in treatment of various psychiatric problems such as depression, posttraumatic stress disorder, and borderline personality disorder in comparison with wait-list controls and treatment as usual (Leichsenring, Rabung, & Leibing, 2004). Results of another meta-analysis supported the effectiveness of long-term psychodynamic psychotherapy (LTPP) on complex mental disorders, as personality disorders, multiple mental disorders, or chronic mental disorders, even after long-term follow-up (Leichsenring & Rabung, 2008). Moreover, one meta-analysis demonstrated the LTPP's effectiveness on both symptomatic improvement and changes in personality, more importantly these benefits were found to be persistent in increasing in the long-term follow-up (De Maat, De Jonghe, Schoevers, & Dekker, 2009). After the publication of Shedler's investigation, two consecutive meta-analyses reported evidence for efficacy and effectiveness of psychodynamic psychotherapy on

depression (Driessen et al., 2010; Driessen et al., 2015) and anxiety (Keefe, McCarthy, Dinger, Zilcha-Mano, & Barber, 2014).

These studies display the increasing development in adult psychotherapy; unfortunately, research in demonstrating the evidence basis of psychodynamic psychotherapy for children and adolescents falls behind (Fonagy & Target, 1997; Midgley, 2009; Midgley & Kennedy, 2011). In his overview on child and adolescent psychotherapy research, Midgley (2009) highlighted Boston's assertion regarding the underdevelopment of research in psychodynamic psychotherapy for children and adolescents. She observed that there had been a gap between clinicians and researchers in the field of child psychotherapy (Boston, 1989). While clinicians considered research as superficial and futile, researchers appraised psychodynamic practice as biased and dubious. By pointing out the recent developments, Midgley maintained that this split has been diminishing. After the publication of Midgley's chapter in 2009, two reviews investigated the empirical research on psychodynamic child psychotherapy. First of the reviews, based on research published until 2011, exhibited the preliminary evidence supporting the effectiveness of psychodynamic child psychotherapy; however, the authors highlighted some important limitations that should be addressed in the future research (Midgley & Kennedy, 2011). First, conclusions from the findings of these studies require caution as the majority of them were small-scale and frequently deficient in delicately constructed control groups. Second, most of these studies were independent of each other and no study has been conducted as a further research building on the findings of a previous one; thus, improvement of systematic evidence base has been impeded. The following review, focusing on the recent developments after 2011, indicated that the progress in manualized psychodynamic treatments for various age groups and childhood disorders; and increment in the number of RCTs were considerable advancements in the establishment of evidence basis for psychodynamic psychotherapy for children and adolescents (Midgley et al., 2017). In addition with these conclusions, authors underlined the ongoing need for well-designed

studies investigating the effectiveness of psychodynamic psychotherapy for children on particular diagnostic groups.

One important example of these studies in child and adolescent literature (Abbass, Rabung, Leichsenring, Refseth, & Midgley, 2013) displayed the effectiveness of psychodynamic psychotherapy for children and adolescents on different common mental disorders including depression, anxiety, borderline personality disorder and anorexia nervosa. Another study compared LTPP without medication with behavioral therapy with or without medication on the treatment of children with attention deficit hyperactivity disorder and oppositional defiant disorder (Laezer, 2015). Although there were no differences among them, both treatment groups have been found to be equally effective on symptom reduction. One recent example of the empirical studies reviewed in Midgley et al., 2017 is the IMPACT study (Goodyer et al., 2017), a large RCT assessing the effectiveness of STPP and CBT, compared with a brief psychosocial intervention (BPI), with adolescent participants diagnosed with depression. Results of the study showed that although effects of the three interventions were statistically equal, 85% of the adolescents under STPP did not meet the diagnostic criteria for depression in one year follow up while these percentages for CBT and BPI were 75% and 73% respectively.

1.2. PROCESS RESEARCH

The findings presented above provide support for the efficacy and effectiveness of psychodynamic psychotherapy for adults, children, and adolescents. One problem about outcome studies is that they fall through when it comes to show differences between psychotherapy methods although some distinctions are apparent and identify mechanisms of change related to outcome (Shedler, 2010). This problem is related to the famous discussion, “dodo bird verdict” (Luborsky, Singer, & Luborsky, 1975), named after dodo bird’s line in *Alice in Wonderland*: “Everybody has won, and all must have prizes”. Such a conclusion may precipitately or falsely lead researchers to consider only non-

specific factors (or common factors), intrinsic to any positive human interaction, are effective in the psychotherapy (Jones, Cumming, & Horowitz, 1988; Ablon, Levy, & Smith-Hansen, 2011). A further step in psychodynamic psychotherapy research is to study specific factors, that are intentional interventions of the therapist based on the theory (Jones et al., 1988), and their associations with the outcome rather than focusing merely on whether it works (Diener et al., 2007). Such empirical study of why change occurs in psychotherapy by looking at the specific facets, such as the techniques used during the sessions, and their associations with the outcome is called in the psychotherapy research literature as process-outcome research (Midgley, 2009; Levy et al. 2014). Despite the increasing amount of research examining the effectiveness of psychodynamic child psychotherapy, which does not explain the associations between specific processes in psychotherapy and outcome, there is a huge need for examining which techniques account for the treatment outcome both for children and adults (Kazdin, 2000; Gibbons et al., 2009).

1.3. PSYCHODYNAMIC TECHNIQUE IN ADULT PSYCHOTHERAPY

Definition and description of what psychodynamic technique comprises is the crucial part of operationalizing the specific factors investigated in the current study. Psychodynamic or psychoanalytic psychotherapies appertain to diverse interventions based on but consisting of shorter process with less frequent sessions than traditional psychoanalysis (Shedler, 2010). In order to identify essential facets that characterize the psychodynamic psychotherapy, Blagys and Hilsenroth (2000) have conducted an extensive review on the empirical studies in comparative literature. They put together seven major ingredients that distinguish psychodynamic psychotherapy from CBT:

1. *A focus on affect and the expression of patients' emotions.* Exploration and discussion of affective experience of the patient is central to the psychodynamic psychotherapy. Psychotherapist facilitates the verbalization of the feelings, especially the contradictory feelings,

unconscious feelings, and the feelings that patients perceive as disturbing or threatening. Furthermore, cognitive or intellectual awareness is not sufficient to elicit change. Psychodynamic technique emphasizes an emotional and experiential insight which is expressing, understanding and being at ease with intense affective experience. Therefore, patients may obtain proficiency over repressed feelings that underlie their problems rather than controlling, attenuating and managing the emotions.

2. *An exploration of patients' attempts to avoid topics or engage in activities that hinder the progress of therapy.* During the psychotherapy process, patient may avoid unpleasant or elusive experiences that evoked in the sessions with conscious or unconscious acts. He or she may evade discussing germane topics, deny the therapist's suggestions, or prefer a cursory interaction with the therapist. The resistance of the patient may take a form that impeding the progress by arriving late, skipping the sessions or forgetting to pay the bills. Psychodynamic psychotherapists put emphasize on recognition and the exploration the resistance.
3. *The identification of patterns in patients' actions, thoughts, feelings, experiences, and relationship.* Psychodynamic psychotherapists emphasize the recognition and exploration of recurrent experiences; such as repeating feelings, thoughts, or relational patterns hampering the life of the patient. They may not be aware of repeating patterns or may be aware of but feel entangled among these experiences.
4. *An emphasis on past experiences.* Psychodynamic theory suggests that an individual's past experiences, unresolved conflicts, and attachment relationships affect his or her present life. Psychodynamic psychotherapists focus on working with the patient's past experiences in relation with the present problems.
5. *A focus on patients' interpersonal experiences.* Psychodynamic literature considers interpersonal problems as an important source of psychological difficulty. Troublesome interaction with other individuals may inhibit the patient's fulfillment of basic or emotional needs. Psychodynamic

therapists work with the adaptive or maladaptive personality characteristics associated with interpersonal patterns in order to help patients to obtain more adaptive interpersonal functioning.

6. *An emphasis on the therapeutic relationship.* Therapeutic relationship, or alliance is important in most of the psychotherapy frameworks; however, what is distinctive in psychodynamic psychotherapy is the utilization of therapeutic relationship as a medium for creating change. The psychoanalytic concept of transference implies that patient's recurrent relational patterns will eventually emerge within his or her relationship with the psychotherapist. Psychodynamic psychotherapists often remark interpersonal and transference experiences in the session to bring to light the patient's unconscious dynamics that shape maladaptive relationships.
7. *An exploration of patients' wishes, dreams, or fantasies.* Compared to other psychotherapy methods, psychodynamic psychotherapists focus on bringing forth the exploration of patient's fantasies, dreams and desires which are affluent in information about the patient's unconscious conflicts, feelings and experience; as well as concept of self and others (Shedler, 2010). Psychodynamic psychotherapists facilitate the exploration of fantasies by allowing patient to freely express his or her mind without interfering.

1.4. ASSESSMENT OF PSYCHOTHERAPY PROCESS AND PSYCHODYNAMIC TECHNIQUE IN ADULT PSYCHOTHERAPY

Based on these distinctive features of psychodynamic psychotherapy and a consequent review on the distinctive features of CBT (Blagys & Hilsenroth, 2002), Hilsenroth, Blagys, Ackerman, Bonge, and Blais (2005) developed the Comparative Psychotherapy Process Scale (CPPS). CPPS assesses the in-session adherence of psychotherapists to characteristic techniques of psychodynamic psychotherapy and CBT for adults. Distinctively, CPPS allows researchers to examine non-manualized treatment methods in natural setting, compare various

types of psychodynamic treatments and CBT (Hilsenroth et al., 2005). The scale can be rated by the psychotherapist, patient or an independent judge. CPPS items assessing psychodynamic interventions include such as the psychotherapist's exploration of uncomfortable feelings, linking the current feelings to past experiences, focusing on recurrent relational patterns and feelings, discussion of therapeutic relationship, encouragement of emotional expression, addressing the changes in emotions.

Empirical studies exhibit support for the associations between psychotherapist's adherence to psychodynamic techniques and symptomatic outcome using the CPPS. More specifically, use of psychodynamic techniques in general predicted changes in depression (Hilsenroth, Ackerman, Blagys, Baity, & Mooney, 2003; Katz & Hilsenroth, 2017) anxiety symptoms (Slavdin-Mulford, Hilsenroth, Weinberger, & Gold, 2011; Pitman, Slavdin-Mulford, & Hilsenroth, 2014; Pitman, Hilsenroth, Weinberger, Conway, & Owen, 2017). These studies also examined the associations between CPPS items covering specific psychodynamic interventions and symptomatic change. Psychodynamic techniques such as encouraging the experience of feelings; addressing the patient's avoidance of certain topics and changes in the mood; and identifying recurrent patterns in the patient's behavior, feelings and experiences, were found to be associated with decreases in depression symptoms (Katz & Hilsenroth, 2017). For anxiety, focusing on fantasies, dreams and memories; making links between past and present feelings; highlighting the patients repeating relational patterns; and suggesting alternative ways to understand their experiences were found to be associated with positive change (Slavdin-Mulford et al., 2011; Pitman et al., 2014; Pitman et al., 2017).

Another influential assessment method of psychotherapy process in adult psychotherapy research is the Psychotherapy Process Q-set (PQS; Jones, 1985). PQS consists of 100 items that assess the characteristics of a psychotherapy session taking into account the therapist's and patient's behaviors and attitudes as well as their interaction observed in a single session (Jones, 2000). Rather than scoring each item, raters q-sort them into nine categories based on the degree to

which each item is characteristic of the session. Each category has a restricted number of available slots to be taken by items; therefore, judges are forced to q-sort 100 items in an array representing a normal distribution same for every session. With the Q-methodology, PQS can assess a session within its uniqueness while allowing the comparison with other sessions and patients (Jones, 2000). By analyzing 30 psychodynamic and 32 cognitive-behavioral psychotherapy processes, Jones and Pulos (1993) have found that the psychodynamic psychotherapists emphasized the evocation of affective experience along with interpreting the unconscious feelings, linking the current and past life incidents, and focusing on the therapeutic relationship, whereas cognitive-behavioral psychotherapists mostly dealt with negative emotions via encouragement, support, reassurance, and the utilization of reasoning. In the second study (Ablon & Jones, 1998) psychotherapy experts using psychodynamic and cognitive behavioral frameworks constructed with PQS the prototypical scores of sessions from both frameworks. Items assessing therapists' focus on affect were scored greater in the ideally conducted psychodynamic psychotherapy.

Ablon and his colleagues (2011) put together the ways PQS used in the psychotherapy research. Although there are numerous applications of PQS, one of them is closely relevant to content of the current study, that is PQS can be used to assess the effect of specific therapist interventions in psychotherapy. In that vein, a former research with PQS conducted by Jones, Cumming, and Horowitz (1988) studied the psychodynamic psychotherapy processes of 40 patients with post-traumatic stress disorder. Results of the study indicated that therapist intervention such as emphasizing the feelings of patients for a deeper experience, making links between therapeutic relationship and other social relationships were associated with better outcome for the patients with mild symptoms. On the other hand, for the severely disturbed patients, supportive and directive interventions were more successful. Another former study reported positive correlations between therapist's comments on the patient's mood shifts, and interpretation of unconscious feelings; and symptomatic outcome (Jones, Parke, & Pulos, 1992). Moreover, affect focused techniques such as emphasizing feelings, especially the

ones that patients deem uncomfortable; and focusing on guilt have been found to be associated with positive outcome in panic symptoms (Ablon, Levy, & Katzenstein, 2006).

Among all the techniques, focus on affect was the most emphasized intervention inherent to psychodynamic psychotherapy (Blagys & Hilsenroth, 2000; Diener & Hilsenroth, 2009). Along with the findings from the process studies utilizing CPPS and PQS, a meta-analysis reviewing the studies investigating affect focused interventions in psychodynamic psychotherapy, supported these relationships with symptomatic improvement of patients (Diener et al., 2007).

1.5. PSYCHODYNAMIC TECHNIQUE IN CHILD PSYCHOTHERAPY

Based on the PQS, Schneider, and Jones (2004) developed the Child Psychotherapy Process Q-Set (CPQ) for administration in child psychotherapy. CPQ has similar content of items, methodology and applications with PQS, except for items being adapted to child psychotherapy (Schneider, 2004; Goodman & Athey-Lloyd, 2011). In order to test the possibility whether the expert psychotherapists could agree on CPQ items that constitute distinct prototypes of psychodynamic child psychotherapy and CBT, Goodman, Midgley, and Schneider (2016) asked expert clinicians to sort the CPQ items in a distribution that best represents an ideally conducted psychodynamic and cognitive behavioral therapy session. Ten items most characteristic of psychodynamic therapy prototype included (1) *Therapist is sensitive to the child's feelings*; (2) *therapist tolerates child's strong affect or impulses*; (3) *therapist makes links between Child's feelings and experience*; (4) *therapist interprets warded-off or unconscious wishes, feelings, or ideas*; (5) *therapist points out a recurrent theme in the child's experience or conduct*; (6) *therapist clarifies, restates, or rephrases child's communication*; (7) *therapist draws connections between the therapeutic relationship and other relationships*; (8) *therapist points out child's use of defences*; (9) *therapist and child demonstrate a shared vocabulary or*

understanding when referring to events or feelings; (10) the therapy relationship is discussed.

The PQS and CPQ have also been used to identify interaction structures (IS; Jones, 2000), which are mutual interactions between the patient and the therapist that occurs repeatedly throughout the therapeutic process (Ablon, & Jones, 2005). Statistically, IS refers to clusters of PQS or CPQ items derived from factor analytic techniques (Jones, 2000; Schneider, Midgley, & Duncan, 2010) that characterize the course of the psychotherapy (Jones, 2000). A recent research (Halfon, Goodman, and Bulut, 2018) studied the facets of interaction between the child and psychotherapist in psychodynamic psychotherapy for children using CPQ. Researchers identified an IS describing the frequent psychodynamic techniques used in the sessions investigated in their sample; such as, interpreting of the child's play; pointing out the defenses; linking the child's experience and feelings; highlighting the feelings (e.g. anger, envy, or excitement) that child may regard unacceptable; emphasizing feelings to enhance the affective experience; interpreting of unconscious feelings, wishes, and ideas; discussion of the therapeutic relationship; and accentuating the recurrent themes. Therapists implemented these techniques in a natural stance without structuring or exerting control over the sessions. Among other factors named *therapeutic alliance*, *children's emotion expression*, and *child-centered technique*, only the *psychodynamic technique* positively predicted outcome in total behavioral problems. The findings of both of the studies are consistent with the major ingredients of psychodynamic psychotherapy identified by Blagys and Hilsenroth (2000).

1.6. AFFECT, SYMPTOMATOLOGY, AND TREATMENT IN THE CONTEXT OF PSYCHODYNAMIC CHILD PSYCHOTHERAPY

Before reviewing the place of affect focus in the technique of psychodynamic child psychotherapy, child's capacity for affect regulation; its association with behavioral problems; and how they are conceptualized and

worked in psychodynamic psychotherapy will be discussed due to strong interrelations among these concepts.

1.6.1. Development of Affect Regulation

Affect regulation has been conceptualized as a self-modulatory process through which one can manage and alter emotion-related internal states (Eisenberg, Spinrad & Eggum, 2010). Psychodynamic theories consider early interaction between infant and caregiver as the key to the formation of affect regulatory capacities. Fonagy, Gergely, Jurist & Target (2002) emphasized the development of mentalization and symbolic play in the development of affect regulation. Mentalization, or mentalizing, is the capacity to comprehend and interpret the mental states of self or others (Fonagy, 1989), and their role in behaviors and social interaction (Fonagy et al., 2002). A related term mainly used in empirical research, reflective function (RF), refers to the operationalization and quantification of mentalization within the attachment context (Fonagy, 2006). Child capacity for mentalization burgeons in early attachment relationship between the caregiver and child through the caregiver's provision of contingent and marked mirroring that is the reflection of child's mental states consistent with the affect but attenuated in intensity (Fonagy et al., 2002). Children's early understanding of affective states are characterized by a psychic equivalence between internal and external world. Repeated marked mirroring of the caregiver enables child to decouple the internal states from the external world and give the child a sense of pretense. As result, dealing with distressing feelings become more secure as the child knows that such feelings could be represented with words, therefore, will not destroy the external world. If the caregiver persistently becomes devastated by the child's internal state and returns it with the exact intensity, the child may experience mental states as dangerous and unrepresentable in a psychic equivalent way. Or, if the caregiver mirrors the child affective state with incongruent emotions, child may acquire a false understanding of his/her own mental states. Either way, the child may experience fragmentation

within the self-representation, leading to inability to accurately reflect on and manage his/her own internal states. For that reason, marked mirroring is also referred as affect-regulative mirroring (Fonagy et al., 2002).

Another key concept related to the development affect regulation and mentalization is symbolic play. It constitutes a field free from the limitations of external world where child explores and manifests his/her internal reality with the awareness of the representational nature of play content (Fonagy & Target, 1998). In other words, child plays with his/her own internal conflicts, but keeps in mind that these were just “as if” scenarios; therefore, he/she can experiment with distressing emotions and develop more adaptive strategies to regulate them (Fonagy et al., 2002; Chazan, 2002). Without the awareness of being in the state of playing, i.e. in the psychic equivalence mode, child’s play lacks the flexibility through which the child can acquire mastery over intense affective experience (Fonagy et al.,2002). This lack of awareness of being in a state of playing may interfere with the child’s capacity to play symbolically because the emerging feelings and fantasies become excruciating as they are experienced as physically real and dangerous to be approached and coped with. In order to acquire ability to construct symbolic play child needs to acquire the ability to reflect on mental states in a pretend mode, deliver them to his/her symbolic play, and regulate affective experiences emerging in the play narrative. From this perspective, development symbolic play is closely related to parent’s marked mirroring in its way of being experienced as not exactly realistic but consistent with the affect.

There is empirical evidence that parent’s attribution to mental states in parent-child interactive symbolic play is associated with children’s symbolic play and affect regulation capacities observed in the play (Halfon, Bekar, Ababay, & Çöklü, 2017). In addition, with these findings, researches indicated that mental state talk in the context of pretend play was related with lower levels of internalizing symptoms of the child, whereas direct attributions to the child’s affective states aside from symbolic play were associated with more behavioral problems, especially the externalizing problems. Furthermore, another study exhibited that symbolic play together with mental state talk, is related with higher

affect regulation (Galyer & Evans, 2001). These results show the importance of symbolization as a field in which caregiver's affective mirroring can improve the child's affect regulatory capacities.

1.6.2. Affect Regulation and Behavioral Problems

Behavioral problems observed in children are considered as bifurcating into two extensive clusters of symptoms. First category, externalizing problems include symptoms related to undercontrolled behavior, such as aggression, attention deficit hyperactivity disorder, and conduct disorders; second category, internalizing problems contain overcontrolled behavior as anxiety, depression, and fear (Vaillancourt & Boylan, 2015). Inability to regulate affective responses is considered to play a central role in the development of internalizing and externalizing behavior problems (Eisenberg et al., 1996; Eisenberg et al., 2010; Hoffman et al., 2016).

Empirical literature supports that negative emotionality deficits, in relation with affect regulation, are associated both with externalizing and internalizing problems (Eisenberg et al., 2005; Hill et al., 2006). In particular, children with externalizing problems exhibit high impulsivity, anger and low regulation, compared to children without any behavioral problem or internalizing children; whereas children with internalizing problems display, low impulsivity, high sadness, anxiety, and depression (Eisenberg et al., 2001, Eisenberg et al., 2005; Lengua, 2003; Oldehinkel, Hartman, De Winter, Veenstra, & Ormel, 2004; Eisenberg et al., 2009) and tend to over-control and restrict their overt affective reactions (Eisenberg et al., 2010).

Although externalizing has been linked to aggression and internalizing has been characterized by problems such as anxiety and depression, there is evidence blurring this differentiation (Eisenberg et al., 2010). Eisenberg and her colleagues (2005) reported that externalizing children demonstrate marginally more anger, and internalizing children showed slightly more sadness compared to each other, however anger and sadness were prevalent and higher in both problem groups

compared to control group. In addition to anger and sadness, fear has been found to be associated with both internalizing and externalizing (Lemery, Essex, & Smider, 2002). In spite of their frequent comorbidity, externalizing and internalizing problems have been demonstrated to be distinct in terms of emotions and regulation (Eisenberg et al., 2001); nevertheless, considering the subsequent findings, the present study investigates behavioral problems dimensionally for each child rather than dividing the participants into two problem behavior groups.

Along with affect regulation problems, some studies indicate that externalizing and internalizing problems are associated with some deficits in capacity for mentalization and facilitation of symbolic play. For mentalization problems, externalizing children often have erroneous mentalization, such as they tend to ascribe negative intentions to other people (Ha, Sharp, & Goodyer, 2011), have troubles in assessing the social impact of their behavior (Sutton, Reeves, & Keogh, 2000), have difficulty verbalizing past emotional experiences (Cook, Greenberg, & Kusche, 1994), disavow their mental states to evade responsibility (Sutton et al., 2000). Children with internalizing problems lean towards using “hyper-vigilant mentalization”; they inappropriately and negatively evaluate social interactions (Banerjee, 2008). For the play characteristics of children with externalizing and internalizing problems, studies show that these children may have difficulties in the organization of symbolic play, especially related with regulation of negative emotions. If the engagement in an organized symbolic play requires a representational distance from the overwhelming emotional content, namely pretend mode, these children cannot play symbolically because they are unable to verbalize and represent negative affective states coherently in the play narrative (Fonagy et al., 2002). Externalizing children display hostility and disruptive emotions, especially anger (Dunn & Hughes, 2001; Halfon, Oktay, & Salah, 2016) together with low regulation and organization in symbolic play (Butcher & Niec, 2005). Furthermore, children’s incoherent play narratives, intrusion of negative themes, and dysregulated aggression observed in attachment related play tasks are found to be correlated with externalizing symptoms reported by parents (Von Klitzing, Kelsay, Emde, Robinson, & Schmitz, 2000).

Internalizing children, on the other hand, present high levels of negative emotions, low affective arousal (Halfon et al., 2016), less organization, and tend to play solitary rather than involving in interactive play (Christian, Russ, & Short, 2011). Furthermore, depressed children show low levels of symbolic play and narrative coherence compared to non-depressed children (Lous, De Wit, De Bruyn, & Riksen-Walraven, 2002).

1.6.3. How Psychodynamic Child Psychotherapy Work with Affect Regulation and Behavioral Problems

The major difference between child and adult treatment models is that the psychodynamic child psychotherapy models use symbolic play as a cardinal vehicle to work with the child's internal world because play is an important means for the expression of unconscious conflicts, desires, feelings, and fantasies for the children (Fonagy & Target, 1996; Chazan, 2002). In that vein, psychodynamic models of child psychotherapy use play activity as a medium to develop affect regulation capacities, which is suggested to bring change in internalizing and externalizing symptoms (Hoffman et al., 2016; Kernberg & Chazan, 1991; Muratori et al., 2003). However, children who are referred to psychotherapy, start with different levels of capacities to engage in symbolic play which is depending on the severity and nature of psychopathology (Ensink, Berthelot, Bernazzani, Normandin, & Fonagy, 2014). Psychodynamic psychotherapy cannot occur without the ability to engage in symbolic play (Winnicott, 1971) and affect regulation, symbolic play and mentalization are considered to be closely intertwined (Fonagy et al., 2002). Therefore, some of the most important therapeutic goals and mechanisms of change in the psychodynamic treatment of children with behavioral disorders are improvement of the capacity for symbolization and mentalization in play (Slade, 1994; Fonagy, 2000). More specifically, psychodynamic approach aims to construct adaptive play in treating children. Adaptive play is defined as the play in which child shows active engagement in the surroundings, strives for integrating positive and negative

experiences, flexibly modulates affect when faced with frustration and generates new coping strategies (Chazan, 2002). Research shows that the emergence of new and more adaptive play profiles is vital and psychodynamic psychotherapy is capable of improving them (Halfon et al., 2016). Furthermore, there is empirical evidence that symbolic play in the psychodynamic sessions was associated with affect regulation improvement over the course of the treatment (Halfon, Yılmaz, & Çavdar, 2019).

1.7. AFFECT FOCUS IN PSYCHODYNAMIC CHILD PSYCHOTHERAPY

Verheugt-Pleiter, Zevalkink, and Schmeets (2008) suggested that practice of mentalization of affective states and thoughts within the sessions, that are experienced by the child as unacceptable or painful, constitutes the integral part of the psychodynamic treatment for children. They identified five mentalizing principles that are inherent to psychodynamic child psychotherapy:

1. *Work in the here-and-now of the relationship.* Therapist actively attends to the affective experience in the therapeutic interaction and provides marked reflection of the child's mental states in order to promote the his/her capacity for mentalization.
2. *Recognizing the child's level of mental functioning and meeting at the same level.* Therapist accurately attunes and adjusts the therapeutic interventions to the child's level of mental functioning.
3. *Giving reality value to inner experiences.* Therapist states the child's current affective states in order to give the child's perspective a reality value. (E.g. therapist verbalizing the underlying intentions and feelings if the child exhibits verbal or physical attack.)
4. *Playing with reality.* Therapist actively encourages the symbolic play to improve the child's ability to use it as a means to explore his/her inner world and experience.

5. *The process is more important than the technique.* The process itself which occurs implicitly in the intersubjectivity of the therapeutic relationship comes before the explicit techniques.

These principles are comparable to the seven clusters of techniques specific to psychodynamic psychotherapy identified by Blagys and Hilsenroth (2000), especially to the *focus on affect and the expression of patients' emotions*. In order to facilitate child's comprehension of affective states, psychotherapist initially adopts a mentalizing stance, that is, being present and nondirective with sharing and supporting the patient's subjective experience without attempting to change them (Fonagy, 2000). Then, as the play advances, it allows the child to experience feelings, thoughts, and desires as significant and relevant but not taking place as physical reality (Bateman & Fonagy, 2004). Inside this holding environment, therapist promotes the comprehension of affective states and their associations with the behavior of self and others through commenting on and instilling curiosity over the mental states and affective experience underlying the play narrative, characters, and child's behavior; along with emphasizing the uniqueness of the child's internal world (Fonagy, 2000).

Similarly, to what discussed by Blagys and Hilsenroth (2000) under the affect focus in psychodynamic technique, the process of working with the child's affect in play embrace emotional containment rather than merely focusing on cognitive understanding of mental states. For that purpose, therapist provide an empathic presence for entering into the symbolic world of the play to share and bear with the child's experiences, which in return introduces the child to the emotional understanding that feelings are not solid and tangible, rather they can be approached and molded in play's symbolic essence (Fonagy & Target, 1998; Slade, 1994). To sum up, through its provision of secure and holding "as if" platform where the child can experience his or her perturbing affective states from a representation distance, symbolic play facilitates affect regulation (Bretherton, 1984; Fonagy & Target, 1996). Also, focusing on affect in psychodynamic play sessions improves the comprehension of mental states and ability to link them with the behaviors, therefore facilitates the emergence of self-narrative coherence

and development of affective regulation as well (Fonagy & Target, 1996; Fonagy et al., 2002; Ensink & Mayes, 2010).

1.8. EMPIRICAL EVIDENCE CONSIDERING THE AFFECT REGULATION AND BEHAVIORAL PROBLEMS IN PSYCHODYNAMIC CHILD PSYCHOTHERAPY

Empirical research supports the effectiveness of psychodynamic child psychotherapy on externalizing and internalizing problems (Fonagy & Target 1994; Target & Fonagy, 1994; Midgley & Kennedy, 2011; Midgley et al., 2017). Recent process studies provide support for the relations between affective work in the psychotherapy sessions and regulation focus in consideration with the symptomatic improvement; adherence to mentalizing principles in psychodynamic child psychotherapy was observed to be associated with improvement of affect regulation (Halfon & Bulut, 2017), and in sessions with high mentalization adherence, expression of dysphoric affect in symbolic play was related with higher affect regulation compared with session with low mentalization adherence (Halfon et al., 2019). Halfon, Bekar, and Gürleyen (2017) have found that psychodynamic child therapists' focus on affective work through using mental state talk in psychotherapy sessions predicted affect regulation, and the children's use of mental state talk predicted affect regulation only for the children who displayed clinically significant symptomatic improvement.

Manualized psychodynamic treatment models provide additional theoretical and empirical support for these associations. These models work with the affect regulatory capacities in the play environment, in which children are encouraged to express their negative feelings, to understand the possible reasons for avoiding unpleasant emotions and to experience them more deeply within a safe therapeutic relationship (Kernberg & Chazan, 1991). Hoffman and his colleagues (2016) created the Regulation-Focused Psychotherapy for Children (RFP-C), a manualized treatment for children with externalizing problems. Based on the psychodynamic conceptualization, they suggested that every disruptive

behavior has a meaning in the service of avoiding painful dysphoric affect (e.g., guilt, shame, fear, anxiety, anger). Therefore, the RFP-C aims to help children discover these avoidance mechanisms, and delineate the feelings hidden in their behavior until they do not feel the need to rely on such defensive processes, and eventually regulate negative emotions (Hoffman et al., 2016). Prout, Gaines, Gerber, Rice, and Hoffman (2015) demonstrates how RFP-C worked by examining a single case. Although RFP-C has been built on collective empirical and clinical experience, pilot trials of RFP-C are planned (Prout et al., 2015).

For the internalizing problems, Göttken, White, Klein, and Klitzing (2014) developed Short-Term Psychoanalytic Child Therapy (PaCT). The main objectives of this emotion-oriented play-focused treatment are the modification of (1) interpersonal conflicts within the family system and of (2) rigid maladaptive defense mechanisms toward more flexible affect regulatory strategies. A quasi-experimental wait-list controlled study was conducted in order to examine the effectiveness of the PaCT and they found significant improvement in internalizing symptomatology reported by children, parents and teachers (Göttken et al., 2014). Moreover, a 2-year follow-up of psychodynamic psychotherapy for children with internalizing problems showed that only the treatment group shifted from clinical to nonclinical range and improved in global functioning, while maintaining these improvements for 2 years (Muratori et al., 2003). These findings suggest that emphasizing children's representations in relation to self and others, particularly within the attachment relationship, encouraging them in giving words to underlying feelings, and linking with mental states were associated with successful outcome.

1.9. THE CURRENT STUDY

1.9.1. Considerations About Assessment of the Variables

Although the recent findings of Halfon and her colleagues (2018), that cluster of CPQ items assessing psychotherapist's psychodynamic interventions

predicted outcome, constitute preliminary support for the utilization of CPQ to investigate specific interventions, large scale studies investigating therapist's adherence to psychodynamic techniques, especially facilitation of affective work, are needed in child psychotherapy literature. In order to quantify therapist's affect focus in psychodynamic technique, all CPQ items were screened and 9 of them were identified. These items describe different therapist interventions and attitudes related to affect focus in psychodynamic technique. Relevance of the identified items was determined based on the literature discussed in the previous sections (e.g. Blagys & Hilsenroth, 2000; Hilsenroth et al., 2005; Jones and Pulos, 1993; Ablon & Jones, 1998; Goodman et al., 2016; Halfon et al., 2018; Verheugt-Pleiter et al., 2008). Average scores of the 9 items were used as the score of therapist's adherence to affect focus in psychodynamic technique. These CPQ items measure the therapist's being responsive and affectively engaged to the child's feelings; emphasizing and the verbalizing the affective states to help child to experience them more deeply; highlighting the feelings that child may regard unacceptable; interpreting the unconscious feelings; relating the child's feelings and experience; emphasizing the changes in the child affect; and tolerating the child's strong affective reactions.

Child's capacity for affect regulation was assessed within the sessions using the Children's Play Therapy Instrument (CPTI; Kernberg, Chazan, & Normandin, 1998). In session observations of affect regulation is central to the current study because child's ability for adaptively experiencing and expressing affective states in the play narrative is an indicator of affect regulation capacities (Chazan, 2002). For example, tantrums, abrupt shifts between affective states, problems in affective flexibility, or refraining from emotional expression in the face of the sources of distress indicate poor affect regulation in the play activity as opposed to regulating one's emotional reactions. On the other hand, conceptualization of the affect regulation development in the play environment, supported by the therapist's affect focused attitude and interventions, is another major reason for quantifying affect regulation by CPTI observations in the play sessions.

An influential meta-analysis conducted by Achenbach, McConaughy, and Howell (1987) on 119 studies have found that different informants (e.g. parents, teachers, children themselves) had discrepant agreement on the behavioral problems of the children. Discrepancies across informants were higher for internalizing compared to externalizing problems. These results have been replicated by numerous following studies (De Los Reyes & Kazdin, 2005). Drawing from the similar findings, it is possible to conclude that informants tend to provide greater correspondence on reporting the problems that are easier to observe as externalizing problems (De Los Reyes et al., 2015). Therefore, in the present study, parent-reports of externalizing problems, and self-report scales for the internalizing problems such as depression and anxiety were used. Specifically, externalizing problem scale of The Child Behavior Checklist (CBCL; Achenbach, 1991) reported by parents; the Children's Depression Inventory (CDI; Kovacs, 1981), and the Screen for Child Anxiety Related Emotional Disorders (SCARED; Birmaher et al, 1997) reported by children are the instruments that were used to assess symptoms of children.

1.9.2. Aim of the Current Study

As discussed earlier, one important goal of psychodynamic child psychotherapy is to use play activity as a means to improve affect regulation capacities in order to bring symptomatic change (e.g., Hoffman, et al., 2016; Kernberg & Chazan, 1991; Muratori., 2003). In conjunction with other empirical findings discussed in the previous sections, it is plausible to conclude that therapist's affective focus, child's affect regulation and improvement in symptoms are associated.

The aim of the current study is to investigate mediating role of change in affect regulation observed in the child's play on the association between psychotherapist's affect focused interventions at different time points of the psychodynamic child psychotherapy process and symptomatic improvement reported by parent's and the children.

1.9.3. Hypotheses

Considering the discussed links between affect focus in psychodynamic technique, affect regulation and behavioral problems, it was hypothesized that:

1. Change in affect regulation observed in play from the beginning to the end of the psychotherapy is expected to mediate the association between affect focused psychodynamic interventions in the beginning of psychotherapy and symptomatic improvement in the children's:
 - 1.a. Externalizing problems (i.e. higher affect focus in the first phase will be associated with lower symptom levels by its positive association with the subsequent gains in the affect regulation which is expected to be negatively associated with externalizing problems after the psychotherapy).
 - 1.b. Depression (i.e. higher affect focus early in the treatment will be associated with lower symptom levels by its positive association with the subsequent gains in the affect regulation which is expected to be negatively associated with depression symptoms after the psychotherapy).
 - 1.c. Anxiety (i.e. higher affect focus in the beginning will be associated with lower symptom levels by its positive association with the subsequent gains in the affect regulation which is expected to be negatively associated with anxiety symptoms after the psychotherapy).
2. Change in affect regulation observed in play from the middle to the end of the psychotherapy is expected to mediate the association between affect focused psychodynamic interventions in the middle of psychotherapy and symptomatic improvement in the children's:
 - 2.a. Externalizing, (i.e. higher affect focus in the middle phase of psychotherapy will be associated with lower symptom levels through its positive association with the subsequent gains in the

affect regulation which is expected to be negatively associated with externalizing symptoms after the psychotherapy).

2.b. Depression (i.e. higher affect focus in the middle of psychotherapy will be associated with lower symptom levels through its positive association with the subsequent gains in the affect regulation which is expected to be negatively associated with depression symptoms after the psychotherapy).

2.c. Anxiety symptoms (i.e. higher affect focus in the middle of psychotherapy will be associated with lower symptom levels through its positive association with the subsequent gains in the affect regulation which is expected to be negatively associated with anxiety symptoms after the psychotherapy).

1.9.4. Implications

To the best of our knowledge, there exist no other empirical research conducted on the relationship between affect focused psychodynamic techniques and outcome in child psychotherapy literature, particularly with a focus on the proposed mediator (i.e., affect regulation) and with the consideration of a therapy stages (i.e., techniques used in the beginning and middle in the treatment). In that vein, the present study significantly contributes to the literature in process research of psychodynamic child psychotherapy.

CHAPTER 2

METHOD

2.1. PARTICIPANTS

The data of the current study comes from Istanbul Bilgi University Psychotherapy Process Research Laboratory located in Istanbul Bilgi University Psychological Counselling Center (BUPCC) that provides low-cost psychodynamic psychotherapy for referrals from medical, mental health, and child welfare professionals or parents themselves. After the application for psychotherapy, the patients are screened by a licensed clinical psychologist according to following inclusion criteria of the study: (1) age between 4 and 10 years old, (2) absence of psychotic symptoms, (3) absence of developmental delays, (4) no drug abuse, (5) no significant suicidal risk. If the children met these criteria, they and their parents are informed about procedures of study before the beginning of psychotherapy. If the children and their parents voluntarily agree on participating in the study, the parents give informed consent and the children give oral permission for the confidential use of their data collected as questionnaires and video recordings of sessions. Approval of the study is provided by Istanbul Bilgi University Ethics Committee.

70 children participated in the current study. Ages of the children were ranged between 5 and 10 ($M = 7.63$, $SD = 1.50$). 54.3% of the participants were females ($N = 38$) and 45.7% were males ($N = 32$). Pre-treatment externalizing problem t scores assessed by CBCL parent reports ranged between 33 and 82 ($M = 62.76$, $SD = 10.28$) where t scores between 59 - 64 indicate borderline and t scores equal to or above 64 show clinical level of functioning. For externalizing problems, 48.6% of children were in clinical range ($N = 34$), 11.4% were in borderline range ($N = 8$), and 40% were in non-clinical range ($N = 28$). Depression scores assessed before the treatment by CDI self-report were between 0 and 35 ($M = 14.82$, $SD = 8.33$) where scores equal to or higher than 19 show clinical functioning. 28.6% of the children were in clinical range ($N = 20$) while 71.4%

were in non-clinical range of depression symptoms ($N = 50$). Anxiety symptom scores before the treatment, assessed by SCARED child form, were within the range of 7 and 54 ($M = 29.26$, $SD = 12.68$) where scores higher than 25 indicate a need for clinical attention; and 58.6% of the children were in clinical attention range ($N = 41$) while 41.4% were in non-clinical range ($N = 29$). Ages of the mothers were ranged from 24 to 53 ($M = 36.51$, $SD = 4.85$) and that of the fathers were between 25 and 62 ($M = 40.93$, $SD = 6.23$). Additional demographic information of the participants is presented in the Table 2.1.

Table 2.1 Additional Demographic Characteristics of the Sample

Variables	Categories	<i>N</i>	%
Child's Education Level	Preschool	6	8.6
	1st Grade	18	26.7
	2nd Grade	12	17.1
	3rd Grade	14	20.0
	4th Grade	11	15.7
	5th Grade	7	10.0
	6th Grade	2	2.9
Socioeconomic Status	Low	12	17.1
	Low-Middle	24	34.3
	Middle	26	37.1
	Middle-High	6	8.6
	High	2	2.9
Application Reason	Aggressive Behavior	33	47.1
	Anxiety	13	18.6
	Depression	1	1.4
	Somatic Problems	4	5.7
	School and Learning Problems	12	17.1
	Relationship Problems	7	10.0
Parents' Marital Status	Married	60	85.7
	Other	10	14.3

Table 2.1 (Cont'd)

Education Level of Mother	Elementary School	17	24.3
	Middle School	6	8.6
	High School	19	27.1
	University (Licence)	24	34.3
	University (Postgraduate)	2	2.9
	Unknown	2	2.9
Education Level of Father	Elementary School	10	14.3
	Middle School	14	20.0
	High School	23	32.9
	University (Licence)	19	27.1
	University (Postgraduate)	2	2.9
	Unknown	2	2.9
Employment Status of Mother	Employed	36	51.4
	Unemployed	34	48.6
Employment Status of Father	Employed	65	92.9
	Unemployed	5	7.1
Trauma History of the Child	Yes	22	31.4
	No	48	68.6
Trauma Type	Early Separation	4	5.7
	Loss	1	1.4
	Domestic Violence	6	8.6
	Sexual Abuse	1	1.4
	Physical Abuse	2	2.9
	Illness or Hospitalization	7	10
	Displacement	1	1.4
	No Trauma History	48	68.6

2.2. THERAPISTS

The therapists were 34 clinical psychology master's level clinicians, 32 of them were females and 2 of them were males, their ages ranged between 23 to 35 years old ($M = 25.06$, $SD = 2.82$). They have been trained in psychodynamic play therapy informed with mentalization principles (Verheugt-Pleiter et al., 2008)

with minimum 4 hours of supervision per week for at least 1 year, by licensed psychodynamic supervisors with at least 10 years of experience.

2.3. TREATMENT

The standard treatment at BUPCC is based on psychodynamic play therapy informed with mentalization principles (Verheugt-Pleiter et al., 2008). In the first session therapist conducts a standard interview with the parents in order to collect information about the presenting problem, children's developmental history, and family background. The second session is conducted with the children, in this session therapists allow the child to play freely and inform him/her about the safety rules. After the assessment sessions, therapist presents a clinical formulation and related treatment plan to the parents.

The treatment in BUPCC is not manualized, however five core principles are followed by each therapist and their adherence is checked in supervision sessions. These principles are: (1) the therapist actively attends to the child and encourages him/her to communicate and reflect on his/her feelings, thoughts and perceptions; (2) therapist sets limits while verbalizing the underlying intentions and feelings if the child exhibits potentially harmful behavior; (3) Therapist mentalizes the play narrative by inviting the child to explore behaviors and mental states of the characters depicted in the play; (4) Therapist interprets the play and cautiously helps the child to make links between internal conflicts and affect; (5) Therapist identifies repetitive patterns in the child's play and makes links with his/her actual experience and feelings in real life. The standard psychotherapy conducted BUPCC includes once a week child play session and once a month parallel parent work where the therapist helps parents to reflect on the child's mind in order to explore feelings and motivations behind the child's behavior. The treatment is open-ended, and termination is based on the agreement between therapist, child and parents on whether the progress towards goals is achieved. In the current study, the average number of sessions was 40.37 ($SD = 20.61$) for the 70 participants.

2.4. MEASURES

2.4.1. Assessment of Psychotherapist's Affect Focused Psychodynamic Interventions

The Child Psychotherapy Q-Set (Schneider, & Jones, 2004) is a coding system that assesses the characteristics of a child psychotherapy session. It has been adapted from Psychotherapy Process Q-Set (PQS; Jones, 1985) which is previously developed for adult psychotherapy research. CPQ was developed for the assessment of psychotherapy process of children between the ages of 3 and 13 years with diverse psychopathology, socioeconomic status, or ethnic background (Schneider, Midgley, & Pruetzel-Thomas, 2009). Majority of CPQ items are similar to PQS except for the items that are characteristic of child psychotherapy and play (Schneider, 2004; Goodman & Athey-Lloyd, 2011).

CPQ consists of 100 items describing (1) the child's behavior (e.g. "Child appears unwilling to examine thoughts, reactions, or motivations related to problems"); (2) therapist's behavior/interventions (e.g. "Therapist interprets warded-off or unconscious wishes, feelings, or ideas"); and (3) therapist-child interaction in the session (e.g. "Therapist and child demonstrate a shared vocabulary or understanding when referring to events or feelings"). After watching the video tape of the session, raters use the q-sort technique which is ordering the 100 CPQ items into nine piles that scored from 1 to 9 based on the degree to which each item is characteristic of the session (Pile 1 is "The most uncharacteristic", score 1; Pile 9 is "The most characteristic", score 9). Number of items to be assigned are specified for each pile, therefore final distribution of the scores for each session resembles a perfect normal curve. Specifically, 5 cards are placed into the piles 1 and 9; 8 cards into the piles 2 and 8; 12 cards into the piles 3 and 7; 16 cards into the piles 4 and 6; and 18 cards into the pile 5. After the q-sort process, number of the category is designated as the score of the items in that category (e.g. A score of 1 refers to extremely uncharacteristic while 9 refers to extremely characteristic of the session). Because raters are forced to sort items

into a fixed distribution, score of each item is determined in relation with other items capturing the unique profile of the session (Goodman & Athey-Lloyd, 2011).

Reliability and validity of the CPQ were demonstrated in different studies (Halfon et al., 2018). The pilot study conducted by Schneider (2004) has demonstrated the CPQ's validity and inter-rater reliability (ICC's ranging from 0.58 to 0.88). These results suggested that validity and reliability of the CPQ were not affected by the theoretical background of the raters. Furthermore, CPQ was able to distinguish between psychodynamic psychotherapy and CBT; a finding supporting the discriminant validity of the measure (Schneider et al., 2009). In the present study, 10 CPQ coders who were master's level research assistants were trained by Dr. Geoffrey Goodman. During the training they coded training sessions until they have achieved ICC scores at least 0.70. After the training, pairs of reliable coders, who were blind to the hypotheses of the study, independently Q-sorted randomly assigned sessions. Afterwards, two ratings of each coded session were averaged. In the current study, 132 CPQ ratings were used and showed interrater reliabilities ranging from ICCs of 0.70 to 0.93 ($M = 0.81$, $SD = 0.07$).

In order to assess therapists' use of affect focused psychodynamic techniques, all CPQ items describing affect related therapist interventions were selected. Based on the literature, such as distinctive features of psychodynamic psychotherapy (Blagys & Hilsenroth, 2000), mentalization principles in psychodynamic child psychotherapy (Verheugt-Pleiter et al., 2008), and empirical findings related to psychodynamic technique (e.g. Hilsenroth et al., 2005; Jones and Pulos, 1993; Ablon & Jones, 1998; Goodman et al., 2016; Halfon et al., 2018) 9 items were retained. The average score of these items was used to quantify Affect Focused Psychodynamic Interventions variable and yielded good internal consistency ($\alpha = 0.73$). The items are presented in Table 2.2.

Table 2.2 CPQ Items Used in the Assessment of Psychotherapists Affect Focused Psychodynamic Interventions

CPQ Item
Item 6. Therapist is sensitive to the child's feelings.
Item 45. Therapist tolerates child's strong affect or impulses.
Item 50. Therapist draws attention to feelings regarded by the child as unacceptable (e.g., anger, envy, or excitement).
Item 67. Therapist interprets warded-off or unconscious wishes, feelings, or ideas.
Item 76. Therapist makes links between child's feelings and experience.
Item 79. Therapist comments on changes in child's mood or affect.
Item 81. Therapist emphasizes feelings to help child experience them more deeply.
Item 97. Therapist emphasizes verbalization of internal states and affects.
<i>Reversed Item</i>
Item 9: Therapist is nonresponsive [vs. affectively engaged].

Note. CPQ = Child Psychotherapy Process Q-Set.

2.4.2. Assessment of Affect Regulation in Play

The Children's Play Therapy Instrument (CPTI; Kernberg et al., 1998) is a psychodynamic-oriented tool developed for assessing various aspects of the child's play activity in psychotherapy. Rating process of CPTI was conducted in two steps. First psychotherapy sessions were segmented into pre-play, play activity, non-play, and interruption sections. Non-play activity is any type of behavior that is not play, such as having a conversation with the psychotherapist without touching the toys. Pre-play is the child's behavior intended for the preparation of the play, such as arranging the toys in order to set the scene for a role play. Play activity is indicated by child's intentional initiation and affective and concentrated involvement in the play. Finally, interruption is child's absence from the play setting such as going to bathroom. Following the segmentation of the psychotherapy session, judges rate the longest play segments in each session. They proceed to the dimensional analysis of play activity which includes

numerous subscales such as descriptive analysis, structural analysis, developmental analysis, and functional analysis.

Inter-rater reliability of CPTI in the segmentation was found to be ICC score of 0.72; and the dimensional analysis was ICC scores ranging from 0.52 to 0.89 (Kernberg et al., 1998). Other studies using CPTI have presented good inter-rater reliability (Chari, Hirisave, & Appaji, 2013; Kernberg et al., 1998), predictive validity in terms of the relationship between child's play profiles and behavioral problems (Halfon, 2017), discriminant validity in differentiating normal play and traumatic play (Cohen, Chazan, Lerner, & Maimon, 2010). Additionally, CPTI has been found to be sensitive in detecting the changes in psychotherapy process (Chazan, 2000). In the present study, 11 research assistants that were master's level clinical psychologists received 20 hours of training by Sibel Halfon, who has been trained by Saralea Chazan. Assistants then coded 10 training videotapes in pairs until they reached ICC of 0.70. After the training, sessions only with the children were randomly assigned to the pairs of raters independent of each other and blind to the purposes of the study, In the current study 210 CPTI codings were used, and their interrater reliabilities (ICC) were in the range from 0.76 to 1.00 ($M = 0.95$, $SD = 0.06$).

In the current study affect regulation (AR) is considered as the child's ability to manifest affect adaptively, such as regulating the emotion if a distressful content appears in play activity. The AR composite scale score was based on a previous study (Halfon et al., 2017). The composite was calculated by taking the mean of the following CPTI items that were scored between 1 and 5: (1) *Modulation of affect* that assesses the degree to which the child has flexible control over the various intensities of emotions (1 = "very rigid", 5 = "very flexible"), (2) *transition between affective states* that is the child's ability to move between different emotions smoothly (1 = "always abrupt", 5 = "always smooth"), (3) *appropriateness of affective tone to content* assessing the consistency of affective states to the play content (1 = "never appropriate", 5 = "always appropriate") (4) *using adaptive strategies in face of disruptive affects* that assesses the child's ability to adaptively cope with distressing emotions or

situations in play such as adaptation, problem-solving, and humor (1 = “no evidence”, 5 = “most characteristic”). In the previous study the AR composite provided a good internal consistency ($\alpha = 0.75$; Halfon et al., 2017), and in the current study internal consistency of the AR composite was $\alpha = 0.75$.

2.4.3. Outcome Measures

2.4.3.1. Assessment of Externalizing Symptoms

The Child Behavior Checklist (CBCL; Achenbach, 1991) is a frequently used reliable measurement developed for identifying behavioral problems in children. The CBCL has two separate forms for children aged 1.5-5 and 6-18 years old, respectively 99 and 112 problem behavior items included in two forms. Items are scored by parents on a three-point scale (0 = “not true”, 1 = “somewhat or sometimes true”, 2 = “very true or often true”). Behavioral problems can be determined for internalizing (e.g. anxiety, depression), externalizing (e.g. rule-breaking, aggression), and total problems. Turkish adaptation of CBCL showed good internal consistency and test-retest reliability for internalizing ($\alpha = 0.87$, $r = 0.93$), externalizing ($\alpha = 0.90$, $r = 0.93$) and the total problem scales ($\alpha = 0.94$, $r = 0.93$; Erol & Şimşek, 2000). In the present study CBCL was given to parents pre and post-treatment, in order to assess outcome in externalizing problems, and T scores of the scale were used. Externalizing scale of CBCL 1.5-5 ($\alpha = 0.93$) and CBCL 6-18 ($\alpha = 0.90$) showed good internal consistency.

2.4.3.2. Assessment of Depression Symptoms

The Children’s Depression Inventory (CDI; Kovacs, 1981) is a self-report depression scale for administration with children. CDI is adapted from Beck Depression Inventory (BDI; Beck & Beamesderfer 1974) that developed for adults. CDI consists of 27 items, each including three statements about a depression symptom scored from 0 to 2 based on the severity; 0 refers to absence

of the symptom and 2 refers to severe symptom. Generally, CDI items read by an examiner and children are asked to choose one of the statements that best describes his or her experience during last two weeks. The total depression score is the sum of the statement scores chosen by the children. The original scale yielded good internal consistency ($\alpha = 0.82$ to 0.89 ; Smucker, Craighead, Craighead, & Green, 1986). Turkish adaptation of CDI was done by Öy (1991) and showed good internal consistency and test retest reliability ($\alpha = 0.77$, $r = 0.80$). Turkish form of CDI is applicable for children between 6 and 17 years old. In the current study, CDI is used for assessment of depression symptoms and displayed good internal consistency ($\alpha = 0.83$).

2.4.3.3. Assessment of Anxiety Symptoms

The Screen for Child Anxiety Related Emotional Disorders (SCARED; Birmaher, 1997) was developed for assessment of anxiety symptoms in children for administration to children or their parents. SCARED includes 38 items scored from 0 to 2 based on the extent to which item applies for the child (0 = “almost never”, 1 = “sometimes”, 2 = “often”). Original SCARED included five factors that calculated by summing the corresponding items: (1) somatic/panic, (2) general anxiety, (3) separation anxiety, (4) social phobia, and (5) school phobia. Total score of SCARED is the total of all items. SCARED yielded good internal consistency and interrater reliability ($\alpha = 0.74$ to 0.93 , $r = 0.70$ to 0.90). Turkish adaptation of SCARED (Karaceylan, 2004), consists of 41 items rated in the same way and showed good internal consistency ($\alpha = 0.88$ to 0.91). In the present study, total score of child-reported SCARED form is used for quantifying anxiety symptoms and showed good internal consistency ($\alpha = 0.91$).

2.5. PROCEDURES

CBCL forms were administered in the first and the final session of psychotherapy. All sessions were recorded in video and translated verbatim.

Recordings and transcripts were rated by judges independently and in random order. Each child's psychotherapy process was divided into phases consisting of ten sessions (e.g. 1-10, 11-20, 21-30, etc.) and one random session for each phase was selected for coding of CPQ and CPTI. In order to calculate therapist's affect focused psychodynamic interventions, CPQ ratings from the first and the middle phase were used. For the children with even number of phases, the coded session closest to the middle session was used. For the purpose of operationalizing the change in affect regulation in play, the change in AR scores were obtained from CPTI ratings in the first, middle and the final phases. Similarly, for the children with even number of phases, the CPTI coding which was closest to the middle session was used.

2.6. DATA ANALYTIC STRATEGY

2.6.1. Symptomatic Improvement

In order to determine changes in CBCL externalizing problem scores reported by parents, and CDI and SCARED scores reported by children, repeated measures multivariate analysis of variance (MANOVA) was conducted with IBM SPSS software. Furthermore, categories regarding the severity of the externalizing, depression, anxiety symptoms before and after the treatment were reported.

2.6.2. Mediation Analysis

Because the present study has a mediational nature, hypotheses require testing of multiple pathways. For that reason, structural equation modeling (SEM), path analysis with observed variables is our main statistical method. SEM allows researchers to estimate multiple predictions simultaneously with maximum likelihood (ML), providing more consistent and stronger estimates compared to multiple testing with ordinary least squares (OLS) regression (Iacobucci, 2008).

One study using Monte Carlo simulations, have found that SEM produced superior results that were close to population parameters than OLS regression in detecting mediation structures even with a small sample including 30 cases (Iacobucci, Saldanha, & Deng, 2007). Based on these findings, Iacobucci (2008) claimed the common belief that SEM requires large samples might be an over-conservative assumption. Furthermore, the current study uses bias-corrected tests of mediation in order to estimate the significance of indirect and direct effects from therapist's affect focus to symptomatic improvement via gains in affect regulation. The strength of bias-corrected bootstrap method is that it produces reliable results when the sample is small, distributions of the variables are skewed or outliers are present (Fritz & MacKinnon 2007; MacKinnon, 2008; Little, Card, Bovaird, Preacher, Crandall, 2007; Geiser 2013; Hayes, 2013).

Another widely used method of testing mediation with bias-corrected bootstrap is PROCESS (Hayes, 2013). Although PROCESS uses OLS estimations, Hayes (2013) suggested that it produce results similar to SEM using ML only with insignificant differences. However, SEM and Hayes's method has numerous differences. First, while PROCESS is easy to use, SEM softwares provide a considerable flexibility over model construction (Hayes, 2012; Hayes, 2013). For example, PROCESS restricts the analyses to predetermined models with one IV and DV whereas research can construct limitless configuration of models with SEM softwares. Second, SEM programs produce model fit indices that allow researchers to understand the fit of one model and make comparisons across different models (Hayes, 2013). Although the present study uses observed variables, a third advantage of SEM worth mentioning. With SEM it is possible to include latent variables and combine them with observed variables; therefore, accounting for the measurement error of the testing tools researcher may increase the power of hypothesis testing (Hayes, 2013).

SEM path analysis with observed variables was conducted using Mplus Version 8 (Muthén & Muthén, 1998-2017). Model fit was assessed using (1) chi-square statistic (χ^2), (2) ratio of χ^2/df , (3) root mean square of approximation (*RMSEA*), (4) comparative fit index (*CFI*), (5) Tucker-Lewis index (*TLI*), and (6)

standardized root mean-square residual (*SRMR*). Generally agreed criterion of χ^2 is having a p value greater than 0.05; however, χ^2 is sensitive to sample size (Gerbing & Anderson 1985). For that reason, considering the ratio that χ^2/df lower than 3 (Bollen, 1989; Jöreskog and Sörbom, 1993) is a widely used criterion (Iacobucci, 2009). For *RMSEA*, estimates less than 0.05 show good fit, values between 0.05 and 0.08 are adequate fit, values between 0.08 and 0.10 are considered mediocre fit and values greater than 0.10 are bad fit (Browne and Cudeck, 1993). *RMSEA* also contains %90 confidence intervals; for an exact fit, lower boundary should include 0, or for a close fit, it must be lower than 0.05 (MacCallum, Browne, & Sugawara, 1996). According to Browne and Cudeck (1993), *RMSEA* is relatively unaffected by small sample size. For *CFI* and *TLI*, Hu & Bentler (1999) regards values equal to or greater than 0.90 as good fit. Lastly, *SRMR* value lower than 0.80 is considered as good fit (Hu & Bentler, 1999). One advantage of *SRMR* is being less sensitive to skewed distributions and sample size (Anderson & Gerbing, 1984). Direct and indirect effects were tested using bias-corrected 95% confidence intervals provided by bootstrap estimation with 5000 samples. If bootstrapped confidence intervals do not include “0” between upper and lower boundaries, the effect is considered significant at $p < 0.05$ (MacKinnon, Lockwood, Williams, 2004; Hayes, 2013).

2.6.3. Variables and the Models

The independent variables of the current study are affect focused psychodynamic interventions in the first phase of the psychotherapy (AFPI-F) and in the middle of the psychotherapy (AFPI-M). In order to maintain time sequence, the mediators were constructed depending on the independent variables. First mediator, that used with AFPI-F is the gains in affect regulation observed in play from first to last phase of psychotherapy (GAR-FL) that calculated by subtracting the affect regulation scores observed in the first phase (AR-F) from that observed in the last phase (AR-L) of the psychotherapy . Second mediator, that used with AFPI-M is the gains in affect regulation observed in play from middle to last

phase of psychotherapy (GAR-ML) calculated as subtraction of affect regulation observed in middle (AR-M) from AR-L. Dependent variables were CBCL externalizing problem scores (externalizing) reported by parents; and CDI (depression) and SCARED (anxiety) total scores reported by children after the termination of psychotherapy. Each dependent variable was controlled in the model for pretreatment scores of the same scale.

Because GAR-FL and GAR-ML were closely related due to use of AR score observed in the last phase in their calculation, they were analyzed in separate models in order to avoid multicollinearity. As a result, two path models were constructed. The models tested in the present study consisted of (1) AFPI -F, GAR-FL; and the post-treatment scores of externalizing, depression and anxiety; (2) AFPI-M, GAR-ML, and the post-treatment scores of externalizing, depression and anxiety. Each post-treatment symptom score was controlled for pre-treatment scores of the same scale.

CHAPTER 3

RESULTS

3.1. DESCRIPTIVE STATISTICS

Descriptive statistics and inter-correlations of all variables used in the current study are demonstrated in the Table 3.1.

3.2. SYMPTOMATIC IMPROVEMENT

In order to determine changes in symptoms, repeated measure MANOVA was conducted. Results showed that post-treatment externalizing problems ($M = 54.91$, $SD = 10.08$) were significantly lower compared to pretreatment scores ($M = 62.76$, $SD = 10.28$), $F(1,69) = 37.22$, $p < 0.001$, partial $\eta^2 = 0.35$. Depression scores at the end of the psychotherapy ($M = 10.01$, $SD = 5.76$) were significantly lower than pretreatment scores ($M = 14.82$, $SD = 8.46$), $F(1,69) = 22.31$, $p < 0.001$, partial $\eta^2 = 0.24$. Similarly, anxiety scores assessed after the treatment ($M = 24.09$, $SD = 11.84$) were lower than scores before the treatment ($M = 29.26$, $SD = 12.68$), $F(1,69) = 10.67$, $p = 0.002$, partial $\eta^2 = 0.13$.

3.3. MEDIATIONAL MODELS

In order to test hypotheses of the study, SEM path analyses with observed variables were conducted. two models tested with Mplus Version 8. All outcome variables were controlled for the pretreatment scores of the same measures. Considering the correlation between age and posttreatment externalizing scores ($r = -0.25$, $p < 0.01$), both externalizing scores and mediators were controlled for the effect of the child's age. Although gains in affect regulation variables were not correlated, affect regulation observed in the last phase was significantly correlated with gender ($r = -0.26$, $p < 0.01$); therefore, both mediators were controlled for the effect of gender.

Table 3.1 Means, Standard Deviations and Correlations of the Variables

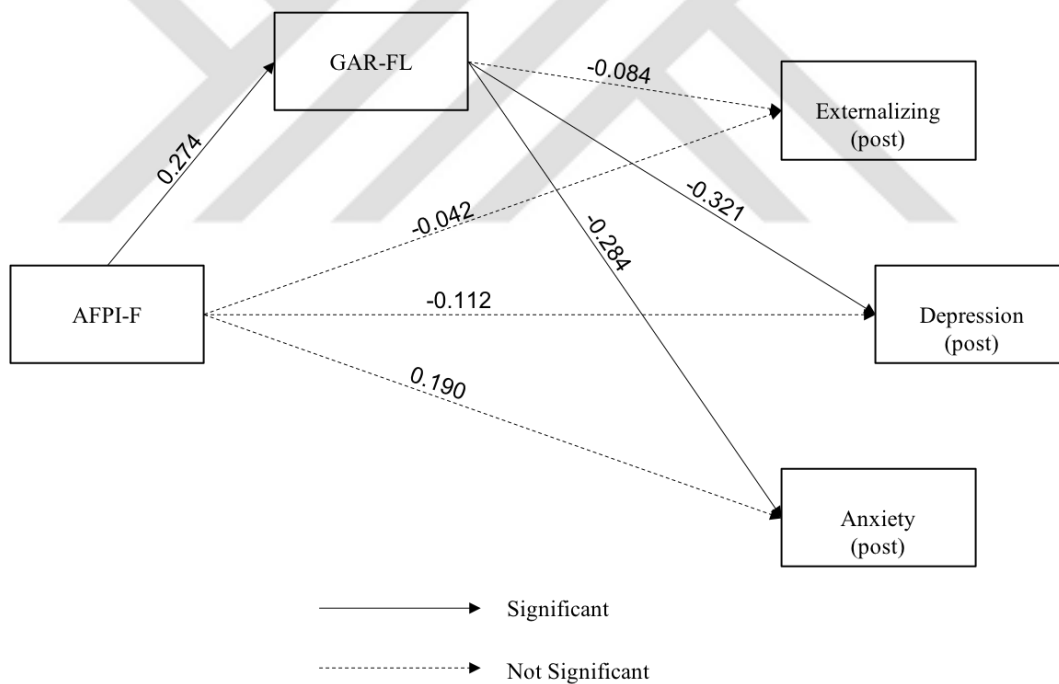
Variable	<i>M</i>	<i>SD</i>	1	2	3	4	5	6	7	8	9	10	11	12
1. Gender	—	—	—											
2. Age	7.63	1.50	-0.00	—										
3. Ext (Pre)	62.76	10.28	0.11	-0.27*	—									
4. Dep (Pre)	14.82	8.33	-0.01	-0.04	0.05	—								
5. Anx (Pre)	29.26	12.68	-0.10	-0.03	-0.01	0.31**	—							
6. AFPI-F	6.29	0.74	-0.07	-0.26*	0.05	-0.03	-0.05	—						
7. AFPI-M	6.61	0.74	-0.04	-0.07	-0.23	-0.02	0.02	0.17	—					
8. GAR-FL	0.06	0.66	-0.12	-0.01	-0.15	0.22	-0.16	0.26*	0.31*	—				
9. GAR-ML	0.11	0.64	-0.16	0.01	-0.04	0.20	-0.12	0.33**	0.30*	0.65**	—			
10. Ext (Post)	54.91	10.09	0.13	-0.25*	0.44**	0.10	-0.02	-0.01	-0.19	-0.16	-0.33**	—		
11. Dep (Post)	10.01	5.76	0.17	-0.15	0.15	0.31**	0.26*	-0.19	-0.39**	-0.28*	-0.26*	0.13	—	
12. Anx (Post)	24.09	11.84	0.04	-0.21	0.09	0.16	0.42**	-0.10	-0.11	-0.29*	-0.20	0.18	0.53**	—

Note. Gender was dummy coded as "0" = female and "1" = male. Ext = externalizing problem scores, Dep = depression scores, Anx = anxiety scores, AFPI-F = affect focused psychodynamic interventions in the first phase; AFPI-M = affect focused psychodynamic interventions in the middle, GAR-FL = gains in affect regulation from first to last phase, GAR-ML = gains in affect regulation from middle to last phase. * = $p < .05$, ** = $p < .01$.

3.3.1. Model 1

Model 1 appertains to the first, second, and third hypotheses suggesting a negative indirect effect from the therapists use of affect focused psychodynamic interventions in the first phase of the psychotherapy (AFPI-F), to symptomatic outcome in (1.a.) externalizing, (1.b.) depression and (1.c.) anxiety symptoms via the mediation of gains in affect regulation from first to last phases of the psychotherapy (GAR-FL). Path diagram of Model 1 including all standardized path estimates are presented in the Figure 3.1.

Figure 3.1 Path Diagram of the Model 1



Note. Path coefficients are standardized. AFPI-F = affect focused psychodynamic interventions in the first phase, GAR-FL = gains in affect regulation from first to last phase.

Model 1 provided adequate fit; $\chi^2(14) = 19.116, p = 0.16; \chi^2/df = 1.365; RMSEA = 0.07$ (90% CI = 0.000, 0.145); CFI = 0.930; TLI = 0.850; SRMR = 0.061. Estimates of all parameters are displayed in Table 3.2.

Table 3.2 Summary of the Path Coefficients in the Model 1

	β	SE	p
Externalizing (post) regressed on			
AFPI-F	-0.042	0.107	0.692
GAR-FL	-0.087	0.139	0.530
Externalizing (pre)	0.394	0.126	0.002
Age	-0.146	0.112	0.190
Depression (post) regressed on			
AFPI-F	-0.112	0.112	0.318
GAR-FL	-0.321	0.117	0.006
Depression (pre)	0.340	0.114	0.003
Anxiety (post) regressed on			
AFPI-F	0.190	0.098	0.052
GAR-FL	-0.284	0.095	0.003
Anxiety (pre)	0.344	0.102	0.001
GAR-FL regressed on			
AFPI-F	0.274	0.119	0.022
Age	0.063	0.107	0.557
Gender	-0.193	0.240	0.557

Note. β = standardized coefficient of the effect, SE = standard error, AFPI-F = affect focused psychodynamic interventions in the first phase, GAR-FL = gains in affect regulation from first to last phase. Statistically significant effects are presented in bold type.

Results showed that AFPI-F had a significant positive effect on GAR-FL ($\beta = 0.274$, $p = 0.022$). Furthermore GAR-FL had negative effect on post-treatment scores of depression ($\beta = -0.321$, $p = 0.006$) and anxiety ($\beta = -0.284$, $p = 0.003$). Additionally, AFPI-F had a non-significant but trend level negative positive direct effect on post-treatment anxiety scores ($\beta = 0.190$, $p = 0.052$); meaning that although the relation was not significant, higher AFPI-F slightly increased anxiety scores regardless of the mediating effect of GAR-F

Mediation tests using bias corrected bootstrap estimation with 5000 samples revealed that there was a significant indirect effect of AFPI-F on post-treatment depression scores, $\beta = -0.088$, $SE = 0.053$, 95% CI [-0.232, -0.015], $p < .05$. There was also a significant indirect effect of AFPI-F on post-treatment anxiety scores, $\beta = -0.078$, $SE = 0.047$, 95% CI [-0.205, -0.013], $p < .05$. In other words, psychotherapist's use of more affect focused psychodynamic interventions

in the first phase of treatment is related with lower post-treatment depression and anxiety symptoms with the mediation of the subsequent increases in the child's affect regulation observed play. The indirect effect of AFPI-F on post treatment externalizing scores was not significant; therefore, these results support the first hypothesis except for externalizing symptoms. To conclude, hypotheses 1.b and 1.c. were supported by these results. Summary of all direct and indirect effects are presented in the Table 3.3 for Model 1.

Table 3.3 Summary of Direct and Indirect Effects in the Model 1

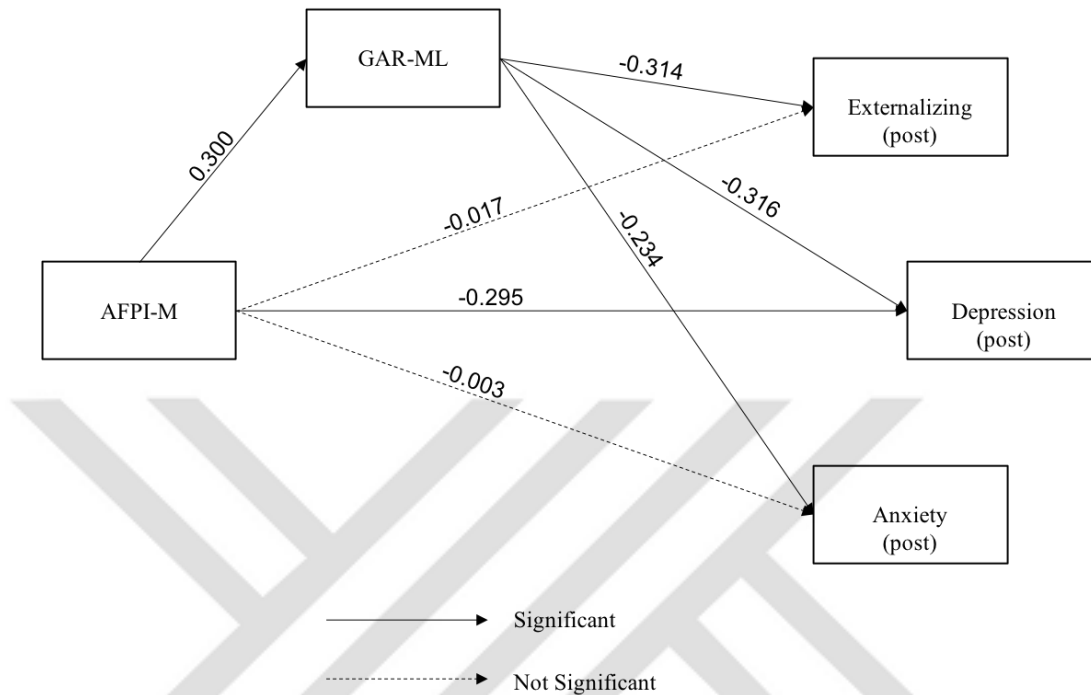
Dependent Variable	Direct			Indirect		
	β	<i>SE</i>	95% <i>CI</i>	β	<i>SE</i>	95% <i>CI</i>
Externalizing (post)	-0.042	0.107	-0.256 to 0.166	-0.024	0.044	-0.144 to 0.045
Depression (post)	-0.112	0.112	-0.356 to 0.083	-0.088	0.053	-0.232 to -0.015
Anxiety (post)	0.190	0.098	-0.001 to 0.386	-0.078	0.047	-0.205 to -0.013

Note. (IV: AFPI-F; M: GAR-FL). β = standardized coefficient of the effect, *SE* = standard error, *CI* = bias-corrected bootstrapped 95% confidence intervals, IV = independent variable, M = mediator, AFPI-F = affect focused psychodynamic interventions in the first phase, GAR-FL = gains in affect regulation from first to last phase. Statistically significant effects are presented in bold type.

3.3.2. Model 2

Model 3 analyses the fourth, fifth, and sixth hypotheses that the therapists use of affect focused psychodynamic interventions in the middle of the process (AFPI-M), would have a negative indirect effect on symptomatic outcome in (2.a.) externalizing, (2.b.) depression and (2.c) anxiety symptoms via the mediation of gains in affect regulation from middle to last phases of the psychotherapy (GAR-ML). Path diagram of Model 2 including all standardized path estimates are presented in the Figure 3.2.

Figure 3.2 Path Diagram of the Model 2



Note. Path coefficients are standardized. AFPI-M = affect focused psychodynamic interventions in the middle, GAR-ML = gains in affect regulation from middle to last phase.

Model 2 provided good fit; $\chi^2(14) = 14.120$, $p = 0.44$; $\chi^2/df = 1.009$; $RMSEA = 0.01$ (90% $CI = 0.000, 0.124$); $CFI = 0.998$; $TLI = 0.997$; $SRMR = 0.050$. Estimates of all parameters are displayed in the Table 3.4 for the Model 2.

Table 3.4 Summary of the Path Coefficients in the Model 2

	β	SE	p
Externalizing (post) regressed on			
AFPI-M	-0.017	0.117	0.883
GAR-ML	-0.314	0.114	0.006
Externalizing (pre)	0.374	0.132	0.005
Age	-0.145	0.108	0.180
Depression (post) regressed on			
AFPI-M	-0.295	0.107	0.006
GAR-ML	-0.316	0.114	0.006
Depression (pre)	0.371	0.096	0.000

Table 3.4 (Cont'd)

	β	<i>SE</i>	<i>p</i>
Anxiety (post) regressed on			
AFPI-M	-0.003	0.114	0.980
GAR-ML	-0.234	0.102	0.022
Anxiety (pre)	0.330	0.114	0.004
GAR-FL regressed on			
AFPI-F	0.300	0.134	0.026
Age	-0.416	0.245	0.090
Gender	0.009	0.106	0.931

Note. β = standardized coefficient of the effect, *SE* = standard error, AFPI-M = affect focused psychodynamic interventions in the middle phase, GAR-ML = gains in affect regulation from middle to last phase. Statistically significant effects are presented in bold type.

Results showed that, AFPI-M had a positive effect on GAR-FM ($\beta = 0.300$, $p = 0.026$). GAR-FL had negative effects on post-treatment scores of externalizing ($\beta = -0.314$, $p = 0.006$), depression ($\beta = -0.316$, $p = 0.006$), and anxiety ($\beta = -0.234$, $p = 0.022$). Furthermore AFPI-M had a significant direct effect on post-treatment depression scores ($\beta = -0.295$, $p = 0.006$).

Bias corrected bootstrap estimation with 5000 samples revealed that indirect effect of AFPI-M was significant on post-treatment externalizing scores, $\beta = -0.094$, $SE = 0.056$, 95% *CI* [-0.237, -0.008], $p < .05$; depression scores, $\beta = -0.095$, $SE = 0.058$, 95% *CI* [-0.244, -0.008], $p < .05$; and anxiety scores, $\beta = -0.070$, $SE = 0.048$, 95% *CI* [-0.190, -0.001], $p < .05$. The results indicated that psychotherapist's use of higher affect focused psychodynamic interventions in the middle phase of treatment is associated with lower post-treatment externalizing, depression and anxiety symptoms through the following increases in child's affect regulation observed play; therefore, these results provide support for the hypotheses 2.a, 2.b, and 2.c. Summaries of all direct and indirect effects are presented in the Table 3.5 for Model 2.

Table 3.5 Summary of Direct and Indirect Effects in the Model 2

Dependent Variable	Direct			Indirect		
	β	<i>SE</i>	95% <i>CI</i>	β	<i>SE</i>	95% <i>CI</i>
Externalizing (post)	-0.017	0.117	-0.260 to 0.205	-0.094	0.056	-0.237 to -0.008
Depression (post)	-0.295	0.107	-0.498 to -0.075	-0.095	0.058	-0.244 to -0.008
Anxiety (post)	-0.003	0.114	-0.231 to 0.217	-0.070	0.048	-0.190 to -0.001

Note. (IV: AFPI-M; M: GAR-ML). β = standardized coefficient of the effect, *SE* = standard error, *CI* = bias-corrected bootstrapped 95% confidence intervals, IV = independent variable, M = mediator, AFPI-M = affect focused psychodynamic interventions in the middle, GAR-ML = gains in affect regulation from middle to last phase. Statistically significant effects are presented in bold type.



CHAPTER 4

DISCUSSION

The aim of the current study was to investigate whether gains in children's AR during the process had a mediating role on the association between psychotherapist's affect focused psychodynamic interventions (AFPI) and symptomatic outcome in externalizing problems, depression and anxiety. Although it was not hypothesized, test of mean differences between symptom assessments before and after the psychotherapy was reported in order to give information about the symptomatic improvement in psychotherapy conducted in the present study. For the assessment of psychotherapist's AFPI, a composite of CPQ items specifically focusing on affective interventions and attitudes inherent to psychodynamic psychotherapy have been constructed. These items were relevant with the literature regarding affect focused interventions in psychodynamic psychotherapy for children and adults (e.g. Blagys & Hilsenroth, 2000; Verheugt-Pleiter et al., 2008). For the purpose of assessing the effect of AFPI at different time points, codings from the first and middle phases were analyzed separately. AR of children was assessed with CPTI. Two gains in AR scores were calculated; first by subtracting AR in first phase from AR in the last phase (as the mediator following the AFPI in the first phase); and second by subtracting AR in the middle phase from AR in the last phase (as the mediator following the AFPI in the middle phase). Furthermore, scores of CBCL externalizing problem scale, CDI (depression), and SCARED (anxiety) before and after the therapy used for the assessment of symptoms. For the mediations, the data analyzed by using path analysis with observed variables, a special case of SEM; both models tested in the current study yielded good model fit. Mean differences between pre and post treatment symptoms were tested with repeated measures MANOVA. Findings will be discussed in the following sections.

4.1. DISCUSSION OF THE FINDINGS

4.1.1. Mean Differences

MANOVA results showed that, there was a significant difference between the children's externalizing problems before and after the treatment. However, these findings are not sufficient to make clear conclusions about the effectiveness of psychodynamic child psychotherapy because of the absence of control groups. A randomized control trial would provide stronger finding to make indications about the effectiveness of psychodynamic child psychotherapy. Furthermore, our sample was not divided into clinical level symptom groups, therefore reading the findings as dimensional reductions in various symptoms would be more appropriate rather than indicating an effectiveness on the treatment of disorders.

Specifically, mothers reported lower externalizing symptoms after the psychotherapy compared with the pretreatment scores. This finding is consistent with previous studies. One of the pioneering studies conducted by Fonagy and Target (1994) on the effectiveness of psychodynamic treatment on externalizing disorders have presented preliminary evidence that considerable percent of children with disruptive disorders were not no longer diagnosed after psychodynamic psychotherapy. A recent study investigated the same question specifically among children with oppositional defiant disorder and/or attention deficit hyperactivity disorder (Laezer, 2015), and there were significant symptom reductions in children underwent psychodynamic psychotherapy.

Similarly, depression symptoms reported by children at the end of the psychotherapy were significantly lower than that reported before the treatment. This finding is comparable to that of previous studies. For example, two studies based on one RCI compared psychodynamic child psychotherapy and family therapy in terms of their effect on depression (Trowell et al., 2007), self-esteem, and social adjustment (Kolaitis et al., 2014). They have found that both treatments were effective on symptomatic improvement in depression (Trowell et al., 2007), and increases in self-esteem, and social adjustment (Kolaitis et al., 2014). Another

effectiveness trial has found that significant reductions in depression symptoms were prevalent in psychodynamic child psychotherapy group both for parent and child report forms while in the waitlist group child report depression symptoms showed no change (Weitkamp et al., 2014).

For anxiety, children reported significantly lower symptom severity after the treatment. In psychodynamic research, high quality studies investigating anxiety is limited (Midgley et al., 2017). One study reported significant decreases in various types symptoms, including anxiety itself, of children and adolescents with anxiety under psychodynamic psychotherapy (Göttken et al., 2014).

4.1.2. Path Analysis

4.1.2.1. Affect Focused Psychodynamic Interventions Predicting Gains in Affect Regulation

Results of the two path models indicated that, AFPI had a positive effect on subsequent changes in AR. Specifically, higher AFPI in the first phase of psychotherapy was associated with higher gains in AFPI, and higher AFPI in the middle phase related to higher gains in AFPI as well. Although there is no other empirical study in psychodynamic child psychotherapy literature investigating direct associations between therapists' AFPI and AR, previous studies focusing on interventions regarding mentalization, a related concept to AFPI, reported significant results. In psychodynamic child psychotherapy, enhancement of the child's AR is a priority. Psychotherapist relates with affective experience of the child with attuning to his level of functioning, then within the pretense of symbolic play provides an as if environment where the child can have mastery over his affective states (Verheugt-Pleiter et al., 2008). In this process, psychotherapist is attentive in order to accurately reflect on and verbalize the expressed feelings if it is convenient. However, purpose of the psychotherapist is not to provide tedious and impersonal interpretation of the feelings, rather, to enhance the mutual affective interaction where the child can express feelings and

these feelings are mirrored in a reflected and regulated form. Therefore, the child progressively internalizes this affect regulating interaction. One recent study observed that mentalization adherence of sessions predicted developments in AR (Halfon & Bulut, 2017). Our findings suggest that therapists' affect focus might be a factor facilitating the development of children's AR observed in play throughout the psychodynamic psychotherapy process.

4.1.2.2. Mediation Tests

Two models were analyzed with path analysis. Model 1 was constructed for testing the first three hypotheses of the present study; Changes in AR observed in play from the first to the last phases of the psychotherapy is expected to mediate the association between AFPI in the beginning of therapy and symptomatic improvement in the children's (1.a.) externalizing, (1.b) depression, and (1.c.) anxiety symptoms. Model 2 tested the fourth, fifth and sixth hypotheses; Gains in affect regulation observed in play from the middle to the last phases of the psychotherapy is expected to mediate the association between AFPI in the middle of psychotherapy and symptomatic improvement in the children's (1.a.) externalizing, (1.b) depression, and (1.c.) anxiety symptoms.

Results showed that the association between AFPI in beginning of the treatment and symptomatic outcome in depression and anxiety symptoms at the end was mediated by the gains in AR from first to last phase. More specifically, therapists' higher adherence to affect focused techniques was associated with subsequent increases in AR and increases in AR was related to lower post treatment depression and anxiety symptoms controlled for pretreatment scores. Furthermore, the indirect effects of AFPI in the middle of the treatment on all symptom categories via AR were found to be significant. These mediations indicate that the therapists' use of AFPI middle in the treatment was associated with following increases in AR and these increases in AR was related to lower post treatment externalizing, depression and anxiety symptoms after accounting for the pretreatment scores.

Hypotheses of the current study were built on the literature basis that one of the most central aims in the scope of psychodynamic child psychotherapy, is promoting affect regulative capacity for the purpose of symptomatic improvement and many other aspects of improvement (e.g. Hoffman et al., 2016; Kernberg & Chazan, 1991; Muratori et al., 2003). These significant findings demonstrate a support the role of AR as a mediator in treatment outcome considering the psychodynamic affect focused interventions implemented in psychodynamic child psychotherapy. Although AFPI has not been directly studied in the psychodynamic child literature, the empirical studies discussed previously have found important links between affective components over the course of treatment and AR (e.g. Halfon & Bulut, 2017). One study has found that therapists' affective work through using mental state words in psychodynamic psychotherapy sessions predicted increases in AR while the children's mental state talk was associated with AR only for the children who showed significant symptomatic reduction (Halfon et al., 2017). Perused in conjunction with this previous study, our findings indicate that AR might be an important change mechanism in psychodynamic child psychotherapy; however, this premise requires a detailed examination of the current findings and the concept of mechanism of change itself.

4.1.2.2.1. Mediations in Externalizing Problems

Only the AFPI in the middle of the treatment had an indirect effect on externalizing problems. Externalizing problems are related to impulsive behavior, aggression and low AR (Eisenberg et al., 2001, Eisenberg et al., 2005): therefore it was possible to expect that AFPI could have an indirect effect on externalizing problems via the mediation of AR at all timepoints of the treatment. However, the non-significant indirect effect of AFPI early in the process creates question mark that cannot be overlooked. In their review on research studying effectiveness of psychodynamic child psychotherapy, Midgley and Kennedy (2011) have reached to a conclusion that children with externalizing problems have difficulty in

engaging to psychotherapy due to their disruptive problems, nevertheless if they can adapt, they may benefit from the treatment. On the other hand, Fonagy and his colleagues (2002) suggest that, aggressive behavior could be related to a teleological mode of understanding self and other. In this mode, feelings are not represented symbolically neither by words nor in play. The experience of affective states is expressed as behavioral acting outs as aggressive behavior. Previous studies show that emotions such as sadness are subtly existent in externalizing children under the presence of high aggression (e.g. Lemery et al., 2002). In fact, the main basis of RFP-C is the postulate that aggressive behavior serves as an avoidance of dysphoric affect such as sadness, guilt and shame (Hoffman et al., 2016, Prout et al., 2015). RFP-C aims to improve affect regulation by focusing on these feelings underlying aggressive behavior; and as a result, symptom relief is expected. Therefore, it might be plausible to infer that rather than directly starting with AFPI such as interpretation and verbalization of affects, initially providing a structure by limit setting and enhancing symbolic play in purpose of endorsing the symbolic understanding of affective states through which negative emotions can be worked (Verheugt-Pleiter et al., 2008).

4.1.2.2.2. Mediations in Internalizing Problems

Therapists' AFPI both early in and middle of the treatment had significant indirect effects on depression and anxiety symptoms. Depression and anxiety have been related to maladaptive AR strategies (Eisenberg et al., 2010). Specifically, depression was linked to over restriction of affective reactions (Eisenberg et al., 2010), but being unable to regulate negative mental material resulting in rumination and ongoing dysphoria (Joormann & Gotlib, 2010). Inability to regulate worries, sadness and aggression due to strong intensity of affective experience have been observed in children with anxiety disorders (Suveg & Zeman, 2004). Therefore, our findings may suggest that use of AFPI in each step of psychotherapy is effective on anxiety and depression symptoms by improving the affect regulation capacities over the course of treatment. This conclusion can

be supported by evidence from empirical research on a manualized psychodynamic treatment, PaCT (Göttken et al., 2014). One of the central aims of PaCT is to promote flexible AR strategies address rigid defense mechanisms. PaCT's effectiveness on internalizing problems have been demonstrated in two articles on a controlled study (Göttken et al., 2014; Muratori et al., 2003).

4.1.2.3. Direct Effects

The hypotheses cover the mediation effects, however, in order to show the face validity of the indirect effects, other components of the models need to be discussed. While mediation analyses support the indirect effects of early AFPI on depression and anxiety, none of the direct effects was significant; but AFPI in early phase had a non-significant but close positive direct effect on anxiety symptoms after the treatment. Higher AFPI was associated with more severe post-treatment anxiety symptoms at a trend level. Although this effect was not significant, the direction of this association and absence of direct effects of AFPI early in the treatment seems contradictory in regard with the studies that have reported direct associations between psychodynamic techniques early in the treatment and symptomatic change in depression and anxiety symptoms (Slavdin-Mulford et al., 2011; Pitman et al., 2014; Pitman et al., 2017; Katz & Hilsenroth, 2017). Some methodological differences can be proposed to explain this inconsistency. First, these studies have been conducted with samples constructed as disorder groups consisting of participants specifically with clinical level symptom levels while the present study utilizes a sample mostly including children with comorbid problems regardless of being at clinical level. Second, previous studies use CPPS which is a Likert scale directly assessing psychodynamic interventions while CPQ relies on Q-sort technique. And most importantly, these studies have been conducted with adults; the psychodynamic interventions could be functioning in different manner between adults and children. As distinct from adults, children were rarely self-referred in our sample; they have been brought to the clinic by their parents or following the suggestion

their teachers. Therefore, psychotherapists' attempts to form therapeutic alliance could have been the most prominent factor during initial phases.

Unexpected trend level effect of early AFPI on the post-treatment symptoms, in spite of an expected indirect effect, may suggest anxiety symptoms seem to worsen if AFPI early in the treatment was not followed by improvements in AR. As discussed earlier, connection of anxiety intensive and hypervigilant affective experience (e.g. Suveg & Zeman, 2004) may contribute to this finding. Beginning the psychotherapy with affective interpretations without forming an alliance and provide a secure environment for affective experience, can be regarded as anxiety inducing for children because their feelings and fantasies that they deem unacceptable could be revealed without feeling secure. Inversely, treatment outcome in anxiety might be better for the cases that responded both early and middle AFPI with greater AR. However, such an argument should be supported by a model taking into account the level of improvement in AR as moderator. If this interpretation has a reality value, then improving assessment methods that can capture which children could respond affective interventions with high AR may help to decide which techniques to implement at the initial stages of psychotherapy. A manualized intervention Child and Adolescent Anxiety Psychodynamic Psychotherapy (CAPP: Silver, Shapiro, & Milrod, 2013) works with anxious children by first making assessments in order to decide which techniques will be used, then, after forming the therapeutic alliance proceeds to implement these techniques; for instance working with the aggression that child may experience as unacceptable or fantasies related to emerging anxiety and symptoms (Milrod et al., 2013).

In the middle phase, AFPI only had a significant direct effect on depression symptoms; as middle AFPI increased, depression symptoms decreased. On the other hand, direct effect of early AFPI was not significant for depression or it was not deteriorating as that on anxiety. Initial AR characteristics of depressive children's affective experience were described as rigid and restricted (Eisenberg et al., 2010). Depression is further linked to inability to regulate negative affect which leads to a ruminative coping (Joormann & Gotlib, 2010); and dampening of

positive affective experience related to anhedonia (Werner-Seidler, Banks, Dunn, & Moulds, 2013). Therefore, it may be suggested that AFPI in the early treatment did not directly related to outcome because children with higher depression may have avoided affective interaction. Nevertheless, AFPI both early and middle in the treatment may have an indirect effect on depression by replacing ruminative styles with adaptive AR strategies. And, in the middle of the psychotherapy AFPI could be a factor that facilitates the child's emotion experience and expression, especially the positive affect, therefore directly accounting for the treatment outcome in depression.

For externalizing problems, none of the direct effects were significant. Initially, externalizing symptoms are related to impulsivity, aggression and low affective and behavioral regulation (Eisenberg et al., 2010). Therefore, AFPI may have an effect via AR, by improving regulation of aggressive behavior and underlying affect. However, expressive nature of AFPI might not have effect on externalizing problems as these problems are already rooted in a lack of inhibition of aggressive feelings. Postulates and findings of another manualized treatment, Supportive Expressive Play Psychotherapy (SEPP: Kernberg & Chazan, 1991), provide support for this proposition. SEPP starts with formation of therapeutic alliance and supportive interventions such as facilitating play, providing suggestions, and setting rules, because children with disruptive problems can be less reflective and integrated compared to children with other problems. Then psychotherapists proceed to facilitative interventions such as encouragement of affective expression and reflection. After this step therapist introduces interpretive techniques gradually. A qualitative study on SEPP and conduct disorders have found that patients exposed to too early interpretations, had rejected to attend psychotherapy, and one participant whose therapist have also used early interpretations had not been disturbed, but this child had a stronger mental organization compared to other children (Erasund, 2007). Therefore, it could be suggested that treatment of externalizing symptoms with psychodynamic techniques require beginning with implementing supportive interventions and focusing on therapeutic alliance, then proceeding to AFPI later in the treatment

could be preferable. However, in our sample only the indirect effect of middle AFPI was significant, similarly to the anxiety symptoms, psychodynamic treatment of externalizing children may also need AR as a mediator.

4.2. AFFECT REGULATION AS A MECHANISM OF CHANGE

The mediating role of gains in AR between affect focused interventions and outcome shows a possibility that AR can be understood as a mechanism of change. Except for the path from first phase AFPI to externalizing problems, which can be explained with literature and clinical experience, AR mediated all of the pathways from interventions to outcome. For the direct effects, the most interesting result was the unexpected direct effect of early AFPI on anxiety. If our explanation for that effect reflects the actual clinical situation, where AFPI early in the treatment predicted expected outcome only if it is followed by improvements in AR, the proposed mechanism of change function of AR increases. In order to demonstrate this function of AR, further research should investigate moderations explaining whether there are pre-treatment characteristics accounting for this association or this finding is arbitrary.

Kazdin has discussed the notion mechanism of change in his article published in 2007. C (1) There should be a strong association between the predictors, mediators and dependent variables. In the current study, magnitudes of pathway estimates are acceptable within clinical research. (2) The path from the intervention to outcome through the proposed mediator needs to be specific; that is, the researcher should demonstrate that meaningful factors other than do not explain treatment outcome. This is a limitation in the present study as AR has been formulated in connection with symbolic play and mentalization. Further research can investigate these links, but actually these constructs are so interrelated that they may be subcategories of a global construct. (3) Results must be consistent and replicable across different studies and samples. The present findings are consistent with the relevant research; nonetheless, they need to be replicated by further studies with different samples. (4) An experimental

manipulation strengthens the researcher's clarity in demonstrating the mechanism of change. The present study conducted as a naturalistic research without experimental essence; comparison with control groups needs to be regarded in the future. (5) Variables are required to be established in a time sequence as predictors are preceded by mediators which are followed by outcome in order to make causal interpretations. The models tested in our study strictly abide by this principle. (6) Researchers should show a gradient of time sequenced associations; i.e. higher doses of intervention should be associated with higher activation of the proposed mechanism of change then followed by better outcome. The statistical methodology of the current study is regressional, which yields estimates of the associations' linear gradients. (7) How proposed mechanism of change operates in treatment outcome must be able to be explained in a plausible and coherent way with the theoretical framework and accumulative scientific knowledge. Our findings are plausible and coherent in regard with the scientific literature. To conclude, based on our findings it is probable to propose AR as a mechanism of change in psychodynamic child psychotherapy but for clear and broad conclusions, a body of empirical research is needed.

4.3. FURTHER TOPICS

4.3.1. Implications

4.3.1.1. Research Implications

The present research is the first study investigating the role of AR as a mediator in the relationships between AFPI and treatment outcome in child psychotherapy literature. Use of longitudinal design in consideration with specific time points such as early and middle AFPI; and reliance on time sequence gives opportunity for making tentative causal interpretations. To the best of our knowledge, the present research is the first to use SEM as the integral method of hypothesis testing among psychodynamic psychotherapy process studies. By

allowing simultaneous testing of several associations and providing robust indirect effects SEM is a strong methodology that could be used in process research. Also, the findings of the present study can be regarded in emphasizing the function of AR not merely as a mediator but also proposing it as a mechanism of change which requires further investigation.

4.3.1.2. Clinical Implications

Our significant results underscore the importance of therapist's affect focused interventions both in the beginning and ensuing phases of psychodynamic psychotherapy; together with the developments in AR capacities of the child, for the symptomatic relief in externalizing, depression and anxiety after the psychotherapy. Although the current results are not replicated or supported by other large-scale studies, it is possible to recommend the clinicians conducting psychodynamic psychotherapy to maintain affective focus with the intention of improving affect regulative functions in the child's play throughout the child psychotherapy process. Furthermore, being flexible in implementing the AFPI based on the initial symptom characteristics of the child is important. For example, aggressive children show different emotion expression from timid children; psychotherapist first focus on the construction of alliance then move towards the exploration of different affects displayed by children with different symptoms (Göçek, 2017)

These conclusions are not limited to the psychodynamic psychotherapy. Shedler (2010) suggested that ingredients observed in psychotherapy practice cannot not be absolutely presumed by what has been suggested by the theory and supported his assertion by addressing following evidence; even in manualized treatments, therapists have been observed to use their interventions differently for each patient, in fact they incorporated techniques that were not introduced by the manual of the treatment they were performing (Elkin et al., 1989). Sometimes, it was not possible to discriminate between which psychotherapy was being implemented in the sessions (Ablon & Jones, 2002). Studies using CPQ have

indicated that, psychodynamic processes were prevalent in the cognitive behavior session, and adherence to psychodynamic prototype was associated with treatment outcome both in psychodynamic psychotherapy and cognitive behavior therapy (Ablon & Jones, 1998, Jones & Pulos, 1993). As a result, it is possible to recommend psychodynamic affective focus to the clinicians across different frameworks of psychotherapy.

4.3.2. Limitations

There are several limitations of the current study that need to be mentioned. First, sample size is relatively small, especially for SEM which is mostly used with larger samples. Nevertheless, both sample size sensitive model fit criteria, namely chi-square statistic and RMSEA, were in acceptable limits. Second, there was an absence of a control group to which findings could be compared. Third, the treatment method was not manualized or standardized. Fourth, most of the therapists were beginner. These limitations interfere with our ability to generalize the findings; nonetheless, although such a naturalistic study is restricted in internal validity, it has a strength having considerable external validity due to its accurate reflection of how psychotherapy conducted in real clinical setting. Fifth limitation is that AFPI has been assessed with CPQ a general tool developed for the investigation of numerous topics emerging in psychotherapy process, including child behavior as well as techniques related to various treatment frameworks. Regarding the forced coding procedure, all item scores influence each other; therefore, a tool purely assessing therapist interventions individually, such as CPPS developed for adult psychotherapy, may yield different results. Finally, due to the small sample size, we were not able to divide participants into symptom groups in clinical level, rather, we included all children across different levels of clinical functioning and investigated treatment outcome dimensionally, that is each child's externalizing, depression, and anxiety scores were used simultaneously in the analyses.

4.3.3. Directions for Future Research

As this is the only child psychotherapy process study focusing on affect focused psychodynamic techniques prediction of treatment outcome taking into account the AR as a mediator and proposing it as a mechanism of change. These findings need to be replicated by further research especially taking into account the limitations before making confident judgments. One important premise that worth consideration is that the goal of psychodynamic psychotherapy is not merely the symptom remission, in fact, there are other facets of change aimed with more priority than symptoms (Shedler, 2010). Therefore, further research can put significant contributions to the literature by incorporating other constructs such as attachment patterns, object relations, or improvements in personality as treatment outcome or mediators. Moreover, other factors that were discussed in relation to AR could be analyzed as mediators; even further, serial mediation models such as with symbolic play and AR as multiple mediators would provide important contributions. Because our AFPI composite provides a global score of affect focused CPQ items that were related to psychodynamic psychotherapy, the current findings cannot be considered for suggestions regarding specific therapist interventions. Therefore, another suggestion is the investigation of the associations between therapists' specific affect focused interventions; such as labeling the feelings, commenting on changes in mood, or emphasizing feelings that are hard for the child to acknowledge; and outcome. Further studies can also establish stronger reliability and validity of AFPI composite by confirmatory factor analysis, statistical comparisons with related measures. On the other hand, a more sophisticated model such as cross-lagged autoregressive path analysis could yield substantially detailed results by highlighting the temporal and reciprocal relations among the variables; however, such a model requires larger sample size.

CONCLUSION

The present study investigated whether AR has a role as a mediator in the association between AFPI and symptomatic outcome. Our results provided evidence that AFPI early in the treatment was associated indirectly with less symptoms in depression and anxiety with the mediation of following improvements in AR. Moreover, results also indicated that mid-treatment AFPI had an indirect effect on symptomatic remission in externalizing problems, depression, and anxiety via the mediation of AR. The only significant direct effect was observed between mid-treatment AFPI and symptomatic decrease in depression. The presence of indirect effects despite of the absence of direct effects indicates that AR has a probability of operating as a mechanism of change in psychodynamic child psychotherapy. To the best of our knowledge, there have not been a research on AFPI considering AR as a mediator. Therefore, future studies should focus on AR as a mediator with addressing the aforementioned limitation of the current study in order to demonstrate its role as a mechanism of change.

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Appendix A: Child Behavior Checklist for Ages 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 ağızına alıp çiğner.
- 0 1 2 10. Yetişkinlerin dizinin dibinden ayrılmaz, onlara çok bağımlıdır.
- 0 1 2 11. Sürekli yardım ister.
- 0 1 2 12. Kabızdır, kakasını kolay yapamaz (hasta değilken bile).
- 0 1 2 13. Çok ağlar.
- 0 1 2 14. Hayvanlara eziyet eder.
- 0 1 2 15. Karşı gelir.

- 0 1 2 16. İstekleri anında karşılanmalıdır.
- 0 1 2 17. Eşyalarına zarar verir.
- 0 1 2 18. Ailesine ait eşyalara zarar verir.
- 0 1 2 19. Hasta değilken bile ishal olur, kakası yumuşaktır.
- 0 1 2 20. Söz dinlemez, kurallara uymaz.
- 0 1 2 21. Yaşam düzenindeki en ufak bir değişiklikten rahatsız olur.
- 0 1 2 22. Tek başına uyumak istemez.
- 0 1 2 23. Kendisiyle konuşulduğunda yanıt vermez.
- 0 1 2 24. İştahsızdır. (açıklayınız):
- 0 1 2 25. Diğer çocuklarla anlaşamaz.
- 0 1 2 26. Nasıl eğleneceğini bilmez, büyümüş de küçülmüş gibi davranır.
- 0 1 2 27. Hatalı davranışından dolayı suçluluk duymaz.
- 0 1 2 28. Evden dışarı çıkmak istemez.
- 0 1 2 29. Güçlkle karşılaştığında çabuk vazgeçer.
- 0 1 2 30. Kolay kıskanır.
- 0 1 2 31. Yenilip içilmeyecek şeyleri yer ya da içer (kum, kil, kalem, silgi gibi).
(açıklayınız):
- 0 1 2 32: Bazı hayvanlardan, ortamlardan ya da yerlerden korkar.
(açıklayınız):
- 0 1 2 33. Duyguları kolayca incinir.
- 0 1 2 34. Çok sık bir yerlerini incitir, başı kazadan kurtulmaz.
- 0 1 2 35. Çok kavga dövüş eder.
- 0 1 2 36. Her şeye burnunu sokar.
- 0 1 2 37. Anne-babasından ayrıldığında çok tedirgin olur.
- 0 1 2 38. Uykuya dalmakta güçlük çeker.
- 0 1 2 39. Baş ağrıları vardır (tıbbi nedeni olmayan).
- 0 1 2 40: Başkalarına vurur.
- 0 1 2 41. Nefesini tutar.
- 0 1 2 42. Düşünmeden insanlara ya da hayvanlara zarar verir.
- 0 1 2 43. Hiçbir nedeni yokken mutsuz görünür.
- 0 1 2 44. Öfkelidir.
- 0 1 2 45. Midesi bulanır, kendini hasta hisseder (tıbbi nedeni olmayan).
- 0 1 2 46. Bir yerleri seyirir, tikleri vardır (açıklayınız):
- 0 1 2 47. Sinirli ve gergindir.
- 0 1 2 48. Gece kabusları, korkulu rüyalar görür.
- 0 1 2 49. Aşırı yemek yer.
- 0 1 2 50: Aşırı yorgundur.
- 0 1 2 51. Hiçbir neden yokken panik yaşar.
- 0 1 2 52. Kakasını yaparken ağrısı, acısı olur.
- 0 1 2 53. Fiziksel olarak insanlara saldırır, onlara vurur.
- 0 1 2 54. Burnunu karıştırır, cildini ya da vücudunun diğer taraflarını yolar.
(açıklayınız):
- 0 1 2 55. Cinsel organlarıyla çok fazla oynar.
- 0 1 2 56. Hareketlerinde tam kontrollü değildir, sakardır.
- 0 1 2 57. Tıbbi nedeni olmayan, görme bozukluğu dışında göz ile ilgili sorunları vardır. (açıklayınız):
- 0 1 2 58. Cezadan anlamaz, ceza davranışını değiştirmez.
- 0 1 2 59. Bir uğraş ya da faaliyetten diğerine çabuk geçer.
- 0 1 2 60. Döküntüleri ya da başka cilt sorunları vardır (tıbbi nedeni olmayan).
- 0 1 2 61. Yemek yemeyi reddeder.

- 0 1 2 62. Hareketli, canlı oyunlar oynamayı reddeder.
- 0 1 2 63. Başını ve bedenini tekrar tekrar sallar.
- 0 1 2 64. Gece yatağına gitmemek için direnir.
- 0 1 2 65. Tuvalet eğitimine karşı direnir. (açıklayınız):
- 0 1 2 66. Çok bağıırır, 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. Üykusunda konuşur, ağlar, bağıırır.
- 0 1 2 85. Öfke nöbetleri vardır, çok çabuk öfkelenir.
- 0 1 2 86. Temiz, titiz ve düzenlidir.
- 0 1 2 87. Çok korkak ve kaygılıdır.
- 0 1 2 88. İşbirliği yapmaz.
- 0 1 2 89. Hareketsiz ve yavaştır, enerjik değildir.
- 0 1 2 90. Mutsuz, üzgün, çökkün ve keyifsizdir.
- 0 1 2 91. Çok gürültücüdür.
- 0 1 2 92. Yeni tanıdığı insanlardan ve durumlardan çok tedirgin olur.
(açıklayınız):
- 0 1 2 93. Kusmaları vardır (tıbbi nedeni olmayan).
- 0 1 2 94. Geceleri sık sık uyanır.
- 0 1 2 95. Alıp başını gider.
- 0 1 2 96. Çok ilgi ve dikkat ister.
- 0 1 2 97. Sızlanır, mızırdanır.
- 0 1 2 98. İçe kapanıktır, başkalarıyla birlikte olmak istemez.
- 0 1 2 99. Evhamlıdır.
- 0 1 2 100. Çocuğunuzun burada değinilmeyen başka sorunu varsa lütfen yazınız:
- 0 1 2 _____
- 0 1 2 _____
- 0 1 2 _____

Appendix B: Child Behavior Checklist for Ages 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. _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Çocuğunuz her birinde ne kadar başarılıdır?

	Normalden az	Normal	Normalden Fazla	Bilmiyorum
a. _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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. _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Çocuğunuz her birinde ne kadar başarılıdır?

	Normalden az	Normal	Normalden Fazla	Bilmiyorum
a. _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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. _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

II. 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, sofraya 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. _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

III. a. Çocuğunuzun yaklaşık olarak kaç yakın arkadaşı vardır?

(Kardeşlerini katmayınız)

- Hiç yok 1 2 ya da 3 4 ya da fazla

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

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

IV. Yaşıtlarıyla karşılaştırıldığında çocuğunuzun:

V.

a. Kardeşleriyle arası nasıldır?

- Kötü Normal Sayılır Oldukça İyidir Kardeşi Yoktur

b. Diğer çocuklarla arası nasıldır?

- Kötü Normal Sayılır Oldukça İyidir Kardeşi Yoktur

c. Size karşı davranışları nasıldır?

- Kötü Normal Sayılır Oldukça İyidir Kardeşi Yoktur

d. Kendi başına oyun oynaması ve iş yapması nasıldır?

- Kötü Normal Sayılır Oldukça İyidir Kardeşi Yoktur

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

	Başarısız.	Orta.	Başarılı.	Çok Başarılı
a. Türkçe / Türk Dili Edebiyatı	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Hayat Bilgisi / Sosyal Bilgiler	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. Matematik	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
ç. Fen Bilgisi	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Diğer derslerde nasıldır?

Örneğin: Yabancı dil, bilgisayar

(Beden eğitimi, resim ve müziği katmayınız)

- d. _____
- e. _____
- f. _____

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

- Hayır Evet – Ne tür bir sınıf ya da okul? _____

3. Çocuğunuz hiç sınıfta kaldı mı?

- Hayır Evet – Kaçınıcı sınıfta ve nedeni _____

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

O Hayır O Evet – açıklayınız _____

Bu sorunlar ne zaman başladı? _____

Sorunlar bitti mi?

O Hayır O Evet – Ne zaman?

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

O Hayır O Evet – açıklayınız _____

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

Çocuğunuzun en beğendiğiniz özellikleri nelerdir?

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

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

- | | |
|-------|---|
| 0 1 2 | 1. Yaşından çok çocuksu davranır. |
| 0 1 2 | 2. Anne babanın izni olmadan içki içer. |
| 0 1 2 | 3. Çok tartışan bir çocuktur. |
| 0 1 2 | 4. Başladığı etkinlikleri (oyunu, dersleri, işleri) bitiremez. |
| 0 1 2 | 5. Hoşlandığı ya da zevk aldığı çok az şey vardır. |
| 0 1 2 | 6. Kakasını tuvaletten başka yerlere yapar. |
| 0 1 2 | 7. Bir şeylerle övünür, başkalarına hava atar. |
| 0 1 2 | 8. Bir konuya odaklanamaz, dikkatini uzun süre toplayamaz. |
| 0 1 2 | 9. Kafasından atamadığı, onu rahatsız eden bazı düşünceleri vardır (mikrop bulaşma, simetri takıntısı, okul sorunları, bilgisayar gibi) |
| 0 1 2 | 10. Yerinde sakince oturamaz, çok hareketli ve huzursuzdur. |
| 0 1 2 | 11. Gereken gayreti göstermeden, sırtını tamamen büyüklere dayayıp her şeyi onlardan bekler. |
| 0 1 2 | 12. Yalnızlıktan şikayet eder. |

- 0 1 2 13. Kafası karışık, zihni bulanıktır.
0 1 2 14. Çok ağlar.
0 1 2 15. Hayvanlara eziyet eder.
0 1 2 16. Başkalarına eziyet eder, kötü davranır, kabadayılık eder.
0 1 2 17. Hayal kurar, hayallere dalıp gider.
0 1 2 18. Kendine bilerek zarar verdiği ya da intihar girişiminde bulunduğu olmuştur.
0 1 2 19. Hep dikkat çekmeye çalışır.
0 1 2 20. Eşyalarına zarar verir.
0 1 2 21. Ailesine ya da başkalarına ait eşyalara zarar verir.
0 1 2 22. Evde söz dinlemez.
0 1 2 23. Okulda söz dinlemez.
0 1 2 24. İştahsızdır.
0 1 2 25. Başka çocuklarla geçinemez.
0 1 2 26. Hatalı davranışından dolayı suçluluk duymaz, oralı olmaz, aldırmaz.
0 1 2 27. Kolay kıskanır.
0 1 2 28. Ev, okul ya da diğer yerlerde kurallara uymaz, karşı gelir.
0 1 2 29. Bazı hayvanlardan, durumlardan (yüksek yerler) ya da ortamlardan (asansör, karanlık gibi) korkar (okulu katmayınız). (açıklayınız):
0 1 2 30. Okula gitmekten korkar, okul korkusu vardır.
0 1 2 31. Kötü bir şey düşünebileceği ya da yapabileceğinden korkar.
0 1 2 32: Kusursuz, dört dörtlük ve her konuda başarılı olması gerektiğine inanır.
0 1 2 33. Kimsenin onu sevmediğinden yakınır.
0 1 2 34. Başkalarının ona karşı olduğu, zarar vermeye, ya da açığını yakalamaya çalıştığı hissine kapılır.
0 1 2 35. Kendini değersiz, önemsiz ya da yetersiz hisseder.
0 1 2 36. Bir yerlerini kaza ile sık sık incitir.
0 1 2 37. Çok kavga çıkarır, kavgaya karışır.
0 1 2 38. Çok fazla sataşılır, dalga geçilir.
0 1 2 39. Başı belada olan kişilerle dolaşır.
0 1 2 40: Olmayan sesler ve konuşmalar işitir (açıklayınız):
0 1 2 41. Düşünmeden hareket eder, aklına eseni yapar.
0 1 2 42. Başkalarıyla birlikte olmaktansa yalnız olmayı tercih eder.
0 1 2 43. Yalan söyler, hile yapar, aldatır.
0 1 2 44. Tırnaklarını yer.
0 1 2 45. Sinirli ve gergindir.
0 1 2 46. Kasları oynar, seğirmeleri ve tikleri vardır (açıklayınız):
0 1 2 47. Geceleri kabus görür.
0 1 2 48. Başka çocuklar tarafından sevilmez.
0 1 2 49. Kabızlık çeker.
0 1 2 50: Çok korkak ve kaygılıdır.
0 1 2 51. Başı döner, gözleri kararır.
0 1 2 52. Kendini çok suçlu hisseder.
0 1 2 53. Aşırı yer.
0 1 2 54. Sebepsiz yere çok yorgun hissettiği olur.
0 1 2 55. Fazla kiloludur.
0 1 2 56. **Sağlık sorunu olmadığı halde;**
0 1 2 a. Ağrı ve sızılardan yakınır (baş ve karın ağrısı dışında)
0 1 2 b. Baş ağrılarından yakınır (şikayet eder)

- 0 1 2 c. Bulantı, kusma duygusu olur
0 1 2 d. Gözle ilgili şikayetleri olur (Gözlük, lens kullanma dışında)
(açıklayınız):
0 1 2 e. Döküntü, pullanma ya da başka cilt hastalığı olur
0 1 2 f. Mide-karın ağrısından şikayet eder
0 1 2 g. Kusmaları olur
0 1 2 h. Diğer (açıklayınız):
0 1 2 57. İnsanlara vurur, fiziksel saldırıda bulunur.
0 1 2 58. Burnunu karıştırır, derisini ya da vücudunu yolar, saç ve kirpiğini koparır. (açıklayınız):
0 1 2 59. Herkesin içinde cinsel organıyla oynar.
0 1 2 60. Cinsel organıyla çok fazla oynar.
0 1 2 61. Okul ödevlerini tam ve iyi yapamaz.
0 1 2 62. El, kol, bacak hareketlerini ayarlamada güçlük çeker, sakardır.
0 1 2 63. Kendinden büyük çocuklarla vakit geçirmeyi tercih eder.
0 1 2 64. Kendinden küçüklerle vakit geçirmeyi tercih eder.
0 1 2 65. Konuşmayı reddeder.
0 1 2 66. İstemeyerek de olsa, belli bazı davranışları tekrar tekrar yapar (elini defalarca yıkama, kapı kilidini tekrar tekrar kontrol etme gibi) (açıklayınız):
0 1 2 67. Evden kaçır.
0 1 2 68. Çok bağırır.
0 1 2 69. Sırlarını kendine saklar, hiç kimseyle paylaşmaz.
0 1 2 70. Olmayan şeyleri görür. (açıklayınız):
0 1 2 71. Topluluk içinde rahat değildir, başkalarının kendisi hakkında ne düşünecekleri ve ne söyleyecekleriyle ilgili kaygı duyar.
0 1 2 72. Yangın çıkartır.
0 1 2 73. Cinsel sorunları vardır. (açıklayınız):
0 1 2 74. Gösteriş meraklısıdır, maskaralık yapar.
0 1 2 75. Çok utangaç ve çekingendir.
0 1 2 76. Diğer çocuklardan daha az uyur.
0 1 2 77. Gece ve/veya gündüz diğer çocuklardan daha çok uyur. (açıklayınız):
0 1 2 78. Dikkati kolayca dağılır.
0 1 2 79. Konuşma problemi vardır. (açıklayınız):
0 1 2 80. Boş gözlerle bakar.
0 1 2 81. Evden bir şeyler çalar.
0 1 2 82. Ev dışındaki başka yerlerden bir şeyler çalar.
0 1 2 83. İhtiyacı olmadığı halde birçok şey biriktirir. (açıklayınız):
0 1 2 84. Tuhaf, alışılmadık davranışları vardır (eşyaların belli bir düzende ve sırada olmasını isteme gibi). (açıklayınız):
0 1 2 85. Tuhaf, alışılmadık düşünceleri vardır (bazı sayıları, sözcükleri tekrarlama ve bunları zihninden atamama gibi). (açıklayınız):
0 1 2 86. İnatçı ve huysuzdur.
0 1 2 87. Ruhsal durumu ya da duyguları çabuk değişir.
0 1 2 88. Çok sık küser.
0 1 2 89. Şüphelidir, kuşku duyar.
0 1 2 90. Küfürlü ve açık saçık konuşur.
0 1 2 91. Kendini öldürmekten söz eder.
0 1 2 92. Uykuda yürür ve konuşur. (açıklayınız):
0 1 2 93. Çok konuşur.
0 1 2 94. Başkalarına rahat vermez, onlara sataşır, onlarla çok dalga geçer.

- 0 1 2 95. Öfke nöbetleri vardır, çabuk öfkelenir.
0 1 2 96. Cinsel konuları fazlaca düşünür.
0 1 2 97. İnsanları tehdit eder.
0 1 2 98. Parmak emer.
0 1 2 99. Sigara içer, tütün çiğner.
0 1 2 100. Uyumakta zorlanır. (açıklayınız):
0 1 2 101. Okuldan kaçır, dersini asar.
0 1 2 102. Hareketleri yavaştır, enerjik değildir.
0 1 2 103. Mutsuz, üzgün ve çökkündür (depresyondadır).
0 1 2 104. Çok gürültücüdür.
0 1 2 105. Sağlık sorunu olmadığı halde madde kullanır (içki ve sigarayı katmayınız) (açıklayınız):
0 1 2 106. Çevresindeki kişi ve eşyalara kasıtlı olarak zarar verir, zorbalık eder.
0 1 2 107. Gündüz altını ıslatır.
0 1 2 108. Gece yatağını ıslatır.
0 1 2 109. Mızırdanır, sızlanır.
0 1 2 110. Karşı cinsiyetten biri olmayı ister.
0 1 2 111. İçine kapanıktır, başkalarıyla kaynaşmaz.
0 1 2 112. Evhamlıdır, her şeyi dert eder.
113. Çocuğun yukarıdaki listede belirtilmeyen başka sorunu varsa lütfen yazınız:
0 1 2 _____
0 1 2 _____
0 1 2 _____

Appendix C: The Children's Depression Inventory

Aşağıda gruplar halinde bazı cümleler yazılıdır. Her gruptaki cümleleri dikkatlice okuyunuz. Her grup için, bugün dahil son iki hafta içinde size en uygun olan cümlenin yanındaki numarayı daire içine alınız. **Lütfen eksiksiz doldurduğunuzdan emin olunuz.** Teşekkürler.

- 1) 0. Kendimi arada sırada üzgün hissedirim.
1. Kendimi sık sık üzgün hissedirim.
2. Kendimi her zaman üzgün hissedirim.
- 2) 0. İşlerim hiçbir zaman yolunda gitmeyecek.
1. İşlerimin yolunda gidip gitmeyeceğinden emin değilim.
2. İşlerim yolunda gidecek.
- 3) 0. İşlerimin çoğunu doğru yaparım.
1. İşlerimin birçoğunu yanlış yaparım.
2. Her şeyi yanlış yaparım.
- 4) 0. Birçok şeyden hoşlanırım.
1. Bazı şeylerden hoşlanırım.
2. Hiçbir şeyden hoşlanmam.
- 5) 0. Her zaman kötü bir çocuğum.
1. Çoğu zaman kötü bir çocuğum.
2. Arada sırada kötü bir çocuğum.
- 6) 0. Arada sırada başıma kötü bir şeylerin geleceğini düşünüyorum.
1. Sık sık başıma kötü bir şeylerin geleceğinden endişelenirim.
2. Başıma kötü şeyler geleceğinden eminim.
- 7) 0. Kendimden nefret ederim.
1. Kendimi beğenmem.
2. Kendimi beğenirim.
- 8) 0. Bütün kötü şeyler benim hatam.
1. Kötü şeylerin bazıları benim hatam.
2. Kötü şeyler genellikle benim hatam değil.
- 9) 0. Kendimi öldürmeyi düşünmem.
1. Kendimi öldürmeyi düşünürüm ama yapmam.
2. Kendimi öldürmeyi düşünüyorum.

- 10) 0. Her gün içimden ağlamak gelir.
1. Birçok günler içinden ağlama gelir.
2. Arada sırada içimden ağlamak gelir.
- 11) 0. Her şey her zaman beni sıkar.
1. Her şey sık sık beni sıkar.
2. Her şey arada sırada beni sıkar.
- 12) 0. İnsanlarla beraber olmaktan hoşlanırım.
1. Çoğu zaman insanlara beraber olmaktan hoşlanmam.
2. Hiçbir zaman insanlarla beraber olmaktan hoşlanmam.
- 13) 0. Herhangi bir şey hakkında karar veremem.
1. Herhangi bir şey hakkında karar vermek zor gelir.
2. Herhangi bir şey hakkında kolayca karar veririm.
- 14) 0. Güzel/yakışıklı sayılırım.
1. Güzel/yakışıklı olmayan yanlarım var.
2. Çirkinim.
- 15) 0. Okul ödevlerimi yapmak için her zaman kendimi zorlarım.
1. Okul ödevlerimi yapmak için çoğu zaman kendimi zorlarım.
2. Okul ödevlerini yapmak sorun değil.
- 16) 0. Her gece uyumakta zorluk çekerim.
1. Birçok gece uyumakta zorluk çekerim.
2. Oldukça iyi uyurum.
- 17) 0. Arada sırada kendimi yorgun hissederim.
1. Birçok gün kendimi yorgun hissederim.
2. Her zaman kendimi yorgun hissederim.
- 18) 0. Hemen her gün canım yemek yemek istemez.
1. Çoğu gün canım yemek yemek istemez.
2. Oldukça iyi yemek yerim.
- 19) 0. Ağrı ve sızılardan endişe etmem.
1. Çoğu zaman ağrı ve sızılardan endişe ederim.
2. Her zaman ağrı ve sızılardan endişe ederim.
- 20) 0. Kendimi yalnız hissetmem.
1. Çoğu zaman kendimi yalnız hissederim.
2. Her zaman kendimi yalnız hissederim.
- 21) 0. Okuldan hiç hoşlanmam.
1. Arada sırada okuldan hoşlanırım.
2. Çoğu zaman okuldan hoşlanırım.

- 22) 0. Birçok arkadaşım var.
1. Birçok arkadaşım var ama daha fazla olmasını isterim.
2. Hiç arkadaşım yok.
- 23) 0. Okul başarıml iyi.
1. Okul başarıml eskisi kadar iyi değil.
2. Eskiden iyi olduğum derslerde çok başarısızım.
- 24) 0. Hiçbir zaman diğer çocuklar kadar iyi olamıyorum.
1. Eğer istersem diğer çocuklar kadar iyi olurum.
2. Diğer çocuklar kadar iyiyim.
- 25) 0. Kimse beni sevmez.
1. Beni seven insanların olup olmadığından emin değilim.
2. Beni seven insanların olduğundan eminim.
- 26) 0. Bana söyleneni genellikle yaparım.
1. Bana söyleneni çoğu zaman yaparım
2. Bana söyleneni hiçbir zaman yapmam.
- 27) 0. İnsanlarla iyi geçinirim.
1. İnsanlarla sık sık kavga ederim.
2. İnsanlarla her zaman kavga ederim.

Appendix D: The Screen for Child Anxiety Related Emotional Disorders

Aşağıda, insanların kendilerini nasıl hissettiklerini tanımlayan maddeler bulunmaktadır. Her madde için; eğer madde sizin için **doğru ya da çoğu zaman doğru** ise 2'yi, **biraz ya da bazen doğru** ise 1'i, **doğru değil ya da nadiren doğru** ise 0'ı işaretleyin. Bazı maddelerin size uygun olmadığını düşünseniz de boş bırakmayınız.

Lütfen eksiksiz doldurduğunuzdan emin olunuz. Teşekkürler.

0: Doğru değil ya da nadiren doğru

1: Biraz ya da bazen doğru

2: Doğru ya da çoğu zaman doğru

1. Korktuğum zaman nefes almam zorlaşır.	0	1	2
2. Okuldayken başım ağrır.	0	1	2
3. İyi tanımadığım insanlarla birlikte olmaktan hoşlanmam.	0	1	2
4. Evden uzak bir yerde uyursam korkarım.	0	1	2
5. Başka insanların beni sevip sevmediğinden endişelenirim.	0	1	2
6. Korktuğum zaman bayılacak gibi hissederim.	0	1	2
7. Huzursuzum.	0	1	2
8. Nereye giderlerse gitsinler annemin ve babamın peşinden giderim.	0	1	2
9. Birçok insan bana huzursuz görüdüğümü söyler.	0	1	2
10. İyi tanımadığım insanların yanında kendimi huzursuz hissederim.	0	1	2
11. Okuldayken karnım ağrır.	0	1	2
12. Korktuğum zaman aklımı kaçırarak gibi hissederim.	0	1	2
13. Yalnız yatmaktan endişe duyarım.	0	1	2
14. Diğer çocuklar kadar iyi olmadığımdan endişelenirim.	0	1	2
15. Korktuğum zaman olayları gerçek değilmiş gibi hissederim.	0	1	2
16. Annemin ve babamın başına kötü şeylerin geldiği kabuslar (korkunç rüyalar) görürüm.	0	1	2
17. Okula gitmekten endişe duyarım.	0	1	2
18. Korktuğum zaman kalbim hızlı çarpar.	0	1	2
19. Titrerim.	0	1	2

20. Başıma kötü şeylerin geldiği kabuslar (korkunç rüyalar) görürüm.	0	1	2
21. İşlerim yolunda gitmeyecek diye endişelenirim.	0	1	2
22. Korktuğum zaman çok terlerim.	0	1	2
23. Her şeyi kendime dert ederim.	0	1	2
24. Hiçbir neden olmadığı halde çok korktuğum olur.	0	1	2
25. Evde yalnız kalmaktan korkarım.	0	1	2
26. İyi tanımadığım insanlara konuşmak bana zor gelir.	0	1	2
27. Korktuğum zaman boğuluyormuş gibi hissederim.	0	1	2
28. Birçok insan bana çok endişelendiğimi söyler.	0	1	2
29. Ailemden uzakta olmaktan hoşlanmam.	0	1	2
30. Heyecan nöbetleri geçirmekten korkarım.	0	1	2
31. Annemin ve babamın başına kötü şeyler gelecek diye endişelenirim.	0	1	2
32. İyi tanımadığım insanların yanında utanırım.	0	1	2
33. Gelecekte olacaklar konusunda endişelenirim.	0	1	2
34. Korktuğum zaman kusacakmış gibi olurum.	0	1	2
35. İşlerimi ne kadar iyi yaptığımdan endişelenirim.	0	1	2
36. Okula gitmekten korkarım.	0	1	2
37. Olup bitmiş şeyler hakkında endişe duyarım.	0	1	2
38. Korktuğum zaman başım döner.	0	1	2
39. Başka çocuk ve yetişkinlerle birlikteyken ve onlar benim yaptığım şeyi seyrederken kendimi huzursuz hissederim. (ör: Yüksek sesle okurken, konuşurken, oyun oynarken, spor yaparken)	0	1	2
40. İyi tanımadığım insanların bulunacağı partiye, dansa ya da herhangi bir yere giderken kendimi huzursuz hissederim	0	1	2
41. Utangacım.	0	1	2