REORGANIZATION OF OBJECT RELATIONS IN PSYCHOTHERAPY: THE FUNCTION OF RELATIONAL PLAY MATRIX BETWEEN THE PATIENT AND THE THERAPIST

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Reorganization of Object Relations in Psychotherapy: The Function of Relational Play Matrix between the Patient and the Therapist

Psikoterapide Nesne İlişkilerinin Düzenlenmesi: Danışan ve Terapist Arasındaki İlişkisel Oyun Alanının İşlevi

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Abstract

The play activity of the child is a communication to the therapist of his subjective self-experience in relation to others which gets reorganized within the relational play matrix between the therapist and the patient (Winnicott, 1971; Baranger & Baranger, 2008). The aim of this study is to investigate the association between the level of social representations enacted in play and the development of new object relations in time through an empirical investigation of two single cases with similar demographics and presenting problems with quantitative methodology and clinical analysis. For assessing the level of representation and play structures of in psychotherapy Children's Play Therapy Instrument (CPTI; Kernberg, Chazan, & Normandin, 1998), and for identifying the pervasiveness of main interpersonal relationship themes in play Core Conflictual Relationship Theme Method (CCRT; Luborksy, 1998) were used. Results indicated that significant linear increase in trend analyses on complex relational capacity for the case who showed significant clinical improvement in symptoms. Also, according to partial correlation analysis, for the case who showed significant clinical improvement, negative correlation was found between complex relations and the pervasiveness of core conflictual relationship patterns; whereas for the case who did not showed clinical improvement, positive correlation was found between the same variables. Implications are discussed.

Özet

Oyun aktivitesi, çocuğun nesnelerle olan ilişkilerinin kendi öznel deneyimleri üzerinden terapistle kurduğu ilişkiye aktardığı ve bu ilişkilerin terapist ile danışan arasındaki oyun matrisinde yeniden düzenlendiği bir alandır (Winnicott, 1971; Baranger & Baranger, 2008). Bu çalışmanın amacı, oyun içerisindeki zengin sosyal temsil kullanımı ile yeni nesne ilişkilerinin oluşumu arasındaki ilişkiyi benzer demografik özelliklere ve semptomlara sahip iki vaka üzerinden, niceliksel metodoloji ve klinik analizler kullanılarak araştırmaktır. Psikoterapi sürecindeki oyun yapılarını ve temsil seviyesini değerlendirmek için Children Play Therapy Instrument (CPTI; Kernberg, Chazan, & Normandin, 1998), ve oyun içerisindeki temel kişilerarası ilişki temalarını belirlemek için Core Conflictual Relationship Theme Method (CCRT; Luborksy, 1998) kullanıldı. Yapılan regresyon analizleri sonucunda semptomlarında klinik olarak ilerleme görülen vakanın terapi süresince kompleks ilişkisellik kapasitende anlamlı bir artış görülmüştür. Bunun yanında, yapılan korelasyon analizlerine göre klinik olarak ilerleme gösteren vakada kompleks ilişkisellik ve temel çatışmalı ilişki temasının devamlılığı arasında negatif korelasyon görülürken, klinik olarak ilerleme göstermeyen vakada aynı değişkenler arasında pozitif korelasyon bulunmuştur. Çıkarımlar tartışılmıştır.

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1. INTRODUCTION

Play is the primary way of communication in child psychotherapy. Through play, conflictual patterns in interpersonal relations are brought into the room and these patterns are realized, integrated, and accepted into the patient's experience of herself or himself (Winnicott, 1968; Frankel, 1998; Downey 2001). However, this process takes time; it is related with the patient's capacity to play (Winnicott, 1969).

In this study, the association between relationship qualities enacted in play and the development of new object and interpersonal relations in time is investigated through an empirical investigation of two single case studies.

To enhance the understanding of why this study is conducted, in the first part of introduction section, the meaning and function of play will be reviewed briefly. The evolution of theories in the field of child psychotherapy from classical theories to new perspectives will be given a look for observing the changes from one-person theories to relational understanding. Besides, the question of how play reveals the object and interpersonal representations will be reviewed.

The second section will be about the assessment of play within therapy sessions. Although there are several different ways to assess the notion of play, most of them do not address the specific aspects of play that emerge in treatment. Children Play Therapy Instruments (CPTI; Kernberg, Chazan & Normandin, 1998) is a more comprehensive assessment tool that

takes into consideration several facets of play in psychodynamic play therapy.

In the third section, in order to assess the relational patterns enacted in play, the focus will be on Core Conflictual Relationship Theme Method (CCRT; Luborsky & Crits-Christoph, 1998). The CCRT method can identify certain characteristics of a person's recurrent relational patterns. The studies that identify and observe the changes in these patterns in just the beginning of the therapy or throughout the process will be reviewed.

Following these sections, the empirical tendencies regarding the psychotherapy research will be reviewed and the assumptions of single case designs will explained. Lastly, the aims and the hypotheses will be stated.

1.1 The Meaning and Function of Play

Winnicott (1968) thought that the notion of psychotherapy takes place between the patient's and the therapist's overlapping areas. In child psychotherapy, this overlapping area is play, which is a medium of communication that represents the child's core object relation patterns, emotional conflicts and motivations. In other words, play is the area that the patient displays her or his subjective self-experience in relation to others (Schaefer & Kaduson, 2007).

In the 1920s, Klein found a way of reaching the child's unconscious by using a method similar to free association in an adult analysis (Vliegen, 2009). She observed and tried to understand the deep unconscious meaning of the child's symbolic play content (Alvarez & Phillips, 1998). Klein

(1929) considered play as the area in which sexual and aggressive impulses and fantasies can securely be explored. In the child's play, conflictual and impulsive aspects of the inner world are reflected and opportunities are offered to express and integrate these aspects. Play can be approached as a source of information about the child's inner world, about the experiences and internal objects in his familial and social-environment. Also play gives information about the patient's past and present preoccupations. So, it can be seen as something like a dramatized projective technique (Alvarez & Phillips, 1998).

In *Playing and Reality*, Winnicott (1971) defines psychoanalysis as "highly specialized form of playing in the service of communication with oneself and others" (p.41). This communication enables the child to reveal his defenses, adaptive mechanisms, subjective perception about external world, unconscious fantasies and level of relationship (Ornstein, 1984; Lang, 2007). In child work, the evolution of child's capacity to play and the process of playing typically yield a valuable set of information about the individual's psychological and cognitive development, dynamics, diagnosis, and interpersonal relatedness (Gilmore, 2005).

Frankel (1998) states that play is inherently therapeutic; renegotiation can take place through play, or if the patient cannot play, it can help to make play possible. Play in a therapy room is different from the other plays such as playing alone or playing with other adults or children. In therapeutic play, the characters that the child brings to play can represent the aspects of themselves they haven't comfortably been able to own or to bring

out in the world, or the parts that do not seem to mesh well with other people. Lang (2007) states that after some time child patient gains awareness about this difference and prepare himself to exhibit their "psychic experience to modification and mentalization" (p.938).

So, play provides an intersubjective field where therapist and child can manipulate external phenomena in the service of child's inner personal reality and work through core problems (Winnicott, 1968). Winnicott uses the term transitional space for this area of experiencing that lies between fantasy and reality. He thinks that transitional space is necessary for psychological growth and development; because it functions as an area of unintegrated experiences and defensive functioning for anxiety-provoking material. In this state of in-between-ness, in other words in play metaphor, everything is possible. Traumatic and unintegrated aspects of the child's inner life in various developmental dimensions are now in between the fantasy and reality. With the support of the therapist, child is ready to transform, enhance and re-internalize traumatic experiences (Caspary, 1993). With involvement of both action and verbalization, an intersubjective exchange in mutual state of playing is constituted. In this state of playing, child's anxieties and defenses can be transformed with the analyst's clarifications, cooperative engagement and interpretive work (Gilmore, 2005).

In child work where playing is prominent, there are layers of diagnostic, dynamic, and transference meanings within the play, as well as in the freedom where the child reveals his personal “state of playing” and in

the manner where the child draws the analyst into the play and allows the emergence of an intimate dialogue. Originating from Freud's ideas, playing in the analytic setting establishes a space “without real consequences” where communication between the child and the analyst can occur at the developmental level of the child. Both child patient and analyst must be willing to engage in the “conceptual world” that the child creates with the analyst (Gilmore, 2005). Over time, the analyst readily launches herself into the singular world of her patient's “state of playing,” a world where rhythms, rules, and rituals as well as opportunities for therapeutic work are unique and to some extent idiosyncratic to the particular individual and the dyad; among these are the pathological adaptations that can be addressed best by being in that world with the child. This state includes unconscious communication and intuitive leaps that can result in dramatic shifts in the child's tolerance for affects and rejected self-representations.

1.2 Play, its Theoretical Situation and Representations in Play

By taking Freud's theories as a baseline, Anna Freud and Melanie Klein generated their own theories in the area of child psychoanalysis (Bonovitz, 2004). On the one hand, Anna Freud put her emphasis on defenses of the ego. Her interventions was originated from educational psychology and based on the principles that being more supportive towards the patient. On the other hand, Klein came up with her own theory which focused mainly on the phantasy life of the baby.

For Klein, reaching the child's unconsciousness is easier than that of the adult's. The way to the child's inner world is through play which contains symbolic manifestations of phantasies. Most of the time, these phantasies represent the internal objects that are mental and emotional images of an external object. A complex interaction continues throughout life between the world of internalized objects and the real world via repeated cycles of projection and introjection. According to Kleinian theory, the state of internal object is considered as one of the prominent aspects for the development and mental health of the individual. The introjection and identification with a stable good object is crucial to the ego's capacity to integrate experience. Damaged internal objects cause enormous anxiety and can lead to personality disintegration. On the other hand, objects that securely internalize promote confidence and well-being (Klein, 1946; Klein, 1958).

From a developmental view point, Klein (1946) suggested two positions. The more primitive one is paranoid-schizoid position in which child seeks to introject good objects and project bad objects onto an external object. In this developmental level, child's ego functions does not have the ability to tolerate or integrate two opposing aspects. On the other hand the depressive position is a prominent step in integration of an object with its both good and bad feature. The shift from paranoid-schizoid position to depressive position is facilitated by another person who is receptive to this projections. So, in Kleinian terms, if the aim of the therapy is to reach the depressive position, therapeutic field is the area where both patient and

therapist try to acknowledge the aggression and anxiety in paranoid-schizoid position. Newirth (1992) states that, in paranoid position, two different experiences are contained: one is the passive paranoid position, in which the aggression is projected outward and individual feels powerless, persecuted and attacked by the external world; another one is active paranoid position, in which individual acknowledge and enjoys his aggression. In *Notes on Some Schizoid Mechanisms* Klein (1946) used the term projective identification and explained it as in the paranoid-schizoid episode of development, where in bad parts of the self are split off and projected into another person in an effort to rid the self of one's bad objects. Later, Bion (1962) extended the notion of projective identification in scope of a more intersubjective conceptualization.

Starting with the Kleinian theory, several psychoanalytic and cognitive oriented theories also argue that children transform and internalize interactions with primary caregivers, and these interactions regulate and direct a wide range of emotion and behavior, especially in interpersonal relationships (Blatt & Auerbach, 2001). These early interactions also influence individual's developmental level and prominent aspects of psychic life such as impulses, affects, drives and fantasies. According to Sandler and Rosenblatt (1962), representations that are constructed by child enable her or him to perceive sensations, organize, and structure them in a meaningful way. The ego functions transform sensory data into meaningful perception and thus, child creates, within its perceptual and representational world, images and organizations of his internal as well as his external environment.

Imagination and fantasy, direct and modified action, language and symbols all stem from this representational world. Last but not least, if these early experiences are pathological and disturbing, according to the degree of the damage, primitive and pathological distortions can cause psychopathologies. With distortions or lack of flexibility in representations, the enactments rather than balanced psychic experiences will be experienced (Fonagy & Target, 2000).

With the repetition of the interaction with primary caregivers in infancy, these patterns are internalized in individual's internal world. They became the templates that structure how one thinks and feels about oneself and about others (Blatt & Auerbach, 2001). Daniel Stern (1985) names the repetitive experiences of self in the presence of a self-regulating other as Representations of Interactions that have been Generalized (RIGs). RIGs can be described as the basic unit for the representation of the core self. The experience of being with a self-regulating other gradually forms RIGs. They constitute the several realities and the various perceptual and affective attributions integrate into a whole. These memories are retrievable whenever one of the attributes, that recall cues to reactive the lived experience, of the RIG is present.

1.3 Transformation of Internal Representations in Play

The internalized mental representations continue to develop and change throughout life. Psychotherapy is a process that enable the patient to reveal his internal representations and provide a space for transformation.

Patient's earliest experiences are unconsciously available in a psychotherapy process in the form of unconscious object relations (Ackerman, 2010).

According to Piaget (1962), representations enable children to go beyond the perceptual field that can distort reality according to their wishes and subordinate it to the ends they want to achieve. However not all children seem willing to play with their representational ability to the same degree (Wolf & Grollman, 1982). Every child's level of functioning is different from each other, and this differences indicates where the child is standing in developmental spectrum. According to where child stands on this spectrum, the child capacity for progression and regression can be varied. The differences between children can be clearly seen in their level of representation. If a child cannot exhibit his representations in a complex level, this may show a lack of differentiation between self and others, lack of empathy and some disturbances in terms of investment of others (Chazan, 2002).

According to Fonagy and colleagues (1993), three mechanisms of therapeutic action that create changes in mental representations can be identified as integration, elaboration and the genesis of new representational structures. In the first mechanism, the integration of the presented internal representations need to be improved with repeated activation. The second mechanism, elaboration, establishes relationships among representations and creates the kind of network of relations that is fundamental to the process of understanding. In last mechanism, the genesis of new representational structures, the psychoanalytical situation enables the patient

to create the new mental representations. So in representational model, as Fonagy and colleagues named, the process of change is a result of the modification of unconscious mental representations as part of the interpretive works as well as the more generalized aspects of the analytic encounter.

Winnicott's ideas regarding child psychotherapy focus on affective communication in the mutual space created by the patient and the therapist (Winnicott, 1971). He stressed that the therapist must survive from the patient destructive acts in this mutual space, where patient test and try to find a limit for his aggression (Horne, 1989). For Winnicott, the survival from destruction requires the therapist to act as a stable object (Winnicott, 1969). Just like a good-enough mother (Winnicott, 1971), therapist allows and facilitate the regression; so that the child can explore his anxieties. By this way, the child reach the objective reality from the illusion of omnipotence. However, the illusion is necessary up to a point because by the illusion the fantasy world of the child is enriched and external world is become more meaningful. In Winnicotian terms: “Fantasy is more primary than reality” (p. 153) (Winnicott, 1945; as cited in Bonovitz, 2004).

For Winnicott (1971), play itself is therapy, because it is in between the fantasy and reality. Winnicott emphasized the intercommunication between inner and outer worlds, fantasy and reality, objective and subjective, real and illusion, in other words; he explore the ideas of linking and bridging (Bonovitz, 2004). Originating from this interest, he formed the

transitional space concept which is built upon the overlapping areas of individuals, objects or concepts (Winnicott, 1971).

In *Playing: Its Theoretical Status in the Clinical Situation* (1968), Winnicott states this prominent explanation of psychotherapy;

> "Psychotherapy takes in the overlap of two areas of playing, that of the patient and that of the therapist. Psychotherapy has to do with two people playing together. The corollary of this is that where playing is not possible then the work done by the therapist is directed towards bringing the patient from a state of not being able to play into a state of being able to play." (p.591).

In his same paper Winnicott continues: "To control what is outside one has to do things, not simply to think or to wish, and doing things take time. Playing is doing." (p.592).

Winnicott (1969) states that the idea of the use of an object is related to capacity to play. He stresses that the work of the clinician leads to the reconstruction of patient's capacity to play and capacity to find and then use the external world with its own independence and autonomy. Winnicott explained this process in his paper *The Use of an Object* (1969) over two different concepts: object relating and object usage. Object relating is a more primitive form of interaction in which the other object is not separated or differentiated. On the other hand object usage is a more advanced form of interaction in which the other object is used for engagement and collaboration. This capacity is not inborn nor does it develop naturally, but

it is a maturational process that depends on the facilitating environment (Winnicott, 1969; Bion, 1962; Stern, 1985).

For the improvement towards the more advanced form of interaction, the patient need to rehearse this kind of communication in a space that everything can be possible. In 'pretend mode' things that come from inside will not be threatened, because they lost their equivalence to what is real. While the worlds of pretend and reality are distinguished, child can bring up the fantasy representations that may be real or not. Before the pretend and reality mode of functioning are fully integrated, representations from the pretend mode may become so intensively and actively stimulated that they lead to some decrease in reality testing. At this point, the role of the therapist is to be with child and contain the experiences in play and let child observe her mental representations in her playing (Fonagy& Target, 1996a). So, the therapist's play with the child is prominent both for engagement with the child's representational system and for the opportunity to enhance child's understanding of the mental states. Fonagy and Target (2007) state that "The dialectical relationship between what is external and internal emerges in the child's discovery of his own mind." (p.921). Understanding the nature of mental world cannot be done alone, it requires discovery and recognition of the self in the eye of other (Fonagy & Target, 1996b). By this way, the representations of child can be modified and the opportunity for creating more flexible mode of thought can be gained (Fonagy & Target, 1996b).

With the usage of symbols in play activity, the sphere of representational thought and abstraction capacity progress. Eventually this progress leads to the modification of past experiences and the innovation of new relational patterns and coping strategies. Sometimes, the therapist receives a role in the story that the child directs, and it may happen that the therapist-actor has to play those facets that the child has split off (Vliegen, 2009). Play can also be used to communicate with relationships that make one to feel too insecure to convey any aspects of a child's inner world. There are different ways of making this communication, sometimes even demanding therapists' absolute silence is a way of expressing the intrusiveness of the parents and the demand for some space (Weinstein, 2001). By this way, therapist enters the child's play as a real person, attempting to create and discover new meanings. The scenario then is co-constructed by both directors in the playroom, the child and the therapist (Vliegen, 2009). The idea of co-construction is connected with the level of fantasy play, and using the metaphors and different characters in the play (Frankel, 1998; Bonovitz, 2004).

While the focus is on co-construction in the play, it is important to notice the influences of different theories and the differences regarding the technique in the process with child. Bion's conceptualizations regarding projective identification process and containment are prominent in review of child psychoanalysis. In his paper ‘Attacks on Linking’, Bion (1959) takes the concept of projective identification and the idea of the infant possessing a capacity for rudimentary thought, and makes the link between the two

more explicit. Bion (1962) introduced the term ‘reverie’ to describe the process whereby the receptive mother takes on board the infant and through a gradual shifting of the feelings and thoughts she is experiencing, allows them to “evolve into an understanding of what the baby is experiencing”. In the interpersonal setting, the person engages in an unconscious phantasy of carrying an unwanted part in another person. Under optimal circumstances, the recipient contains or processes the evoked feelings and ideas, and thus make available for reinternalization by projector, with a more manageable version of that had been projected (Bion, 1962; Ogden, 1979). So, in Bionien terms, psychotherapy is the containment of projective identifications by therapist. In his own words, Bion (1961) explains this process as "being manipulated so as to be playing a part, no matter how difficult to recognize in somebody else's phantasy" (p. 149).

Starting from contemporary Klenian child analysts, what is going on in here and now interactions between the therapist and patient dyad have started to gain importance apart from the focus on interpretations and comments regarding the personal history of the patient (Alvarez, 1992). Alvarez (1998) emphasized the analyst and patient must play together in order to be exist in the room together. Parallel with this view, containing the projections of patient and focusing the split off parts of the self have become more prominent for the treatment process.

According to Chetnik (1989), play is the area that child's internal conflicts and pathological fantasies originated from the repressed wishes and materials are externalized. With the therapist welcoming and stable

stance towards the patient's projected material, patient enables to explore his internal representations and fantasies. By this way, the pathological or traumatic experiences reveal in play and patient has an opportunity to reconstruct these experiences. So, according to ego psychologists, therapist must focus on underlying conflicts and anxieties of the patient and must facilitate the patient to symbolize them.

With the development of relational theory, play itself has gained attention as a therapeutic process where patient improve his or her awareness and explore more adaptive ways regarding the interpersonal relationships or expression of affect (Gaines, 1995; Frankel, 1998). Especially the fantasy play seen as a tool for change (Krimendahl, 1998). Within the play the therapist represent the internal conflicts and pathological old objects, and with the therapeutic relationship that was established between the therapist and the patient, therapist represent the new and more healthy object in child's internal world (Greenberg, 1986; Altman, 1992). Therapist involve the child's play and consciously or unconsciously joins the patient's representational world. So, it can be said that play is the space between the reality and his or her representational world; and therapist is there to balance these two concepts. By this way, therapist joins the play by being both observer and actor. With this joint drama, a space where the representational conflicts and patterns can be worked through between patient and therapist. In Gruen and Blatt's (1990) two single case study paper, they state that in treatment of disturbed patients, a complex set of interrelationships may present between the cohesive sense of self and the

capacity for self-reflection on the other. In a long term dynamically oriented therapy, modification of pathological images of self and other is possible.

Strongly influenced by Bion's notion of projective identification, analyst's reverie and containment (Ferro, 1992) are prominent concepts for therapeutic process. According to Civitarse and Ferro (2013), in analytic field theory, the analyst's reveries and affective and visual transformations based on the patient's narration, together with any metaphors that stem from these, are the actual factors of growth. Ferro and Foresti (2008) believe that "Every analysis session is characterized by the emergence and taking shape of stories in which 'characters' of various forms and emotional depth play a significant role." (p.71). These characters are from within the discourse that the analytic couple develops. For progress of the analysis process, the analyst firstly tries to understand the psychic function of these figures, and secondly intuit how they can be used to develop the couple's interaction and dialogue. He suggests that if analyst takes patient's point of view as 'true', which signals a functioning of the relational field in which we are just as involved as she is, and within which the interpretation plays a minor role, the process will proceed. Bezoari and Ferro (1991) scrutinized what is the true exchange between the analyst and patient. According to them, apart from verbal communication and linguistic meanings, the true exchange is reciprocal projective identification in field between the patient and the therapist.

As a contemporary view, Baranger's field theory provides another perspective for understanding the therapeutic process. According to

Baranger and Baranger (2008; Churcher, 2008), the analytic situation is not only patient who is confronted by therapist who is more indefinite and neutral. It is a situation between two people who are connected, complementary and involved in a single dynamic process as long as the therapy process. Baranger and Baranger (2008) explain in their own words what happened during this process like this:

> "When the placement in the analyst of a given part of the patient's 'self' or the internal objects is made conscious, together with the motivation for this projective identification, this split off part of the patient is re-introjected, the analyst coming into view in his or her real function in the basic contract: analyst and patient are working together and have just taken a step in their work."(p.818)

Overall, it can be said that level of representation can be improved and internal representations regarding the relational patterns can be change in a psychotherapy by the construction of mutual space between the patient and the therapist via play.

1.4 The Assessment of Play Activity

Child psychotherapists can use play in multiple different perspectives including psychoanalytical thinking, research and observation in terms of child's development. Psychotherapists need to be alerted both to the meaning of play and to the level of the child's capacity to play (Alvarez & Phillips, 1998).

During the therapeutic process some changes happen in different dimensions of the child's play. Later on, changes in the child's play activity transform his perspective on significant relationships and alter his adaptation to his surroundings (Chazan, 2002). These alterations happen with the facilitation of the discovery of meaning in play (Slade, 1994). Since the meaning of the play is between the therapist and the patient, the participation of both sides in play activity is needed for the sense-making process (Chazan, 2002). So, it is prominent to assess child's behavior, narrative and play in a psychotherapy setting and also the meaning of the therapeutic actions.

There are several different tools for assessment of children using play in various aspects such as cognitive, social, emotional etc., however, most of them are not applicable to psychotherapy process (Gitlin-Weiner et. al. 2000). It is prominent to use extensive and detailed measures during the assessment of play; because play has several facets, contents and dimensions. So, when considering the sufficiency of an instrument, the availability for application to psychotherapy session and the richness of content is in the foreground.

Howe and Silvern (1981) conducted a preliminary research on forming an instrument for measuring children's playroom behavior to assess areas of functioning relevant to diagnosis, therapy process and outcome. Play Therapy Observation Instrument is the result of this effort and as a result of observation and scoring 31 child behaviors in therapy sessions,

three statistically meaningful subscales were found: emotional discomfort, use of fantasy play as a coping method, and the quality of the child's interaction with the therapist.

The Nova Assessment of Psychotherapy (NAP) play therapy scale is an instrument designed to promote the progress of research and allow the clinician to monitor therapeutic progress and outcome (Faust & Burns, 1991). The NAP consists of behavioral codes for both the child and the therapist. Children are coded on positive/negative nonverbal behaviors and positive/negative verbal behaviors.

Another instrument that assess the development of play activity of the patient within the session is Child Psychoanalytic Play Interview (CPPI; Marans et. al., 1991). The focus of the measure is the retain the thematic differences within a session, analytically. The instrument contain 30 items.

Child Psychotherapy Q-Set (CPQ-Set, Schneider & Jones, 2004) adapted from Jones's (2000) The Psychotherapy Process Q-Set for assessment of child psychotherapy process. Even though some alterations were done for referring the quality of child's play, findings derived from CPQ-Set generalisable to clinical conditions. With this instrument, the psychotherapy process can be assessed in three categories by making session specific statements (Jones, 2000). First one is the patient's attitudes, behaviors and experience; secondly the therapist's behaviors and attitudes and lastly, the therapist-patient interaction. So, CPQ-Set is another

comprehensive measure for assessing the psychotherapy process in several dimensions.

The Children's Play Therapy Instrument (CPTI) was constructed to assess the play activity of a child in psychotherapy (Kernberg, Chazan & Normandin, 1998). Because children have different forms and levels of play, this instrument intended to investigate change and outcome in child treatment. The CPTI is a tool for describing and analyzing the child's play within the session by taking into consideration of child's overall functioning in different perspectives including descriptive, structural and functional. The descriptive perspective includes category of play, script of the interaction between therapist and child, and sphere of play. The structural dimension is formed by various components: affective, cognitive, dynamic and developmental. Finally functional perspective is composed of four clusters of coping and defense mechanisms (Chazan, 2001).

Related with the components of this research, CPTI's role representation in cognitive components and level of representation within the play activity will used as indices to assess the child's relational and representational world. Chazan (1998) states that the structure of social representational world is a crucial dimension of the child's play. From a cognitive view point, it shows the child's capacity of creating narrative structures to represent relationships that have different affective and defensive content. In the more developmentally primitive level of role play, the child is playing with just one character. During the play the child may be

pretend like he or she a different person, animal or object. On the other hand, in plays which are consist of more complex level of role play, child is made several different characters interact with each other and a rich affective and cognitive themes can be observed. Once the representational world of child is in play, another important point to assess is the level of relationship within these representations. Under the dynamic components, the level of relationship category gives information about the interaction patterns between characters in play. Four different level of representations can be observed during the play activity according to the developmental level and personality organization of the child: self, dyadic, triadic and oedipal.

In a series of single case studies, it has shown that the role representations and relational qualities of play improve as a result of effective treatment. Specifically when the child develops the capacity for complex representations and brings to play field several characters that interact with other and takes on different familial and hierarchical roles.

In Chazan's (2000) study, the CPTI was used for assessing the play features during the psychotherapy process and therapy outcome of an autistic girl who was two-year-five-month old. Two sessions was selected; one of the sessions was from the beginning and the other one was selected from the late sessions of the psychotherapy process. These two sessions was quantitatively analyzed comprehensively by the CPTI. A development from more developmentally lower level of role play to more complex

interpersonal role play was observed. In her another study, Chazan (2001) suggested that categories of CPTI could be used to reveal underlying meanings of non-verbal expressions of four-year-six-months old child. Changes in several areas were observed. At the beginning of the process most of the play activity was simple collaborative activity; however through the end, complex collaborative play including new representations were described. In Chazan and Wolf's (2002) study, 5 year old child's, with reason of referral including suicidal behavior and minor stealing, three sessions from the beginning, mid and end of the treatment were coded with CPTI. In this study, the qualitative analysis of three sessions were done and concluded that patient discovered his play realm in the presence of another. Also more time spent in play activity within a session. In another study, for discussing the benefits and feasibility of play therapy in pediatric oncology, Chari, Hirisave and Appaji (2012) conducted a single case design. 20 non-directive play therapy sessions of 4 year old girl diagnosed with leukemia were coded and results indicated the improvements in developmental level, social level, affect range and verbal expression. Also, role representation of patient was improved from solitary role play to complex role play.

1.5 The Assessment of Relational Representations

To decrease patient's suffering, various psychotherapeutic approaches emphasize the role played by the patients' relationships. In an effort to help the patient improve her or his capacity to handle relationships,

therapists focus on the relationship patterns that are expressed by the patient and eventually are carried to the patient and the therapist relationship (Downey, 2001).

There are plenty of instruments that investigate relational patterns of individuals. Most of the instruments collect data by interviewing. For instance, projective techniques such as Rorschach protocols (Mayman, 1967; Blatt & Lerner, 1983; Berg, Packer &Nunno, 1993; Blatt, Tuber & Auerbach, 2011) and TAT (Westen, 1991; Kelly, 1996) have been used for clinical assessment of patients including complexity of representations of people, affect, and capacity for emotional investment in relationships.

Apart from projective protocols, originating from attachment theory, story stems are widely used for identifying the relational patterns in empirical research (Minnis et. al., 2006; Beresford et. al., 2007; Robinson, 2007). Story stem narratives give incomplete scripted events which is completed by the child by personal experience and inner representations (Robinson et. al, 2000). For example, The MacArthur Story Stem Battery (MSSB) works as a psychological signal for subjective attitudes, feelings and emotions draw from her scripted inner representation of world.

As it is mentioned, these instruments needs structured environment to be applied to individuals. When this process is thought in clinical frame, psychotherapy sessions provide several valuable opportunities for investigating this patterns of individuals both in relation to others and in relation to therapist. So, Luborsky's The Core Conflictual Relationship

Theme (CCRT; Luborsky, 1998) is an essential tool for research which allows for coding the relational scenarios that emerge in the treatment situation without pre-structured questions.

Luborsky's(1998) concept of The Core Conflictual Relationship Theme (CCRT) was first conceptualized from specifying the interactional patterns of patient within the session with therapist and outside with other people, in patient's perception (Luborsky, 1994). For studying the core relational patterns that patient exhibit during the therapy, the CCRT has been applied extensively. As a result of series of observations and studies, Luborsky specified three components of relationship narratives during the formulation of core relational patterns of the individuals: what is the wish of the individual in a relationship (Wish: W), how the others treated the individual (Responses of Others: RO) and how the patient reacted to their reactions (Response Self: RS). These three components have become the framework for the CCRT method.

The formulation of the CCRT from the narratives has two phases (Luborsky, 1998): locating and identifying the relationship episodes, and specifying the Core Conflictual Relationship Theme from the relationship episodes. A relationship episode is the part of the sessions that where the relational patterns in self-other narratives was clearly seen. In each relationship episode, the other individual whom the patient was interacting or building the interpersonal relationships must be obviously identified by the judges. This method also assesses the pervasiveness of patterns.

According to Crits-Christoph and Luborsky (1998), pervasiveness is defined as the degree of repetitiveness of a CCRT component across narratives of interpersonal interactions.

The reduction of the frequency of patient's conflictual relationship patterns and increase in flexibility in relational patterns are expected in a psychodynamic therapy (Tisby et. al., 2007). CCRT is one of the most reliable measure that investigate this issue by focusing on the patient's relationship patterns. Research intensifies in adult research, however there are few studies in child literature, too.

Clinically relevant therapeutic changes have occurred when using the CCRT method to measure and understand relationship conflicts. Crits-Christoph and Luborsky (1998) initially discovered that the pervasiveness of relationship patterns in a sample of depressed adults showed small but meaningful positive changes over the course of psychotherapy. Kachele, Dengler, and Scheckenburger (1990) found positive changes in relationship pattern occurred following brief psychoanalytical psychotherapy. In contrast however; Wilczek, Wienryb, Barber, Gustavsson, and Asberg (2004) found that relationship patterns did not change significantly over time. But, the separate pervasiveness of wishes, negative RO and RS decreased. Also, even though the changes were not indicate the symptom change, the positive RO and RS were increased.

When the application of CCRT in child and adolescent samples were reviewed, it can be seen that the CCRT studies focused on adult samples;

only few studies was found for child and adolescent samples. According to Luborsky and his colleagues research (1998), the CCRT clusters remains relatively constant from age 3 to age 5. In this study, the lists of standard categories of CCRT were simplified by cluster analysis to only 8 clusters. According to results, most children had a high pervasiveness within their top two clusters, with the remaining six clusters having considerably less pervasiveness. The positive responses were significantly more observed and the negative responses were significantly less observed in child and adolescent samples compared with adult samples.

In another study, Waldinger, Toth, and Gerber (2001) investigated the differences in CCRT among maltreated and non-maltreated children by using The MacArthur Story Stem Battery. Children's representations of self and other were extracted from the resulting stories using the CCRT Method. According to results, both physically abused and neglected children represented the self as angry and wish for opposing others more frequently. Neglected children represented others as hurt, sad, or anxious more frequently than both abused and non-maltreated children. Compared with all other children, sexually abused children represented others more frequently as liking them, and compared with physically abused children, expressed more frequent wishes to be close to others. In the other study of Waldinger and his colleagues (2002) stated that the CCRT patterns of adolescents were relatively stable over the years. The research team was first interviewed with the adolescents when they were 14 to 17 years old, then the interviewed was

replicated again when they became 20 years old. It was found that the patterns were similar to each other in two different time points.

Agin and Fodor (1996) compared the CCRT profiles of two adolescents who had referred to therapy for the symptoms excessive aggression. The adolescents were treated in different treatment modalities; Gestalt Therapy and Rational Emotional Behavior Therapy. According to qualitative analysis, both patients work through and improve some of their core elements of relationship patterns.

Tishby, Raitchick and Shefler (2007) used the CCRT method for assessing the change in CCRT patterns throughout psychodynamic therapy process with 10 adolescents. Two interviews were done by using the relationship anecdote paradigm interview at the beginning of the psychotherapy process and just before the termination. It was seen that at the end of the therapy, the interactional patterns between the adolescents and their parents were found as more positive. In another study, Atzil-Slonim, Wiseman and Tishby (2015) compared two groups of clients at sequential developmental stages regarding their presenting problem, psychological distress and relationship representations over one year of psychotherapy by using CCRT method. It was found that there were no differences between the groups in the levels of representations of parents; however internal representation of the parents on issues of struggle for autonomy increased in the adolescent group whereas there was no difference in adult group.

1.6 Empirical Tendencies

General methodological preference in empirical child psychotherapy research is large sample size studies, especially randomized clinical trials (RCTs) (Schmidt & Schimmelmann, 2013). These studies that investigate the casual relationships, effectiveness of different type of psychotherapies and differences between the outcomes of psychotherapies can be designed by large scale studies.

Although RCT design is valid and compelling as a method for testing causal relationships between therapy and outcome, its validity threats and methodological limitations have been widely noted (Barker, Pistrang, & Elliott, 2002; Haaga& Stiles, 2000; Shadish, Cook, & Campbell, 2002). Hence, especially in research of psychodynamic child therapy research, some concerns are likely to appear about RCTs (Fonagy, 2002). According to Slade and Pribe (2001), the conceptual disadvantages in RCTs are stated as being group-level research designs, generalization and bias in the evidence base. One of the main difficulties is the diagnosis-based interventions were lack of focus on individualized formulations and treatment modalities. In other words, the large-n studies underestimate the psychic structure in which to elaborate the internal states of individual which is the main basis of psychodynamic child psychotherapy process (Rustin, 2003). Secondly, regarding generalizability issue, statistically Fonagy (2002), stated that most of the studies with large Ns and RCTs are low in external validity even though they are high in external validity

(Weisz et. al., 2005). Furthermore, generalizability can be built into case studies as well through a combination of purposeful case election, use of standardized measures and theoretical sensitivity (Mcleod, 2010). Finally regarding the bias in the evidence base, McLeod (2010) argues that generating bias is valid for all types of research. He identifies four main strategies that have been developed for dealing with this problem: researcher reflexivity, making use of independent 'objective' evidence, making use of multiple researchers, benchmarking against established interpretive criteria.

So, drawbacks related with the large N and RCTs studies leads researchers and clinicians to focus on single-case studies in which most of the disadvantages listed above is overcome by this way.

1.7 Single Case Design

These methodological considerations lead researchers to find different solutions for obtaining more useful and detailed data from the psychotherapeutic work without underestimating patients' individual background and theoretical conceptualizations.

Single case experimental designs are developed for the aim of both preventing the underestimation of uniqueness of each case and insufficiencies in traditional case studies. Single case experimental designs are empirical study of what actually takes place in psychotherapy treatment. So, the prominence of this kind of design comes from mainly because it is a huge opportunity to gain understanding of what takes place during the

therapeutic change process. It is also means by which we systematically explore why and how changes take place as the consequence of therapeutic intervention (Midgley et. al., 2009; Philips, 2009; Elliot, 2010).

According to McLeod (2010) single case studies are based on four different methodological principles:

1. *Reliable and valid measurement of outcome variables:* In single case studies, the measurement of various aspects of participant's behavior, cognition, physiological functioning or social attitude is prominent, especially these attitudes are the target of change. Related with this, the usage of self-report rating scales or questionnaires has been increasing. These standardized instruments are beneficial in making it possible to compare a case study participant with a wider population.
2. *Accurate description of the intervention that is being assessed:* The aim in single case designs is to be as precise as possible about what is caused by what. Therefore, it is usual to find week by week notes regarding sessions. Also, n=1 studies often describe the therapy in detail by taking into consideration several different components for providing readers to find out what therapist would have done to deliver each intervention (see Play Assessment section for some examples of process measures).
3. *Time-series analysis of patterns of change:* Through time-series analysis the accurate effect of the interventions were detected in a

more reliable and valid way. A time series analysis involves the construction of a graph that charts the week by week change in target behavior. By time series analysis, a baseline can be established in order evaluate to the effects of the therapy compared.

4. *The logic of replication:* By taking into consideration several different dimensions, single case designs provides systematic and detailed information regarding the therapy process. However, generalizability is an important and sensitive issue for this kind of designs. So, only by conducting a series of case studies, the results can be generalized.

Since the objectives of this research is more suitable for micro analysis, single case design will be used. Two single cases will be analyzed and discussed regarding the theoretical conceptualizations and statistical results.

1.8 Aim and Hypothesis of the Study

Play is a natural way of communication in child's psychotherapy. It hosts many characters reflective of a child's internal representations of herself or himself and others as well as his social interpersonal representations (Winnicott, 1967). However, every child unique level of functioning is different from each other. If a child is unable to exhibit his representations in a rich and flexible manner, some problems in interpersonal relations such as difficulty in differentiation between self and

others and lack of empathy can be observed (Chazan, 2002). At this point therapeutic action can be enhanced the richness in representations and provide a space for the expression of conflictual relational patterns. Throughout the psychotherapy, child construct a mutual play matrix with therapist where his subjective self-experience in relation to others were expressed (Baranger, 2008). The child's capacity to use the play field in a way where multiple representations are actualized is also a chance to bring core conflictual relations to therapy. As these core conflicts are realized in therapy, the child finds a way to transform them towards more adaptive ways of relating to herself or himself and others.

So, the aim of this study is to investigate the relationship between the level of social representations enacted in play and the change in conflictual relational pattern over the course of psychotherapy process through an empirical investigation of two single case studies. For this aim, these specific hypothesis will be tested:

Hypothesis.1 The relational episodes as assessed by CCRT pervasiveness scores will increase in middle phase of the therapy and decrease in the end.

Hypothesis.2 If the therapy is working, there will be an increase in the level of social representations enacted in play as assessed by the CPTI.

Hypothesis 3. The level of social representation as assessed by CPTI will positively correlate with the pervasiveness scores of CCRT.

*Hypothesis 4.*The play disorganization level as assessed by CPTI will be positively correlated with the CCRT pervasiveness score.

2. METHOD

2.1 Data

The data was provided by Istanbul Bilgi University Psychotherapy Research Laboratory which was founded for studying the psychotherapy outcome and process studies. The data was collected in Istanbul Bilgi University Psychological Counseling Center. Psychotherapists in this center are graduate students in clinical psychology MA program and they are having their professional clinical training. The center is established to provide long term psychological services for outpatients.

2.2 Participants

Cases of the study were selected considering the similarity between their demographics, gender, behavioral problems at the beginning and the number of sessions they took.

*Patient #1.*Patient #1 was a six-year-old male. Reason for referral was difficulty in maintaining his attention accompanied with aggressive and impulsive behaviors. The patient's lack of attention and impulsive behaviors intensified after he started first grade. In the initial interview, his parents reported that Patient#1 had difficulty in maintaining his attention especially in academic settings. He refused to do his homework and got distracted easily. Also, parents mentioned his impulsive behaviors especially when they were

outside. They got into fights quite frequently about "behaving properly" and eventually they start opposing each other in every little incident. It is important to mention that the mother had two difficult losses just after the birth of the patient, her father and her grandfather. She told that after these losses she felt depressed and used antidepressants during three months, and she probably could not provide attention to her child during this process. In terms of general family dynamics, the mother was in the position who provided affection and love to Patient#1. On the other hand, the father was the figure that always made speeches about how to behave properly and how to be “an upright man”; that is to say he is the prescriptive and rigid figure. The father tried to actualize his ideals over his child and it created psychological pressure on the patient. When they behaved stubbornly towards each other, Patient#1 got punishments such as sitting in his room on his own and during these punishments, father continuously talked about responsibilities. Family had a middle socio-economic status.

Regarding play themes of Patient#1, aggression and anxiety are the main themes in his play. The characters are double-edged; in other words while one character is more omnipotent and powerful, the other one is anxious and vulnerable. Especially when he enacts his conflictual issues in play, the wishes of hurting others for powerful characters and the reactions of being hurt for vulnerable characters can be observed frequently. This play theme is meaningful within the

scope of the family dynamics when considering the oppressive attitudes of father and passiveness of mother. During the psychotherapy process, patient had the opportunity to bring his conflictual patterns to therapy in an understanding and supportive environment.

The wish of CCRT pattern for Patient#1 was to oppose and hurt others. The response of self that constituted the CCRT pattern was to hurt and to be anxious. Lastly the response self-pattern was to hurt and oppose other.

*Patient #2.*Patient #2 is a four-year-old male. Reason for referral was difficulties in self-soiling accompanied with aggressive and obstinacy behaviors. In the initial interview, parents mentioned that even though Patient#2 had completed his toilette training; due to some medical condition in his posterior, he started having difficulty in defecation. After some medical interventions the problem was solved, however the patient remained aggressive and persistent. Especially when he had stomach-ache his aggressive and impulsive behaviors were increased. Besides this situation, parents mentioned that from the beginning of his toddlerhood, patient started his aggressive and persistent behaviors, especially towards his sister who is 11 years older than him. Mother had had three miscarriages after their first child and after these incidents, she became pregnant by in vitro fertilization. After the birth, Patient#2 was seen as "a

miracle baby". Because both parents were working until late hours, the patient was raised by his grandmother mostly. It is prominent to note that the parenting attitudes of the mother and grandmother were totally different from each other; so that is to say the patient had two different figures as caregiver. While grandmother was more compliable towards patient's demands, the mother was more rigid and stinting. The father figure was passive and not efficient. Family had a middle socio-economic status.

When the play themes of Patient#2 is observed, conflictual relational patterns, especially based on aggression and destruction, can be seen frequently. The characters in play generally have oppositional tendencies, however after a while, one of the parties becomes anxious and hurt. On the other hand, the need for feeling comfortable and accepted is observed starting from the beginning of the psychotherapy process. Over the course of psychotherapy, the destructiveness and aggression of the patient was frequently enacted in room and met with containment of therapist.

The wish of CCRT pattern for Patient#2 was to oppose and hurt others. The response of self that constituted the CCRT pattern was to hurt and to be anxious. Lastly the response self-pattern was to hurt and oppose other.

2.3 Therapists

Patients had their psychotherapy process with different therapists who were second year clinical psychology MA students and continued the same educational program. They were therapists in counseling center of the University for their internship. Therapists took weekly supervisions from more experienced child psychotherapists regarding the patients in this research. Both of therapists' had same degree of experience in child psychotherapy field and both of them are female with between the ages 25-27.

2.4 Setting and Psychotherapy Process

During the psychotherapy process, a comprehensive assessment procedure was conducted for children. The same assessments were repeated in termination process. In initial session, parents had a semi-structured intake session for obtaining information about the psychodynamic background of the child. Also, parents were given the Child Behavior Checklist (CBCL; Achenbach, 1991) to rate the child's current problematic behaviors and psychosocial functioning. After having four session with child, according to the clinical observation of therapist and the information obtained from the family, the therapist rates the Global Assessment of Functioning Scale (CGAS; Shaffer, 1983). Informed consent form was obtained from the parents before videotaping the sessions.

The psychotherapy process took place in standardized play therapy rooms in counseling center. In therapy rooms, there were several different toys and materials that were suitable for play therapy with children. As treatment, psychodynamic play therapy was applied. In the scope of non-directional play therapy, therapist's function in the room was to accompany the child to provide safe and containing environment and facilitate child's capacity to play.

2.5 Measures

For this research four different measures were used: two outcome measures, The Child Behavior Checklist (CBCL; Achenbach, 2001) and Children's Global Assessment Scale (CGAS; Shaffer, 1983), and two assessment measures, The Children Play Therapy Instrument (CPTI; Kernberg, Chazan & Normandin, 1998) and Core Conflictual Relationship Theme Method (CCRT; Luborsky & Crits-Christoph, 1990).

2.5.1 Outcome Measures

2.5.1.1 The Child Behavior Checklist (CBCL)

The Child Behavior Checklist (CBCL) is an extensively used instrument to assess symptoms and common behaviors of children and adolescents between the ages 6 to 18 (Achenbach, 1999). The CBCL form is rated by parents or primary caregivers of the child. Those who fill the form are expected to grade 113 items on a 3 point likert scale which is designed as 2 points represent very true or often true, 1 points represent somewhat or sometimes true and 0 points represent not true. Statements in checklist scan the academic performance, emotional regulation and social relationships.

Based on the factor analyses, 8 main areas are identified under the name of empirically based syndrome scales: Anxious/Depressed, Withdrawn/Depressed, Somatic Complaints, Social Problems, Thought Problems, Attention Problems, Rule-Breaking Behavior and Aggressive Behavior. The Rule Breaking Behavior and Aggressive Behavior are categorized as externalizing subgroup. Anxious/Depressed, Withdrawn/Depressed and Somatic Complaints are categorized as internalizing subgroup. Furthermore, a total score is obtained from all problem items. Based on t-scores, calculations of clinical population provide cut-off points for the borderline or clinical levels.

Turkish translation and standardization of the CBCL was conducted by Erol and Simsek (2000) by bilingual retest method. The test–retest reliability of the Turkish form is .84 for the Total Problems, and the internal consistency is .88 (Erol, Arslan, & Akcakin, 1995; Erol & Simsek, 2000).

2.5.1.2. Children's Global Assessment Scale (CGAS)

Shaffer (1983) developed the Children's Global Assessment Scale (CGAS) for assessing the general functioning of children. The rating is done by the clinicians. After the clinical observation of the clinician, child got a score which ranges from 1 (the most impaired level) to 100 (superior level of functioning). The CGAS is separated into 10- point intervals. Each interval represents a different level of functioning. According to Mufson and colleagues (2004) CGAS was sensitive in term of catching the change in

clinical processes. Also, the level of reliability and validity was high. According to Shrout (1998), the inter-rater reliability was remarkable and the intra-class correlation coefficient (ICC) was found as 0.84. Also, concurrent and discriminant validity was found for the scale (Weissman et. al. 1990).

2.5.1.3. Reliable Change Index

Reliable Change Index (RCI; Jacobson & Truax, 1991) indicates the change in patients' symptoms and behaviors reported via CBCL. It is a standardized score that used for the investigation of whether a change in an individual score before and after psychotherapy process is statistically significant or not. It is defined as the change in a patient's score divided by the standard error of the difference for the test being used. If the RCI is higher than 1.96, then the change is statistically significant. If the RCI is lower than 1.96, then the difference is not significant. Point 1.96 equated to the 95% confidence interval.

Through Reliable Change Index, change in clients' symptoms and behaviors reported in the Child behavior Checklist during the psychotherapy process was evaluated. For Patient#1 no change has been reported in Reliable Change Index Scores of CBCL (Parent) Externalizing Behaviors (RCI=1, 18), CBCL Internalizing Behaviors (RCI=0, 92) and CBCL Total (RCI=1, 39). On the other hand, for patient #2, there is a change according to Reliable Change Index Scores in CBCL (Parent) Externalizing Behaviors (RCI=2,25) and CBCL (Parent) Total (RCI=1,96); and no change reported

in CBCL (Parent) Internalizing Behaviors (RCI=0,34). This scores indicated that while Patient#2 clinically significant progress with the reported symptoms over the course of the psychotherapy process, Patient#1 showed no clinically significant change in the symptoms (see Table 1).

The intake assessment CGAS score of Patient#1 is 58 which corresponds to moderate difficulty in social occupational or social functioning; and the termination GAF score is 70 which corresponded some difficulty in social, occupational, or school functioning. So, although parents did not report progress regarding the child, the therapist observed a progress in psychosocial competencies. The intake assessment CGAS score of Patient#2 is 68, which means some difficulty in social, occupational or school functioning; and termination CGAS score is 75 which equals to no more than slight impairment in social, occupational or school functioning. So, in this case both parents and the therapist reported change in psychosocial competencies of Patient#2 (see Table 1).

Table 1. Calculations of Outcome Scores for Patient#1 and Patient#2

	Assessment GAF	Termination GAF	CBCL Externalizing RCI	CBCL Internalizing RCI	CBCL Total RCI
Patient #1	58	70	1,18	0,34	1,39
Patient #2	68	75	2,25*	0,92	1,96*

** Significant scores according to RCI.*

2. 5. 2. Process Measures

2. 5. 2. 1. The Children Play Therapy Instrument (CPTI)

The Children Play Therapy Instrument (CPTI; Kernberg, Chazan&Normandin, 1998) was developed for assessing the child's play in the psychotherapy process. It can be used as an objective instrument to measure change and outcome in child treatment using the child's play activity as an index of the child's functioning in treatment.

Segmentation

The first step in the application of CPTI is the categorization and discrimination of child's behaviors in therapy session. There are four different types of activity are named as Play, Pre-Play, Non-Play, and Play Interruption. Non-play is the category which includes a variety of behaviors or activities that outside the realm of play activity. Pre-Play is the category

that refer the preparation of play activity. In other words, Chazan (2002) described this category as 'setting the stage' (p.213) for the play. Play activity is the state in which child is actually engaging and maintaining the play. It can be identify by scanning the clues of an expression of intent, actions indicating initiative, an expression affects, focused attention and development of a narrative by using toy objects. Play Interruption refers to the situation when child leaves the room. For example going to bathroom, leaving the room for seeing own parents can be counted as play interruption.

Dimensional Analysis

After the segmentation, only play segments are coded. According to Dimensional Analysis, three dimensions are constituted for examination of play activity: Descriptive Analysis, Structural Analysis and Functional Analysis (see Table 2). Every category has different subscales and 5-point Likert scale is used for rating (5: Most Characteristic, 1: No Evidence) (Chazan, 2000).

Table 2. Dimensions of CPTI Used For Assessing the Play Activity Segments within Sessions (Halfon, Çavdar & Akırmak, unpublished manuscript)

DESCRIPTIVE ANALYSIS
Category of the Play Activity: *Gross Motor Activity, Exploratory Activity, Manipulation, Fantasy, Game Play, Art*
Script Description of the Play Activity: *Initiation of Play, Facilitation of Play, Inhibition of Play, Ending of Play*
Sphere of the Play Activity: *Autosphere, Microsphere, Macrospheres*
STRUCTURAL ANALYSIS
Affective Components of the Play Activity - Child's Affective Modulation: *Hedonic Tone, Spectrum of Affects, Regulation of Affect, Transition between Affects, Appropriateness of Affect to Content* - Affects Expressed by the Child: *Anger, Anxiety, Fear, Boredom, Pleasure, Sadness, Shame, Guilt*
Cognitive Components of the Play Activity - Level of Representation: *Complex Roles, Dyadic Roles, Solitary Roles* - Stability of Representations: *Stable/Fluid Transformations, Voluntary/Involuntary Transformations* - Style of Representation: *Realistic, Magical, Bizarre* - Use of Play Object: *Realistic, Substitution, Sensory*
Narrative Components of the Play Activity -Play Themes: *Aggression, Attachment (Nurture, Separation), Body, Cleaning, Competition, Construction / Destruction, Danger / Protection , Death, Rules, Sex / Reproduction and Torture*
Relational Components of the Play Activity - Level of Relationship Portrayed: *Self, Dyadic Relations, Triadic Relations, Oedipal Relations* - Quality of Relationship among Characters: *Autonomous, Parallel, Dependent, Twinning, Malevolent Control, Destruction and Annihilation*
Use of Language by the Child: *Silence, Sounds, Verbalization of Roles, Talking about the Play, Talking about Something Other than the Play, Talking about the Meaning of Play*
DEVELOPMENTAL ANALYSIS
Social Level of the Play Activity*: Isolated, Play Alone, Parallel Play, Reciprocal Play, Cooperative Play*
FUNCTIONAL ANALYSIS
Coping and Defensive Strategies *(Cluster 1: Adaptive, Cluster 2: Conflicted, Cluster3:Polarized, Cluster 4:Extreme Anxiety)*
Awareness of the Child that He is in Play

Descriptive Analysis

Descriptive analysis is composed of three sub scales: category of play activity, script description and sphere of play activity.

Category of play activity indicates different types of play that child exhibits during his play activity. The categories are defined as gross motor activity, exploration, manipulation, fantasy, game play and art. Two of the most characteristic activities are selected.

Script description measures the child's capacity to organize and initiate play. The degree of initiation, facilitation and inhibition by child during the play activity are assessed. Also, the reason of ending the play activity is identified in this subscale.

Sphere of the play activity component assesses the spatial features of the play activity. This subscale consists of three components: If the focus of the child's play is on his or her body, autosphere; if the focus of the child's play is on toys and if he or she is playing with these toys in a small settings, microsphere; and if the focus of the child's plays spread the entire room, macrosphere.

Structural Analysis

In structural analysis, the affective, cognitive, narrative and developmental components of the play are measured.

Affective components consists of the assessment of overall hedonic tone, spectrum of affects, affect regulation, affective transitions, appropriateness of the affective tone and range of eight types of emotions.

Cognitive components of the play are measured to see the capacity of creating narrative structures to exhibit his representations. Cognitive components of play consists of four subscales. The first one, Level of Representations, indicates how a child utilizes character roles. Three different level of representations are identified: If the child creates multiple characters in his play, Complex; if the child interacts with any other character and a duality is observed; Dyadic; and if only one character is depicted; Solitary. The second subscale of cognitive component is stability of representation which evaluates the amount and quality of transformation of representations in play. The representations can be stable, fluid, or no transformation is observed. Also type of transformations are assessed too under the categories of voluntary, involuntary and mixed types of transformations. Third subscale in this component is the use of play object. This subscale includes three options: the realistic use of play object, substitution of play object and using object as sensory input. Finally last subscale in this component is the style of representations which are categorized as realistic, magical and bizarre.

Narrative components consider the theme and topic of the play. According to the content of play, the absence or presence of the following themes are marked: Aggression, Attachment (Nurture, Separation, Body,

Cleaning, Competition, Construction / Destruction, Danger / Protection, Death, Rules, Sex / Reproduction and Torture. Moreover, the quality of relationship is stated by coding the autonomous, parallel, dependent, twinning, malevolent control, destruction and annihilation options. Also, in this component the level of relationship is assessed. If the child is playing with one character, self; if there are two characters including the therapist and the child, dyadic; if there are more than two characters, triadic; and finally if there is plenty of characters and there is generational difference such as mother - father - child, oedipal section is coded. Furthermore, language codes such as silence/utterances, verbalization of roles, talking about play, talking about the meaning of play and talking about something other than play are coded according to the usage of language and sounds of the child.

Even though developmental component consists of more subscales, due to reliability problems (Chazan, 1998) the sections that compare the chronological age and gender are not included in this research. Only social level of play is assessed, which gives the information about the interaction between the child and the therapist. Isolated play, playing alone, parallel play, reciprocal play and cooperative play are the dimensions in social level of play.

Functional Analysis

Finally in functional analysis, the child's observable play behaviors are classified as manifesting specific coping/defensive strategies grouped

into four clusters: defense cluster 1 (adaptive strategies), defense cluster 2 (conflicted; neurotic defenses such as avoidance, somatization, obsession etc.), defense cluster 3 (polarized; borderline defenses such as projection, introjection, split etc.) and defense cluster 4 (extreme anxiety; psychotic defenses such as fusion, dispersal etc.). Besides, child's level of awareness regarding the play is coded.

According to Kernberg, Chazan and Normandin's reliability study (1998), the agreement for segmentation was found as good (Kappa = 0.72). Also, the interrater reliability was found as ranged from acceptable to excellent (ICC = 0.52 - 0.89; x 0.71) for ordinal categories, and for nominal categories it was acceptable (Kappa = 0.42 - 1.00; x 0.65).

CPTI was translated into Turkish by Istanbul Bilgi University Psychotherapy Research Laboratory Team. The interrater reliability was found as ranged from good to excellent (ICC = 0.78 - 0.89) for ordinal categories, and for nominal categories it was ranged from good to excellent as well (Kappa = 0.84 - 1.00).

An Exploratory Factor Analysis was calculated for CPTI variables (Halfon, Çavdar & Akırmak, 2015, unpublished manuscript). Factor analysis deduced 5-factor solutions found to be statistically and theoretically more meaningful: Isolated Relations in which shows the level of isolation of child within the play, Complex Relations in which represents more advanced form of relating and shows the capacity of child to engage in a play activity with multiple characters; Affect Modulation in which indicate

the capacity to regulate and modulate the affective dimensions; Play Disorganization in which the representational style and the lower levels of defenses are represented, and finally Play Engagement in which the degree of engagement of the child regarding the play activity is shown. The internal consistencies for all factors were satisfactory. The details of factor structure and factor loadings can be seen in Table 3 and 4.

Table 3. *Cronbach Alpha Coefficients and Descriptive Statistics for Each Factor in CPTI.*

	Number of Items	Cronbach Alpha	Mean	SD
F1 Isolated Relations	5	,87	1,78	0,86
F2 Complex Relations	4	,72	1,61	0,72
F3 Affect Modulation	5	,74	3,36	0,50
F4 Play Disorganization	6	,73	1,56	0,56
F5 Play Engagement	3	,63	4,02	0,59

Table 4. *Factor Structures of CPTI Variables*

Factor1:Isolated Relations	Play Alone Solitary Roles Single Character Silence Reciprocal Play
Factor2: Complex Relations	Complex Roles Oedipal Relations Verbalizations of Roles Triadic Relations
Factor3: Affect Modulation	Awareness of Being in Play Defense Cluster1 Affect Transitions Affect Appropriateness Affect Regulation
Factor4: Play Disorganization	Magical Representations Realistic Representations Defense Cluster 4 Bizarre Representations Defense Cluster 3 Transformation of Roles
Factor5: Play Engagement	Inhibition of Play Hedonic Tone Facilitation of Play

2. 5. 2. 2. The Core Conflictual Relationship Theme Method (CCRT)

The Core Conflictual Relationship Method (CCRT; Luborsky & Crits-Christoph, 1998) is identified through the narratives of patients, and sometimes even enactments, in therapy process. There are two phases for identification of CCRT from the narratives: The first phase is for specifying the relationship episodes during the session and the second phase is designating the CCRT from these relationship episodes.

A relationship episode is specified according to the part of a session where the patient manifests a clear narrative about relationships with others. In each relationship episode the interaction between the main other person or object and patient must be clearly identified. The recognition of these episodes must include the beginning, middle and ending phase of the interaction. Narratives are generally formed by the patient's characteristics regarding the patterns of relationship representations (Luborsky, Popp, Luborsky & Mark, 1994).

Once the sessions were transcribed and the relationship episodes is determined, the main relational theme is identified. Three components are to be identified in each relationship episode: the wishes, needs, or intentions (W); the responses from others (RO), and the responses of self (RS). In first place, the identification of central relationship theme is made according to judge's own clinical observation by using their own words without taking any standardized categories as a base Later on, an additional method was

developed to standardize the observations. In this method, there are common categories and all judges labeled the relational episodes according to these categories. The standard categories of three components are clustered by Luborsky and Crits-Christoph (1998). 8 standard categories for the wishes, 8 standard categories for the response from other, and 8 standard categories for the responses of self can be seen in Table 5.

Table 5. *Core Conflictual Relationship Theme (CCRT) Standard Category Clusters (Luborsky & Crits-Christoph, 1990)*

	Wishes (W)		Responses of Others (RO)		Responses of Self (RS)
W1	To Assert Myself & Be Independent *To have self-control, to be my own person*	RO1	Strong *independent, happy*	RS1	Helpful *am open, understand*
W2	To Oppose, Hurt & Control Others	RO2	Controlling *Strict*	RS2	Unreceptive *Don't understand, am not open, dislike others*
W3	To Be Controlled, Hurt & Not *Responsible not obligated, not helped, to be like others*	RO3	Upset Hurt, dependent, *anxious, angry, out of control*	RS3	Respected & Accepted Feel comfortable, *happy, loved, feel like others*
W4	To Be Distant & Avoid Conflicts *to not be hurt*	RO4	Bad *Not trustworthy*	RS4	Oppose & Hurt Others
W5	To Be Close & Accepting *To respect others, to be open, to have trust, to be opened up to*	RO5	Rejecting & Opposing *Doesn't trust me, doesn't respect me, is not understanding, dislikes me, is distant, unhelpful, hurts me*	RS5	Self-Controlled & Self-Confident *Independent, in control*
W6	To Be Loved & Understood *To be respected, accepted, liked*	RO6	Helpful *cooperative*	RS6	Helpless *Out of control, uncertain, dependent*

W7	To Feel Good &Comfortable *To have stability, to feel happy, to feel good about myself*	RO7	Likes Me *Respects me, loves me, gives me independence*	RS7	Disappointed & Depressed *Angry, unloved, jealous*
W8	To Achieve & Help Others *To better myself, to be good*	RO8	Understanding *Open, accepting*	RS8	Anxious & Ashamed *Guilty*

After coding the data, a pervasiveness score is calculated. The pervasiveness score gives the pervasiveness of different relationship patterns across the therapy process. With this score, the percentage of change in central relationship patterns can be observed. To calculate this score, the frequency scores of a specified relationship pattern (generally the core conflictual relationship theme) was derived and these scores were divided by the total number of relationship episode:

$$CCRT\ Pervasiveness = \frac{Number\ of\ REs\ that\ include\ the\ CCRT\ component}{Total\ REs\ in\ the\ segment\ or\ session}$$

In this study, transcripts of 13 sessions for Patient#1 and 16 sessions for Patient#2 were coded with CCRT Method. 76 relationship episodes for Patient#1 and 146 relationship episodes for Patient#2 were identified to score each of the three components. For each patient a core conflictual relationship pattern was identified and the pervasiveness scores of these patterns were calculated.

The interrater validity of CCRT Method was found as satisfactory .68 (p<.01) (Crits-Christoph et. al., 1998). Also, for the identification of other whom the patient was interacting during the relational episode, the inter-rater agreement was found as satisfactory. 89% had same other person identified by both judges. To determine the reliability of standard categories Cohen's weighted kappa (as cited in Luborsky, 1994) was used. In contrast to regular kappa, weighted kappa (Cohen, 1968) allows different weights for different levels of agreement. It means that a higher weight can be given if agreement between the two judges occur on the most frequent clustered standard categories. This also means that a lower weight can be given if the agreement is not provided between the judges. In a review of interrater reliability coding relationship themes across eight CCRT studies (Luborsky & Diguer, 1998), mean weighted kappa's were wishes .60, responses of others .68, and responses of self .71.

For this study, 15 sessions were coded by two independent judges for reliability. To correct the chance agreement, the weighted kappa (Cohen, 1968; Crits-Christoph et. al, 1998; Sim & Wright, 2005) were calculated for assessing the interjudge reliability of the three CCRT components. This calculation was performed separately for wish, responses of other and responses of self. The strength of agreement was very good, for wish category .97, for responses of other category .94 and for responses of self-category .94.

2. 6. Procedure of the Study

The sessions of the two patient were recorded and transcribed on weekly basis. During the treatment Patient#1 had 24 sessions and Patient#2 had 22 sessions. Number of the sessions recorded for Patient#1 was 13 sessions and for Patient#2 16 sessions. The distribution of the sessions are more or less equal between beginning, middle and late sessions. By using the CPTI, the sessions were segmented and the play segments were coded. The number of play segments for Patient#1 is 43 and for Patient#2 is 19. After coding the play segments according to CPTI, the factor scores calculated for each factor structure (Halfon, Çavdar & Akırmak, unpublished manuscript). For CCRT coding, first of all, the relational episodes were extracted in play segments. Then, the relational patterns were identified according to standard category clusters (Luborsky & Crits-Christoph, 1998) and the most frequent relational pattern was identified as core conflictual relationship theme. Later, the pervasiveness scores of core conflictual relationship theme and the pervasiveness scores of wish, response of other and responses of self-components of the identified core conflictual relationship were calculated separately for every segment.

3. Results

3.1. Data Analysis

For the analysis of the data set both descriptive, quantitative and qualitative analyses will be done. In the first place, the descriptive analysis of the data set will be given and hypothesis 1 will be descriptively analyzed. Secondly, in order to test the hypothesis 2, linear regression analysis will be conducted. For testing hypothesis 3 and 4 partial correlation tests will be performed. However, before this analysis, as there are three CPTI factors and four CCRT related pervasiveness score in data set, it is theoretically assumed that there will be common variance among these variables. Following this assumption, the Principal Component Analysis (PCA) is conducted to determine this common variance (Distefano, Zhu & Mindrila, 2013). Then partial correlation will be conducted by considering the results of PCA analysis. Finally, psychotherapy process will be qualitatively analyzed.

3. 2. Descriptive Analysis

Since the data set is complex and there are several variables, it is important to give the descriptive analysis of the data set in order to have general opinion. In this section, the categorical data of CPTI and pervasiveness scores of CCRT are given.

In table 6, the descriptive analysis for action type as assessed by CPTI is presented for both patients. There are four different action types: Non-Play, Pre-Play, Play and Interruption. It can be seen that both patients had similar percentages in play activity (44,3% for Patient#1, and 43,2% for Patient#2), even though a difference have been observed in terms of the total segment number.

Table 6.*Descriptive Analysis for Action Type as Assessed by CPTI for Patient#1 and Patient#2*

	Action Type	Frequency	Percentage
Patient #1	Non Play	22	22,7%
	Pre Play	23	23,7%
	Play	43	44,3%
	Interruption	9	9,3%
	Total	97	100%
Patient #2	Non Play	18	40,9%
	Pre Play	6	13,6%
	Play	19	43,2%
	Interruption	1	2,3%
	Total	44	100%

The descriptive analysis for play category as assessed by CPTI for both patients is demonstrated in Table 8. There are six different play categories (for detail see method): Art, Exploration, Fantasy, Game Play, Gross Motor Activity and Manipulation. According to percentages, it can be observed that, Patient#1 preferred various different play categories, whereas Patient#2 preferred dominantly fantasy play in his sessions.

Table 7.*Descriptive Analysis for Play Category as Assessed by CPTI for Patient#1 and Patient#2*

	Play Category	Frequency	Percentage
Patient #1	Art	2	4,7%
	Exploration	2	4,7%
	Fantasy	12	27,9%
	Game Play	6	14%
	Gross Motor Activity	10	23,3%
	Manipulation	11	25,6%
	Total	43	100%
Patient #2	Art	0	0%
	Exploration	2	10,5%
	Fantasy	16	84,2%
	Game Play	0	0%
	Gross Motor Activity	1	5,3%
	Manipulation	0	0%
	Total	19	100%

For both patients, descriptive analysis for play themes as assessed by CPTI are represented in Table 8. Patients preferred eight different play theme categories: Aggression, Attachment, Body, Cleaning, Competition, Construction/Destruction, Death and Rules. Both patients dominantly play the Aggression theme in their play activity (71,2% for Patient#1, 73,7% for Patient#2).

Table 8. *Descriptive Analysis for Play Themes as Assessed by CPTI for Patient#1 and Patient#2*

	Play Themes	Frequency	Percentage
Patient #1	Aggression	31	72,1%
	Attachment	0	0%
	Body	1	2,3%
	Cleaning	1	2,3%
	Competition	4	9,3%
	Construction/Destruction	4	9,3%
	Death	1	2,3%
	Rules	1	2,3%
	Total	43	100%
Patient #2	Aggression	14	73,7%
	Attachment	4	21,1%
	Body	0	0%
	Cleaning	0	0%
	Competition	1	5,3%
	Construction/Destruction	0	0%
	Death	0	0%
	Rules	0	0%
	Total	19	100%

Hypothesis 1. *The relational episodes as assessed by CCRT pervasiveness scores will be increase in middle phase of the therapy and decrease in the end.*

As previously mentioned in method section, for Patient#1 and Patient#2, the same CCRT patterns were found. To explore hypothesis 1, two sessions from the beginning, two sessions from middle sessions and two

sessions from the late sessions of psychotherapy process were selected. The pervasiveness scores of CCRT patterns in these sessions were calculated for both patients. The scores are portrayed in Table 9. For patient#1, in early sessions the pervasiveness score of CCRT pattern is .17, for mid sessions .45 and for late sessions .30. For patient#2, in early sessions the pervasiveness score of CCRT pattern is .50, for mid sessions .45 and for late sessions .10.

Table 9.*CCRT Pervasiveness Scores as Assessed by CCRT Method for Patient#1 and Patient#2*

	Early Sessions	Mid Sessions	Late Sessions
Patient #1	.17	.45	.30
Patient #2	.50	.45	.10

3. 3. Quantitative Analysis

Hypothesis 2. *If the therapy is effective, there will be an increase in the level of social representations enacted in play as assessed by the CPTI.*

In this hypothesis, an increase is expected in social representations enacted in play if the therapy is effective. Since there are two patients, one of them showed significant clinical improvement and the other one did not show clinical improvement, for testing this hypothesis, the linear regression test is conducted for both patients. For the patient who did not show significant clinical improvement (Patient#1), calculations were made for

predicting the changes in factor 2 (complex relations) based on time. A non-significant equation was found. For the patient who showed significant clinical improvement (Patient#2), a significant increase is seen through the linear equation ($F (1, 17) = 17,036$, $p<.001$) with a R^2 of .501.

So, according to results, hypothesis 2 is given evidence for. In an effective therapy, the complex representations enacted in play are increased over the course of psychotherapy. Table 10 portrays the results of linear regression equations for both patients.

Table 10. Standardized Regression Coefficients for Capacity to Bring Multiple Representations Scores of Patient #1 and Patient #2

	B	SE	β
Patient #1	-.002	.008	-.035
Patient #2	.096	.023	.707**

**p<.001

Principal Component Analysis

Before moving on analysis between variables, the Principal Component Analysis (O'Rouke & Hatcher, 2013) was conducted in order to reduce dimensions of the data set. Thinking the correlation matrix as a multidimensional space, principal component analysis is defined as a linear combination of optimally weighted observed variables. In most analyses, only few components are retained, interpreted and used in subsequent analysis. In other words, the fundamental aim is to maximize validity by producing factor scores that are highly correlated with a given factor and to

obtain unbiased estimates of true factor scores. So, by this analysis, the regression factor scores are created, producing standardized scores similar to Z-score metric (DiStefano, Zhu & Mindrila, 2009). Regression factor scores that are obtained as a result of Principal Component Analysis predict the location of each score on the factor or component. DiStefano and colleagues (2013) states that "Following regression terminology, with this method, independent variables in the regression equation are the standardized observed values of the items in the estimated factors or components." (p.4).

In terms of this data set, on one hand, there are CPTI factors; these factors represent a way to categorize what happens within the play segment. On the other hand, there are CCRT pervasiveness; these scores represent the relational patterns of patient. Principal Component Analysis focuses on the correlation structure between the variables. So, it is useful to decide what component represents the meaningful amount of variance. Following this assumption, the Principal Component Analysis is conducted to determine the internal correlations and to clear the noise of the data separately for both patients.

According to results, for Patient#1, 6 of the 7 items correlated at minimum .4 with at least one other item. The Kaiser-Meyer-Olkin measure of sampling adequacy was .65, above the recommended value of .6. Bartlett's test of sphericity was significant (χ^2 (21) = 131,359, p < .000). The initial Eigen values showed that the first regression factor score explained 44% of the variance, the second regression factor score 24% of the variance

and the third regression factor score explained 12%. In conclusion, Principal Component Analysis found three main components explain 80% variance of data. However they are separate by construction. Second and third scores represent the internal correlations of two different measures. So, it can be concluded that the first regression factor score describes most of the variability. No rotation is made for variables, because unrotated solution is based on the idea that each variable tries to maximize variance explained (see Table 11).

Table 11.*Unrotated Component Matrix of Principal Component Analysis for Patient #1*

	Regression Factor Score 1	Regression Factor Score 2	Regression Factor Score 3
% of variance explained	44.301	24.253	12.002
Cumulative %	44.301	68.554	80.556
Capacity to Bring Multiple Representations	.607	-.425	.517
Affect Regulation	.050	.808	.506
Play Disorganization	.438	-.805	.051
CCRT Pervasiveness	.878	.093	-.146
W2 Pervasiveness	.739	.387	-.060
RO3 Pervasiveness	.905	.060	.154
RS4 Pervasiveness	.636	.234	-.515

According to results for Patient#2, 4 of the 7 items correlated at least .3 with at least one other item. The Kaiser-Meyer-Olkin measure of sampling adequacy was .66, above the recommended value of .6. Bartlett's test of sphericity was significant (χ^2 (21) = 77,878, p < .000). The initial Eigen values showed that the first regression factor score explained 50% of the variance, the second score 27% of the variance and the third one explained 7%. In conclusion, Principal Component Analysis found three main components explain 84% variance of data. However, as stated for Patient#1, the components are separate by construction. Second and third scores represent the internal correlations of two different measures. Because of this, the first component describes most of the variability. No rotation is

made for variables, because unrotated solution is based on the idea that each variable tries to maximize variance explained (see table 12).

Table 12.*Unrotated Component Matrix of Principal Component Analysis for Patient #2*

	Regression Factor Score 1	Regression Factor Score 2	Regression Factor Score 3
% of variance explained	50.319	27.593	7.761
Cumulative %	50.319	77.912	85.673
Capacity to Bring Multiple Representations	.881	.332	-.194
Affect Regulation	.853	.264	.064
Play Disorganization	.808	.444	-.056
CCRT Pervasiveness	.791	.218	.251
W2 Pervasiveness	-572	.718	.049
RO3 Pervasiveness	-.438	.712	-.472
RS4 Pervasiveness	-.470	.696	.458

So, taking into consideration the results of the Principal Component Analysis, the partial correlation is decided to conduct by controlling the regression factor score 2 and regression factor score 3 for controlling the internal correlations and the noise of the data.

Hypothesis 3.*The level of social representation as assessed by the CPTI will positively correlate with the pervasiveness scores of CCRT.*

According to results, when the regression factor score 2 and regression factor score 3 are controlled on the relationship between capacity to bring multiple representations and CCRT pervasiveness score, a positive correlation is found $r = .662$, $p = .000$ for the patient that did not show clinical improvement (Patient#1). For the patient who showed significant

clinical improvement (Patient#2), when both regression factor scores are controlled on the relationship between capacity to bring multiple representations and CCRT pervasiveness score, a negative correlation is found r = -.808, p = .000.

Hypothesis 4. *The play disorganization level as assessed by CPTI will be positively correlated with the CCRT pervasiveness score.*

When the regression factor score 2 and regression factor score 3 are controlled on the relationship between play disorganization and CCRT pervasiveness score, a positive correlation is found r = .560, p = .000 for the patient that did not show clinical improvement patient (Patient#1). For clinically improved patient (Patient#2), when the both regression factor scores are controlled on the relationship between play disorganization and CCRT pervasiveness score, a negative correlation is found r = -.724, p = .001

Table 13 and Table 14 portray the correlations between CPTI variables and CCRT variables for patient #1 and patient #2.

Table13. Partial Correlations between the CPTI Variables and CCRT Variables by Controlling Regression Factor Score 2 and Regression Factor Score 3 for Patient #1.

	CCRTper	W2per	RO3per	RS4per
Capacity to Bring Multiple Representations	.677**	.545**	.612**	.907**
Play Disorganization	.647**	.691**	.726**	.804**

**p<.001

Table14. Partial Correlations Between the CPTI Variables and CCRT Variables by Controlling Regression Factor Score 2 and Regression Factor Score 3 for Patient #2.

	CCRTper	W2per	RO3per	RS4per
Capacity to Bring Multiple Representations	-.808 **	-.657 *	-.797**	-.658*
Play Disorganization	-.724**	-.877**	-.877**	-.542*

*p<.05
**p<.001

3. 4.Clinical Analysis

Since this study is designed as a comparison of two single case processes, an additional clinical analysis is done for enhancing the understanding on descriptive and quantitative analysis and for investigating the content more in detail.

At the beginning of the qualitative analysis, for providing the integrity with the quantitative analysis, the values in regression factor score 1 in Principal Component Analysis is graphed for both patients. Because it explains the 44% of variability in data set for Patient#1 and 50% of variability for Patient#2 in data set, the graphs will indicate the change in variability of the main CCRT and CPTI variables throughout the psychotherapy process. The regression factor scores for factor 1 obtained via Principal Component Analysis were calculated as z scores and the progression of factor 1 over the course of psychotherapy process is graphed.

Time points chosen for the qualitative analysis are around or two standard deviations above or below the mean. This kind of determination is sensitive to changes in variability across the phases of single-subject design (Nourbakhsh & Ottenbacher, 1994). From the selected segments, representative session vignettes were determined to show examples of specific patterns and important points during the psychotherapy process.

3. 4. 1. Clinical Analysis for Patient#1

Figure 1 represents the line of regression factor score 1 over the course of therapy for Patient #1. According to time points that around or above ±2 standard deviations, the qualitative analysis is going to be done.

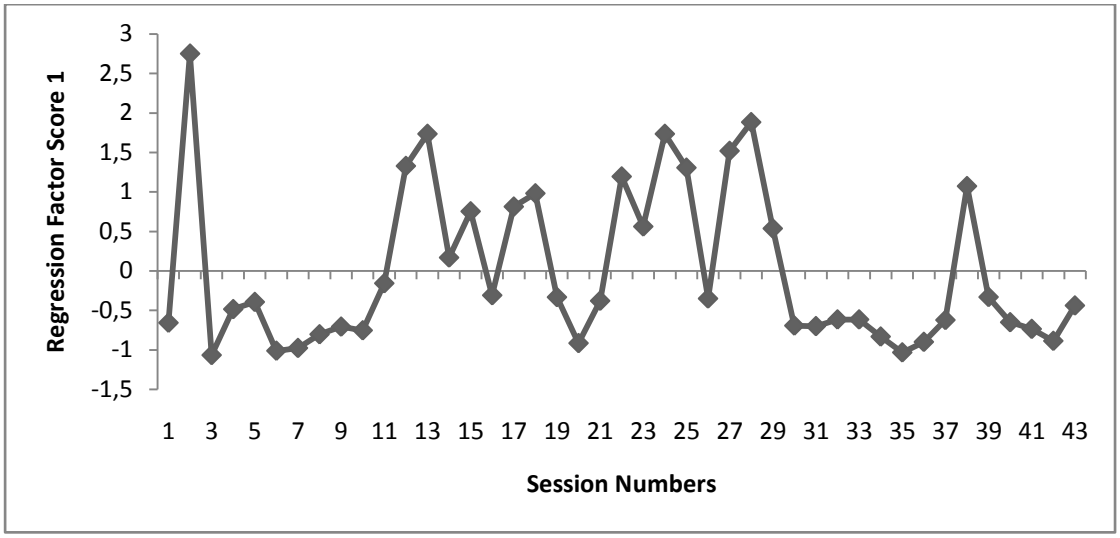

Figure 1. Regression Line of Factor Score 1 for Patient #1

According to graph, the 2nd, 13th, 18th and 28th time points on the graph will be qualitatively analyzed.

The 2nd time point in the graph (2.session's 4th segment) is located two standard deviations above the mean. The variability at this point is very high when it is compared with the rest of the process, even though this segment is in the beginning phase of the psychotherapy. This segment is prominent in the sense that it indicates some prominent cues about Patient#1's play patterns and his core conflictual relationship theme which is identified as the wish to oppose and hurt others; and being hurt and anxious as response of others; and to oppose and hurt others as responses of self. Important features that make this time point different from other segments is the expression of the core conflictual relational pattern for the first time and the high levels of disorganization in play.

At the beginning of the segment, patient played with trains in an explorative manner. His play was not well-organized and following the flow of the play activity was difficult. Later on, the weapons suddenly attracted his attention and play became aggressive and destructive (CPTI Aggression Affect Type: 4) After this shift, he searched more aggressive toys such as wild animals. During this search, abrupt transitions was observed between aggressive and anxious feelings (CPTI Affective Tone Abrupt Transition: 4). Then, he played with two wild animals aggressively by labeling them as "megapower" and "powerangels".

Patient#1:Megapower! Sio! (Some meaningless voices) Red snake pink dragon yellow tiger black snake shark. There are two more

left.(He started to shoot the powerangels characters by saying their name one by one.)

Therapist: Only two enemies left.

Patient#1: Megapower blue! Now it is time for the shark! (He continuing to shoot the powerangels characters one by one.)

At this point of the play, when the aggression level of the play increased, it was observed that patient lost the line between the fantasy and reality. The characters in play was polarized (CPTI Polarized Defense Cluster: 4) and this situation leads high levels of anxiety (CPTI Anxiety Affect Type: 4) and bizarreness in play (CPTI Bizarre Style of Representation: 3). Therapist was not included as a character in play activity by patient. Therapist frequently mirrored patient's play, however she did not regulate his fluctuating emotions. Overall, in this segment, patient manifested his internal representations in a disorganized play and the therapist was outside of the play activity by mirroring his intentions.

In 13th time point (13th session, 1st segment), which correspond to middle sessions of the psychotherapy process, the regression factor score 1 is nearly two standard deviations above the mean. The clinical analysis shows that this segment is one of the most intense points of psychotherapy process of Patient#1. From the beginning of the segment, child played with several animal and human figures and he included the therapist into his fantasy play (CPTI Complex Level of Representation: 4). Generally, one of the characters showed aggressive and omnipotent features, while the other

one was weak and got hurt. He repeated similar scenarios with different characters several times throughout the segment. The scenarios were parallel with his CCRT: A human character walks and suddenly gets attacked by an evil animal character and gets hurt. Patient identified with the evil animal character during the play.

Therapist: Oh, my friend is lying on the ground! My friend, what happened to you?

Patient#1: Frog attack!! (Frog is attacking to character that therapist makes play)

Therapist: Oh, help me! Frog is on me, he is oppressing me! Help me!

With the inclusion of therapist within the play activity, patient enacted more complex representations in play. Patient started to specify each character's intention and reaction clearly and invited therapist to be the part of it. By this way therapist had more opportunity to involve the internal world of patient more directly. However, therapist did not make any comments about the repetition of same play activity by referring his feelings. Apart from that, she played directly in direction of patient's projections.

Later on this segment, a considerable difference in play was observed. Apart from just hurting the human characters, the child transformed the character that was in victim position into "bad person".

Patient#1: (Holds a spider just above the upcoming character. Slowly comes closer to character and attacks.) Cıyuvv! Cıv, cıv, cıv!

Therapist: The spider hurts her with its cobweb!

Patient#1: No, he is not hurting her. He is going to turn her into bad. (Shifting his tone into a different character) I am turning you into a bad one!

Therapist: Oh he is going to turn her into bad!

Patient#1: Now she is bad. She was the mother.

In this play, patient's play started to show more idiosyncratic and bizarre features (CPTI Bizarre Style of Representation: 3). He created a scene by aiming to victimize the passive character and make him hurt. So, still the characters in play were polarized (CPTI Polarized Defense Cluster: 4). Also, oedipal relationality was observed slightly in this vignette, which refers to the awareness of differences in generations and the highest form of relationship level in CPTI (CPTI Oedipal Relationship Level: 2). However, it was observed that even though patient wanted therapist to involve the play, she preferred talking outside the character rather than vocalize it. It can be interpreted as an unconscious defensive reaction of therapist against the intensity of play. Another important point was despite of the changes in content of play, still the relational pattern was parallel with his CCRT. Overall, in this segment the pervasiveness of CCRT was high (CCRT Pervasiveness Score: 0,75). All in all, this segment is fruitful for observing

the increase in level of representations with the involvement of therapist into the play, the increase in disorganization in play and the increased frequency of enactment of CCRT.

Towards the end of the psychotherapy process, on 24th time point (18th sessions' 7th segment), again it can be observed that regression factor score 1 is two standard deviations above the mean. At the beginning of the segment, patient gave a sword to therapist and the dyad started to fight with each other.

Patient#1: I will not fight you again. You have to improve yourself if you want me to fight you.

Therapist: I am not good enough to fight with you.

Patient#1: This time I am really going to ruin you!

Therapist: Oh!

Patient#1: (Suddenly quits the play.) (By mentioning his sword) This sword becomes really weak when it is like this (Showing the on-off button of the sword. He turns off the sword.).It is getting scary.

Patient was highly aggressive and omnipotent during this play, and directly projected his aggression towards the therapist. However, such aggressiveness and omnipotence affected the patient's awareness that he is in a state of play (CPTI Level of Awareness: 3). Also, later on this segment he transformed the weak character into a robot, so it can be seen that the high levels of aggression and omnipotence made him feel anxious as well

(CPTI Anxiety Affect Type: 4; CPTI Extreme Anxiety Defense Cluster: 3). During the segment, it was confusing for the reader to understand with whom the patient was identified himself because the inside and outside boundaries meld into each other. When the therapist's stance was observed during this play, even though she was a character in the play, she seemed distant and disengaged. She did not make any comments regarding the high levels of anxiety and disorganization in the play. So, lack of attunement between the therapist and patient was observed in this highly disorganized and anxious segment.

The time point (20th session 3rd segment) corresponds to the last sessions of psychotherapy process. From the beginning of this segment, the child was exhibiting his core conflictual relationship theme (CCRT Pervasiveness Score: 0,50), in a disorganized and idiosyncratic manner. At the beginning of the represented vignette, the therapist was police and the patient was thief. However, a sudden transformation happened and they switched the roles.

Patient#1: I am going to stop you. You forgot to kill some people and now these people stop you. Hair, is this your hair?

Therapist: No, my hair is not black.

Patient#1: (Silence. After a while) Now, I am going to make you stop.

Therapist: There is someone who is going to stop me. I cannot kill everybody.

In the rest of the segment, play became highly disorganized and the weak character's attitudes were punitive and sadistic in his attitudes towards the previously aggressive character. It can be observed that stopping or even trying to stop the aggression was very confusing for him. In between the lines, he seemed for searching the answer of this question: When I stopped, will I be punished? This anxiety provoking question made him fluctuate within his fearful and aggressive feelings (CPTI Affective Tone: 3) and made him more vulnerable towards the change. Originated from this vulnerability and anxiety, several attempts for interrupting the play activity was seen during the segment. At this point, when the therapist's attitude was observed, it was seen that she did not make any comments regarding his play or attempts for interruption. Rather, she imitated the patient's projections without spontaneous and containing attributions and seemed distant from the play in mutual space.

So, taking into consideration the analysis for Patient#1, it can be observed that when the segments that made peak on the graph are examined, the child plays in fantasy category, the complexity of representations and relationship qualities are increased and the play is highly disorganized. Even though the patient had attempts for transforming his conflictual patterns within the play over the course of psychotherapy process, he could not

actualize it. The reasons for this lack of transformation will be discussed in discussion section.

3. 4. 2. Clinical Analysis for Patient#2

Graph 2 represents the change in regression factor score 1 over the course of therapy for Patient #2. The qualitative analysis is going to be done on the points that around or above ±2 standard deviations from the mean.

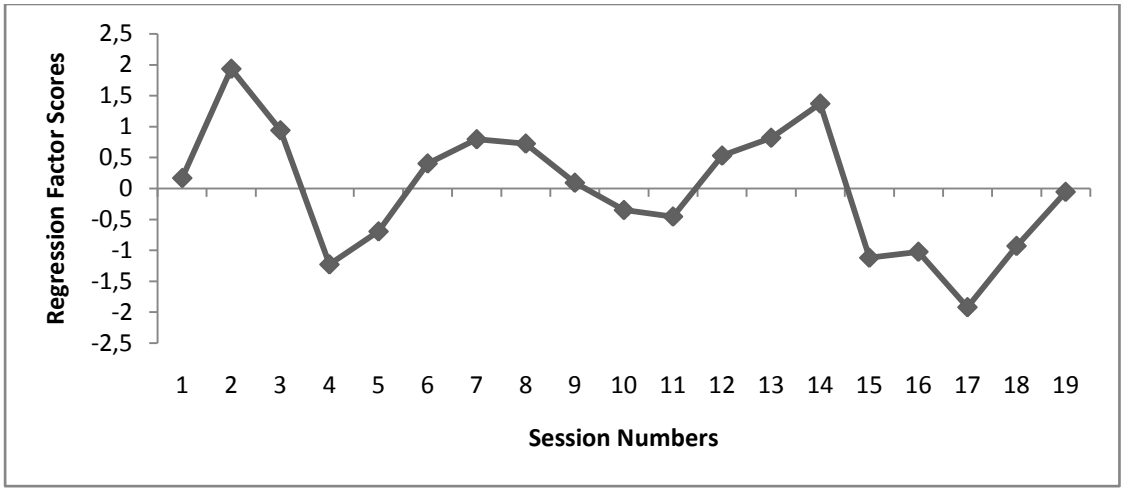

Figure 2. Regression Line of Regression Factor Score for Patient#2

When the component graph of Patient#2 is examined, various differences were observed compared with Patient#1. Although they have approximately equal number of sessions, Patient#2 seemed to play less segmental. Apart from the three peak/trough points in graph, a prominent segment from the middle session is also examined.

The 2nd point (7th session 2nd segment) in the graph is two standard deviations above the mean. From the beginning of the segment, the child's play was disorganized and it included several abrupt transitions between toys and characters (CPTI Affective Tone Transition: 5). Patient's attention could be captured by different things easily; so it seemed hard to maintain a structured play activity without any distraction or abrupt transition. He enacted brief fantasy plays, and these plays represented his equal opposing wishes such as having an accident and fixing the vehicle immediately (CPTI Conflicted Defense Cluster: 4).

Patient#2: (He takes ambulance and he is attacking to other animals.) Dead. The crocodile is dead. They are dead, we got rid of them!

Therapist: You got rid of them, yey! You got scared from them.

Patient#2: The horses are dead too. The crocodile, dead.

Therapist: This ambulance wants to kill all of the aggressive animals.

Patient#2: (He points the crocodile that he killed before.) Look, it stands up.

Even though he exhibited relational representations within the play (CCRT Pervasiveness Score: 0.66), the regulation of emotion during the play is rigid (CPTI Affective Tone Regulation: 2) and the play was inhibited several times (CPTI Script Inhibited by Child: 3) by abrupt transitions. The

therapist was not included in play as a character, however she was containing patient's projections in play by making integrative comments and she was fluctuating in layers of different emotions with the patient in a supportive manner.

Even though not a remarkable variability is observed, the 7th point in the data (12th session 2nd segment) will be qualitatively analyzed because it is prominent to follow the in session themes and play throughout the psychotherapy process. Patient's play involved destructive, aggressive (CPTI Affect Type Aggression: 4) and fearful (CPTI Affect Type Fear: 3) characteristics. During his play, the CCRT of the patient frequently observed (Pervasiveness Score of CCRT: 0.50). In this relational episodes, generally one of the characters was strong and punitive and the other character was fearful and hiding from the punishment to not get hurt. After the manifestation of severe aggression in relational episodes, suddenly patient started to play in a more adaptive and insightful way: He decided to feed the aggressive animals.

Patient#2: Look, they are so hungry.

Therapist: Oh, the cat is hungry too. Who let them starve for so long?

Patient#2: Look a cake. I bought cake for them. They like eating fish. Look fish.

After this play vignette, Patient#2 started to express fear and anxiety. Also, the abrupt transitions and fluctuating regulations were observed again. The therapist was not included into the patient's play, however therapist's stance was nurturing and containing against destructive projections of the patient. She did not reach aggressively towards his needs, rather she gave meaning to his anxiety provoking aggressive acts by elaborating and exploring his play. So, a new and more adaptive relationality was constructed between the dyad. Towards the end of this segment, the wishes of feeling comfortable and respected was observed from the patient more frequently.

In the 14th point (18th session 2nd segment), again the regression factor score goes high nearly 1, 5 standard deviations above. At the beginning of the segment, the patient played several brief fantasy plays, mainly themed around death and aggression. Later, he wanted to play hide and seek. Starting from the hide and seek game, patient started to include the therapist in his play as a character.

Patient#2: You are going to be a child. I am going to be a cop. Go and hide over there, come on!

Therapist: Oh my god! Does this police establish rules by using his gun? It is scary!

Patient#2: Hide now! (After a while) I found you!

Therapist: Don't shoot me!

Patient#2: I am going to shoot you!

The theme of the play in rest of the segment was highly aggressive (CPTI Affect Type Aggression: 5) and anxiety provoking (CPTI Affect Type Anxiety: 4). With the inclusion of therapist into the play, the aggression and destruction was directed to therapist. It was possible that because the direction of the aggression turned into the therapist, the patient became anxious and frequently switched (CPTI Affective Tone Transition: 4) his emotions and the theme of play, or suddenly stopped the game (Script Inhibited by Child: 3). However, therapist was containing and attuned towards the patient in his destructive moments.

In 17th time point (21th session 2nd segment), which corresponds to the end of the psychotherapy process, the regression factor score 1 shows a remarkable decrease nearly two standard deviations below the x axis. When the session is qualitatively analyzed, different patterns of relationships was observed compared with his core conflictual relationship theme. At the beginning of the segment, he exhibited frequently wish to oppose and hurt others, which is also a component of his core conflictual relationship theme. However, he designated the others' reaction as being rejecting and opposing, apart from being passive and vulnerable. This pattern was new for Patient#2. Moreover, it was observed that from the beginning of the segment, the relational episodes were mainly complex (CPTI Complex Level of Representation: 4) and started to include oedipal relationality (CPTI Oedipal Relational Level: 3). After several relational episodes that

both characters was aggressive towards each other, for the first time the CCRT pattern of Patient#2 started to change. At the beginning of this vignette the scary and strong crocodile kidnapped the children of crocodile family:

Patient#2: Dare to come closer, you will get what you deserve!

Therapist: But we want our children back!

Patient#2: Ok, come and take them back.

Therapist: But I feel scared a little bit.

Patient#2: Come on, take back them!

Therapist: Get out of our way crocodile! We come here to take our children back.

Patient#2: No, go away!

Therapist: No, we come here to take our children back!

Patient#2: (silence) Ok, here your children.

Therapist: Oh, thank you very much crocodile!

Patient#2: Not at all.

Therapist: You seem intimidating, but you help us.

Patient#2: I am not bad, I am crocodile. I live in here. Come on, let's have a cup of tea.

Therapist: Ok, we would love to.

This relational episode can be addressed as one of the turning points of the whole psychotherapy process because after this relational episode, the relational patterns significantly changed. His wishes switched from more destructive and aggressive manner to more the need of being close and accepting. At this point, it is important to notice the intervention of therapist. During play, even though patient's crocodile clearly expressed that he wanted the therapist's crocodile to leave, therapist insisted on take the children back. It seemed that the therapist generated her own unique response spontaneously apart from the child's expectations and projected response of other. With his complex, rich and integrated representational world, he started to designate the others reactions as more helpful and cooperative. Overall, patient generated new and adaptive relational patterns towards the end of this segment.

So, taking into consideration the analysis for Patient#2, it can be observed that when the time points that located ±2 standard deviations above or below the mean were examined, the child was playing mostly in fantasy category. The complexity of representations and relationship qualities were increased throughout the psychotherapy process, even though the play seemed to remain disorganized. Towards the end of the psychotherapy process, less inhibitions were observed and the construction of new and more adaptive relational patterns were seen. The reasons of transformation will be discussed on discussion section.

4. DISCUSSION

The aim of this study is to investigate the relationship between the level of social representations enacted in play and the change in patient's conflictual relational patterns over the course of psychotherapy process. The patient's level of representation is comprised of different enacted roles during play. If the treatment is working, patient brings his internal world to play. As the child's object relational capacity increases, the richness and complexity of the child's representations increase, and multiple autonomous characters in relation with each other emerge. In relational psychoanalytic perspective, psychotherapy serves to improve patient's repetition of old maladaptive relational patterns and helps to form new object relationships that are more adaptive. These old relational patterns usually involve conflictual schemas that are embedded in the patient's relational world and their enactment in psychotherapy provides the opportunity for modification. So, it is expected that over the course of psychotherapy process the conflictual relational patterns decrease and new patterns emerge. For this purpose, the psychotherapy process of two cases, a case who showed a clinically significant improvement in symptoms and a case that didn't, were compared in terms of the change in social representations enacted in play, the change in relational patterns over time and the relationship between these two variables. The findings supported that the child's capacity to use the play field in a way where multiple representations are actualized is also a chance to bring core conflictual relations to therapy. As these core

conflicts are realized in therapy, the child finds a way to transform them towards more adaptive ways of relating to himself and others.

4.1. CCRT Pervasiveness Scores Over the Course of Psychotherapy

According to Frankel (1998), play is an essential process for renegotiation of self-other relationships in psychodynamic child therapy. So, since one the main purpose of the psychodynamic psychotherapy is the reduction in pervasiveness of maladaptive and repetitive self-other relational patterns (Luborsky, 1977, as cited in Crits-Christoph & Luborsky, 1998), the change in conflictual relational pattern of child throughout the psychotherapy process was investigated. It is hypothesized that the core conflictual relational pattern of child will increase in middle phase of the therapy and decrease in the end. According to descriptive analysis, the pervasiveness scores in early, middle and late sessions show different patterns for the case who showed a significant clinical improvement in symptoms and the case that didn't showed clinical improvement. Improved patient (Patient#2) showed lower levels of CCRT pervasiveness score in early sessions. In middle sessions, his pervasiveness scores increased and in late sessions the pervasiveness score slightly deceased compared with middle sessions. On the other hand, the case that didn't showed clinical improvement (Patient#1) exhibited higher levels of CCRT pervasiveness scores in early sessions. The pervasiveness score in middle sessions showed a slight decrease; however in late sessions, the pervasiveness score was still

significantly high. Even though the application of CCRT method is not widespread in child psychotherapy research, these results were consistent with the literature. A meaningful change in pervasiveness scores from early to late in treatment was found with various studies that were done with adult patients with different symptom profiles (Kachele, Dengler, Eckert &Scheckenburger, 1990; Crits-Christoph & Luborsky, 1998; Ciaglia, 2010). Studies with adolescents showed that at the end of the psychotherapy process, an improvement was observed regarding more positive patterns of relationship apart from conflictual ones (Agin & Fodor, 1996; Tishby, Raitchick & Shefler, 2007; Atzil-Slonim, Wiseman & Tishby, 2016).

4.2. Emergence of Rich Social Representations over the Course of Psychotherapy

According to Shrik and Burwell (2010), the change process in psychodynamic psychotherapy involves the broadening self-experience of child by increasing the range, depth and emotional richness of play. One of the most prominent component of a rich play is the affluence and complexity in representational world enacted in play. The level representational world of the child is related with the child's capacity of creating narrative structures to represent various relationships (Kernberg, Chazan & Normandin, 1998). To investigate this change, it was hypothesized that if the therapy is working, an increase in the level of social representations enacted in play as assessed by the CPTI was expected. According to results, the clinically improved patient (Patient#2) enacted

more social representations in his play throughout the psychotherapy process. On the other hand patient that did not improve clinically (Patient#1) did not show any patterns regarding the change in his level of representations. Even though there are few studies regarding the issue of change in level of social representations, the results of this study is parallel with the previous findings. In these case studies, it was found that more complex role representations were enacted to describe many different characters throughout the psychotherapy process (Chazan, 2000). Moreover, towards the end of the psychotherapy process, these several characters started to interact with each other and therapist was included into play activity as a character by the patients (Chazan, 2001; Chazan & Wolf, 2002; Chari, Hirisave & Appaji, 2012).

4.3 The Relation between Social Representations and Conflictual Patterns in Play

Considering the previous findings and discussion, it is thought that the change in pervasiveness of conflictual relational pattern of child and the level of representations enacted in play is related with each other. For assessing the relationship between the level of social representations enacted in play and pervasiveness of conflictual relational pattern, it was hypothesized that the level of social representations enacted in play will positively correlated with the pervasiveness of conflictual relational pattern. According to results, the profiles of Patient#1 and Patient#2 were different from each other. For the patient that showed clinical improvement

(Patient#2), it was found that the level of social representations enacted in play was negatively correlated with the pervasiveness of conflictual relational patterns. Moreover it was found that pervasiveness of new and more adaptive relational patterns were increased. On the other hand, for the patient that didn't show clinical improvement (Patient#1) the level of social representations enacted in play was positively correlated with the pervasiveness of conflictual relational pattern. Besides, no new and adaptive relational patterns were developed by this patient.

At this point, the majority of the theoretical literature discuss the alteration in level of representation and relational patterns in relation to the therapeutic relationship between the therapist and patient dyad. Leowald (1960) stated that improvement in therapy process is associated with the establishment of new object relationships. This process is actualized with the rediscovery of the early paths of the established object-relations. Rediscovery of new object relations leads patient to a new way of relating to objects and himself. This reorganization process occur by the encounter with a 'new object' which has to possess certain qualifications in order to promote the process. In psychotherapy process, the 'new object' is the therapist. Therapist holds himself available to the patient and patient has to hold on the therapeutic process for this reorganization process. Grunes (1984) stated that the therapeutic object relationship is provided by the empathic interaction between the therapist and patient dyad, clarification of self and other boundaries and the evolution of self and object definition

within the context of intimate relation with an object, in other words, with the therapist.

There are some studies for assessing the interaction structures within the psychotherapy process that can create a change in the relational patterns of a patient that improved vs. a patient that did not show improvement in therapy. In Goodman and Athey-Lloyd's research (2011) it was suggested that the interactional structure can be varied according to patient's unique needs. Therapist must be empathically attuned to their patient's unique treatment needs for becoming aware when there is a disengagement or distant between the patient and the therapist. Also; Schattner, Tishby and Wiseman(2016) found that when the patient's and therapist's relational patterns clashed, they influence each other negatively. Moreover, for overcoming this negative effect, therapist could flexibly adapt to patient's relational patterns by expressing openly the disagreements and differences between the dyad, apart from stood defensively out of the play matrix. Because the scope of his research is not examined the interactional structure, qualitative analysis was done for enhancing the understanding of the relationship between these two variables.

4. 4. Discussion of Clinical Analysis

The difference between the results regarding the relationship between the level of social representations enacted in play and pervasiveness scores of conflictual relational patterns brought the question of why such difference took place between the patients. In order to

understand this, clinical in session analysis was conducted for both patients. Mainly, two prominent points were observed: the inclusion of the therapist as a character within the play activity by the patient, and difference between the stance of the two therapists during the play activity.

The inclusion of therapist as a character within the play activity by the patient was an important turning point in both patient's psychotherapy process. However the process after the inclusion of therapist in play was different from each other for the patient who showed clinical improvement (Patient#2) and the patient who did not show clinical improvement (Patient#1). In Patient#2's process, the richness of representations was facilitated by therapist and the mutuality in play activity increased. On the other hand, in Patient#1's process, lack of harmony between the patient and therapist dyad was observed. This finding leads us to the second finding of the in session analysis: the difference between the stance of the therapists within the play activity. In Patient#2's therapy process, the therapist was observed as more open and into the play. On the other side, in Patient#1's therapy process, the therapist was observed as more rigid and defensive. The theoretical and empirical explanations of this findings are represented below.

4. 4. 1. The Inclusion of Therapist within the Play Activity

Winnicott (1969) defined two modes of use of an object: object relatedness and object usage. Object relatedness is a more primitive form of interaction in which the other object is not separated or differentiated; but

only intended for the child's needs and demands. Winnicott called this the subjectively-perceived object. On the other hand, object usage is a more advanced form of relatedness in which the object is encountered as a separate person who can be engaged, taken in, and used for growth. Object usage allows for full engagement and collaboration with others. In qualitative analysis for clinically improved patient (Patient#2), at the beginning of the psychotherapy process it can be observed that the interaction between patient and therapist was more primitive. Even though the child acknowledged the therapist and the play was reciprocal, he did not use the therapist as an object. The therapist's only function was to mirror and support the patient's play. Starting from the middle phases of therapy, a gradual transformation was observed towards a more advanced relatedness.Patient#2 located the therapist inside his play as a character and the play proceeded cooperatively.

The turning point of this shift was the hide and seek game between the dyad. Starting from the hide and seek game, it was observed that the child started to include the therapist inside his game more frequently. In other words, the play became more cooperative and mutual. Hide and seek game contains the concepts of differentiation, practice and rapprochement sub-phases of development (Mahler, 1979; Frankiel, 1993). According to Bergman (1993), the hide and seek game is a step by the child when a certain amount of separateness has been achieved. This certain amount of separateness can only be achieved if the child internalizes the sense of security from his primary caregiver. This developmental process can be

applied to the therapeutic relationship between the therapist and the patient as well. The patient needs to sense the feelings of security and emotional nurturance from the therapist before seeing the therapist as a separate object and create a mutual space with inclusion of the therapist into the patients' representational world.

In qualitative analysis of patient that didn't show clinical improvement (Patient#1), the inclusion of the therapist to child's play as a character was partially observed in middle phase of the therapy process as well. At the beginning of Patient#1's psychotherapy process, therapist was outside of the child's play; however in middle sessions, the child includes the therapist inside his play as a character. However, inclusion of therapist into the play is not enough for the transformation of internal representations. According to Ferro and Foresti (2008) the internal representations that are expressed in the patient's narrative within the play must be elaborated, well-defined and worked through cooperatively by the analyst and patient dyad. When the interactional pattern between the Patient#1 and his therapist was analyzed after the inclusion of therapist into the patient's play, it was observed that the therapist did not elaborate the material that the patient was represented. Rather than elaborating, therapist made play the characters merely in the direction with Patient#1's attributions without any spontaneous and unique contributions. Also, it was observed that therapist was defensive against the prominent moments in the play that could cause transformations if these moments were contained, intervened or interpreted. For instance, when Patient#1 quitted his play suddenly without carrying out his play any

resolution, therapist moved on with the patient without making any remark or comment about this sudden shift. In his paper which was built upon the Winnicott's notion of Use of an Object, Fabozzi (2016) stated that the gradual transformation from subjective object to objective object is possible by containment and survival of patient's destructive attacks. However, Patient#1's case, the destructive attacks of patient towards self and other, in this case therapist, was not contained or worked though by the therapist. Rather, she reacted defensively. She did not make any comments about the dysfunctional patterns in play.

4. 4. 2. The Stance of the Therapist in Therapeutic Relationship

The first part of the in session analysis of two cases points out the importance of therapist's stance in therapeutic relationship. According to Hartmann and Zimberoff (2004) the curative powers of psychotherapy process originates from the expression of aggressiveness and vulnerability by patient without being punished and censured by the therapist. In his article which was based on Leowald ideas regarding the role of internalization, Silverman (2007) suggested that the therapist had three main roles in the therapeutic field. Firstly, therapist must allow the patient to externalize and to project his internal images. Secondly, therapist must allow the patient to invest his internal images on therapist whether this investment is realistic or unrealistic. Finally, therapist must be a new object

and able to present a new model of relationality, in which the therapist must be herself and spontaneous.

These theoretical assumptions takes us to the second prominent clinical implication of this research: the stance of the therapist against the manifestation of destructive and conflictual relational patterns. According to the clinical analysis of two patients, important differences were observed regarding the stance of the therapist within the flow of the play activity. In the psychotherapy process of clinically improved patient (Patient#2), it was observed that the therapist was more involved in the play activity. She adjusted herself with the Patient#2's different developmental levels of play and fluctuated mutually in different levels mutually with the patient. In his article which is based on the developmental principles of Vygotsky's zone of proximal development concept and therapeutic relationship, Hartmann (2007) stated that by making development-oriented comments and interventions, the mutuality therapeutic relationship constructed more securely. Moreover, according to Wilson and Weinstein (1996) the process of zone of proximal development provide the optimal interpersonal context between the patient and therapist which maximizes the accessibility of interventions for the patient. So, the adjustment of therapist herself according to the different developmental levels of play is prominent for both parties for establishing mutuality in their interaction. On the other hand, in the psychotherapy process of patient that did not clinically improved (Patient#1), even though therapist was in patient's play as a character, she

seemed distant from the patient in terms of attunement and affective expression. A sense of mutuality in play did not emerge between this dyad.

These findings are important for understanding the prominence of the relational play matrix between the therapist and the patient. According to Ferro (1993), the analyst and the patient build a bi-personal field that consist of the unique characteristics of both. In this field, projective identifications run back and forth between the analytic couple, more intensely from patient to therapist. By this way, internal representations of patient and therapist is expressed in the co-constructed field and a mutual unconscious communication is established. The internal representations emerged in the field are shaped in accordance with the discourse that analytic couple develops. According to Baranger and Baranger (2008), together with the motivation for gaining insight regarding the projective identifications, analyst and patient are working together. Even though both patients accepted their therapists into their representational world with a more advanced level of relatedness, it can be observed the construction of mutual field between dyads were different from each other. In clinically improved patient (Patient#2), more authentic and spontaneous relationality was established. It was observed that patient was more open to enact his internal representations within the play and in return therapist facilitated the patient's play by going with the flow of the play activity and being spontaneous within the play. It was also observed that therapist was trying to understand the psychic function of the enactments and using this for the development of dyad's interaction. On the other hand, towards the end of the psychotherapy

process, the patient and therapist dyad in clinically did not improved case (Patient#1), the relationality was more rigid and constrained. When patient was enacted his internal representations within the play, the therapist seemed defensively distant from the play.

So, with the construction of bi personal field between the therapist and the patient dyad will lead to reconstruction of new internal representations and development of more adaptive relational patterns in this field. At this point it is important to assess the therapeutic actions that lead to transformation in these concepts in the therapeutic field. When the clinically improved patient (Patient#2) clinical analysis is considered, towards the end of the psychotherapy process, an unusual moment was observed. In this unusual moment, apart from playing out the projections of internal representations of the patient, it was observed that therapist reacted in her own unique way in an affectively intense relational episode that contained high levels of play disorganization(for more detail see Qualitative Analysis of Patient#2 section in Results). This kind of reaction was different from the therapist's previous attitudes within the play. After this intervention, it was observed that the conflictual relational pattern of the Patient#2 was broken. Even though he started playing aggressive and destructive frame, after the therapist spontaneous reaction against his pattern, he did not continue to play by reacting opposing. On the contrary he generated a new way of relating to others which was consisted of wishes of being close and accepting.

Stern and his colleagues (1998) generated a concept called as "implicit relational knowing" (p.905) that originated from the intersubjective moments that take place between the patient and therapist that can lead to the reorganization of both explicit and implicit interactional patterns. Regarding this concept, naturalistic and experimental studies show that infants are interacting with their caregivers on the basis of this implicit relational knowing. The construction of representations are constituted based on this interaction in early years of life (Tronick et. al, 1978; Stern, 1985; Bebe & Lachmann, 1988). Stern and his colleagues (1998) proposed "a moment of meeting" (p. 906) that can rearrange the implicit relational knowing in interpersonal relations. At these moments, the change can be sensed and with the effect of this new context, the past events are reorganized. So, it can be argued that the construction of field between the therapist and patient facilitates the development procedural knowledge between the dyad which is not conscious (Stern et. al, 1998). In this context, the intervention of Patient#2's therapist can be considered as a spontaneous reaction rather than a planned and structured one. Also, it is stated that the change in implicit relational knowing can be experienced as a sudden qualitative change. However this change is not sudden, it is a consequence of the mutual play matrix that reciprocally constructed between the therapist and the patient (Stern et. al, 1998; Ferro & Foresti, 2008). Change in implicit relational knowing forms by achieving more coherent and inclusive ways of being together and in coherent ways of being together establishes through a process of recognition of specificity of mutuality between the

dyad (Bruschweiler-Stern et. al., 2002; Bruschweiler-Stern et. al., 2007). So, the sudden change in Patient#2's relational patterns was a consequence of elaboration and working through within the mutual space between the therapist and the patient. Lyons-Ruth and colleagues (1999) proposed that the changes in representations and relational patterns can be accessed by the integration of semantic and affective meanings in the space between the therapist and the patient by implicit relational procedure. Parallel with this statement, the conflictual relational patterns of Patient#2 decreased and adaptive patterns increased after this intervention.

On the other hand, when the clinical analysis of clinically did not improved patient was examined, no such moment was observed between the dyad. On the contrary, the conflictual patterns were repeated over and over again without any attempt to break the pattern. Freud (1914) pointed out that the repetition of past events or early childhood experiences during the therapy process that shaped the patient's psychopathology was necessary for reconstruction process. Parallel with this view, Crisp (1988) indicated that for reconstruction, the repetitions must take place in analytical relationship. Even though the repetition of conflictual pattern was frequently observed in Patient#1's psychotherapy process, the reconstruction of new and adaptive relational pattern did not emerge. At this point it is important to examine the therapeutic relationship between the patient and the therapist. According to the clinical analysis of session for Patient#1, it was observed the therapist was not able to involve the mutual space between the dyad. She did not elaborate or did not adjust to the patient's different modes of play. Apart

from that she played solely in accordance with the patient's guidance. Leowald (1971) indicated that the reconstruction of past experiences take place in creative act of repetition in psychical field; not in mere imitation.

At this point it is important to think why therapist did not make any interventions to the repetitive acts in play. The countertransference concept is prominent for understanding the stance of the therapist during the play activity. Countertransference is conceptualized as the active participation of the therapist in the unconscious life of the patient in relation to patient's projections (Freedman, 1997). In their empirical study, Freedman, Lasky and Webster (2009) made a distinction between the ordinary transference which is happening within the therapist's consciousness, and the extraordinary countertransference which remains outside of the awareness of the therapist. When the rigidness and distance of Patient#2's therapist is considered, it is possible that she may be experiencing an extraordinary countertransference that hindered her to be involved the play activity of the child spontaneously. Taking into consideration this theoretical and empirical suggestions, it was observed that the therapist did not dwell on the important points in play activity that could be counted as turning points if that moments were worked through by the dyad. At these points, therapist seemed defensively "unaware" of the intensity and importance of these moments. This attitude may lead to deterioration regarding the therapeutic relationship. Safran (1993) defined three kind of rapture. One of them was conceptualized as the therapists participation in dysfunctional interpersonal cycle that is characteristic for the patient. He stated that in this kind of

rapture, therapist engages in dysfunctional patterns of interpersonal relations of patient and this leads dyad to confirmation of patient's conflictual beliefs. The disconnectedness of the therapist and lack of mutuality might lead Patient#1 to become more resistant in exploring different relational patterns.

In their study, Goodman and Athey-Lloyd (2011) defined four different interactional structure between the therapist and the patient by examining two case studies by Child Psychotherapy Q-Set (Schneider & Jones, 2004). One of the interaction structures was labeled as *'judgemental, misattuned therapist with distant, emotionally disconnected, misunderstood child'*. In this interaction structure, it was observed that when the therapist was judgemental and misattuned, the child was more resistant to intervention and more distant from the therapist. The resistance to countertransference awareness may depend on a variety of individual factors as well (Imber, 1990). One of the possible explanations regarding the individual factors is the congruency between the patient's and the therapist's relational patterns. According to Schattner, Tishby and Wiseman (2016), if the patient's and therapist's relational patterns overlap, both parties impact each other negatively. This negativity can cause the projective identifications not contained by the therapist; and the process between dyad can be ended up by feeling upset, helpless and angry for both parties (Crisp, 1987).

4. 5. Clinical Implications

Taking everything into consideration, even though the relation between the social representations enacted in play and the change in conflictual relational patterns throughout the psychotherapy process were not assessed using these measures in previous literature, the results of this study goes parallel with the theoretical conceptualizations. Overall, it was found that in an effective therapy, new and adaptive relational patterns are generated and more complex and rich representations are enacted in play. the transformation from conflictual patterns to adaptive patterns is possible through the construction of mutual play matrix which was formed by the unique and spontaneous characteristics of both patient and therapist dyad, more advanced relatedness with others and the contained stance of the therapist in this mutual play matrix (Tishby, Raitchick & Shefler, 2007; Chazan, 2001; Bruschweiler-Stern et. al., 2002, Freedman, Lasky& Webster, 2006).

In this study, several important clinical implications are found. First of all, the intensity of pervasiveness in conflictual relationships was observed in middle sessions of the psychotherapy process. So, it is important to elaborate and work though the represented material especially at this phase of the psychotherapy process. According to the elaboration and working through in this phase, the pervasiveness scores of conflictual patterns decreased and more adaptive patterns were developed at the end of the process.

Secondly, it was found that the social representations enacted in play increased over the course of psychotherapy, if the therapy was effective. It was known that play is an area that facilitates the expression of intrapersonal and interpersonal representations. So, by this study it was once again confirmed that the increase in complexity and richness of representations is prominent for the effectiveness of psychotherapy.

Another important finding indicates that in an effective therapy there is negative correlation between the level of social representations enacted in play and the pervasiveness of core conflictual issues throughout the psychotherapy process. Besides, new relational patterns were developed which were more adaptive and positive. For finding out the possible reasons of this results, in session analysis was conducted. According to qualitative analysis, two important implications were featured.

In first place, the inclusion of therapist in the patient's play as a character is an important therapeutic moment for constructing the mutual play space. With the inclusion of therapist into the play activity, she involve the representational world of the patient as an object. With the inclusion in play, therapist and patient met in a mutual space where the patient accepts therapist as a separate person who can be engaged and used for growth. This shift leads to complete engagement and collaboration during the play activity within the dyad, in other words the co-construction of bi personal field (Ferro, 2003). At this point, it is important to patient feel secure, contained and emotionally nurtured within the therapeutic relationship.

With the construction of mutual play matrix between the therapist and the patient, therapist become an object that facilitate the richness of representational world of the patient and a new model of relationality (Silverman, 2007). This statement leads us to the second important clinical implication of qualitative analysis: the stance of the therapist during the play activity. The therapist must be herself, authentic and spontaneous in the mutual play matrix that was constructed by the dyad. Even though repetition is an prominent concept for mastering and accepting the disowned part for the patient, just imitating the patients projected representations does not improve the therapeutic process and outcome. On the other hand, with the spontaneity of therapist, both parties are more open towards the intersubjective moments that take place between the dyad. These intersubjective moments are labeled as implicit relational knowing by Stern and colleagues (1998), and this procedural knowledge leads to the rearrangement of intrapersonal and interpersonal relational patterns.

4. 6. Limitations and Recommendations for Further Research

This study has various limitations that must be enhanced in subsequent studies. Further research recommendations are also given together with the limitations of the study.

Using single case design had both had advantages and limitations. In terms of advantages, it allows the researcher to work without underestimating patients' individual background and uniqueness. Moreover, single case designs are more sensitive for enhancing the understanding of

what is happening during the therapeutic change process by providing opportunity of making in depth clinical analysis (Midgley, 2009). Also, single case designs may help developing and evaluating new assessment and treatment techniques (Photos, Michel & Nock, 2002). However, single case study comes with some drawbacks too. Firstly, especially statistically the results cannot be generalized. Secondly, even though the cases in this study were selected according to the similarity between demographics, reason for referral and session number, still these differences among the cases could be found. Poor case selection may lead to overgeneralization or misunderstandings of the associations between processes or variables (Bennett & Elman, 2006). Thirdly, especially for qualitative analysis, the question of researcher subjectivity is an important consideration. Involving deeply into a case may lead to bias towards preconception (Flyvbjerg, 2006). For avoiding these drawbacks, first of all, various single case studies must be done to find out if these results are valid for different patients too. After that, according to results of these studies, if there is a common pattern across cases, then large N studies can be conducted for modeling the change process regarding the level of representations and relational patterns.

Measures of the study is another important issue to be considered. First of all, CPTI provides a detailed description of different levels of play activity. It is a sensitive measure especially in terms of the assessment of different levels of social representations. However, the instrument does not assess the therapist's behaviors within the play activity. Especially when the findings of this study is considered, it is important to have information on

both parties for detecting the change statistically as well, apart from qualitative analysis. So, measures like Child Psychotherapy Q-Set (Schneider & Jones, 2004) can be used for gathering information from both parties. Also, even though there is a high inter-rater reliability, it is prominent to keep in mind the subjective aspect of rating the measure.

For assessing the relational patterns, CCRT was used. CCRT is a conducive measure for identifying the object relations within the play. However, this study was pioneer in terms of the application of CCRT in child psychotherapy. Some alterations were made considering the specific aspects of child treatment especially in terms of identifying the wish, responses of other and responses of self within the play activity. Regarding further research, different adaptations can be generated for the application of CCRT in child psychotherapy.

An important consideration regarding CCRT was about the limitations in data analysis. In some sessions, the CCRT was not observed within the play activity. This situation leads to some problems in data analysis part. Because statistically these values were counted as zero, the CCRT pervasiveness scores of segments that was not exhibited CCRT by the patient was counted as missing values. This leaded reduction in data set; some statistical analysis like Granger Causality Test or Time Series Analysis cannot be done because of the inadequate time points. To overcome this drawback, first of all, all sessions of patients must be videotaped and coded. In this research, due to technical problems, we could

not have access to these sessions. Also, a different coding system can be generated regarding the pervasiveness scores of CCRT. Apart from counting frequency, to what extent patient present his core conflictual relationship may be coded with a Likert scale (Tishby & Vered, 2011). By this way, the missing values will be prevented.

Another important point that has to be considered is the individual differences between the patients and therapists. More detailed pre-test and post-test designs can be added for obtaining a baseline of patient's and therapist's relational patterns for further studies. MacArthur Story Stem Battery (Bretherton & Oppenheim, 2003) for younger children and The Relationship Anecdotes Paradigm (RAP; Luborsky & Crits-Christoph, 1998) for older children and adolescent can be applied before, during and after the psychotherapy process. Also, the therapists narratives about significant others can be collected. Recently, a body of literature has been growing about the effect of patient's and therapist's relational patterns to the psychotherapy process and outcome (Schattner, Tishby & Wiseman, 2016).

It was stated that representations and relational patterns that are enacted in play were originated from the early childhood interactions with primary caregivers (Sandler & Rosenblatt, 1962). So, in child psychotherapy it is important to work with the parents as much as the child (Dowell & Ogles, 2010). Because these sessions can lead to some alterations regarding their attitude towards their children and to some extent the changes and transformations that observe in the psychotherapy process

may derive from parent sessions. So, for not underestimating the effects of these sessions, family sessions also taking into consideration.

5. CONCLUSION

The present study investigates the relationship between the level of social representations enacted in play and the changes in conflictual relational patterns over the course of psychotherapy. Through this study, it is seen that in an effective therapy, with the increase in the level of social representations enacted in play, the conflictual relational patterns decrease and more adaptive relational patterns are formed throughout the therapy process. At this point, play has an important role as being an intersubjective medium of communication between the patient and the therapist. Through play, patient reveal his inner world in relation to other. The material that is brought by the patient to the therapy room, is contained, elaborated and worked through by the therapist. By this way, a mutual play field is constructed between the patient and therapist that leads to improvement in richness and complexity of representations and reorganization of object relations. The mutual field between the dyad is consisted of both parties unique and spontaneous characteristics and the intersubjective moments that take place in this field between the patient and therapist that can lead to the reorganization of both explicit and implicit interactional patterns. However, at this point, the therapist's awareness of her feelings is important for both process and outcome of psychotherapy process.

References

Ackerman, S. (2010). Is infant research useful in clinical work with adults?. *Journal of the American Psychoanalytic Association, 58,* 1201-2011.

Achenbach , T. M. , & Rescorla , L. A. (2001). *Manual for the ASEBA School-Age Forms & Profiles*. Burlington: University of Vermont, Research Center for Children, Youth, and Families.

Agin S. & Fodor I. E. (1996). The use of the core conflictual relationship theme method in describing and comparing gestalt and relational emotive behavior therapy with adolescents. *Journal of Rational-Emotive and Cognitive-Behavior Therapy, 14 (3),* 173-186.

Altman, N. (1992), Relational perspectives on child psychoanalytic psychotherapy. In: *Relational Perspectives in Psychoanalysis*, ed. N. Skolnick & S. Warshaw. Hillsdale, NJ: The Analytic Press, pp. 175–194.

Altman, N., Briggs, R., Frankel, J., Gensler D. & Pantone, P. (2002). *Relational Child Psychotherapy.* New York: Other Press.

Alvarez, A. (1992). *Live Company: Psychoanalytic Psychotherapy with Autistic, Borderline, Deprived, and Abused Children.* New York: Routledge.

Alvarez, A. (1998). Failures to link: attacks or defects?: some questions concerning the thinkability of Oedipal and pre-Oedipal thoughts. *Journal of Child Psychotherapy*, *24*(2), 213-231.

Alvarez, A., & Phillips, A. (1998). The importance of play: A child psychotherapist's view. *Child Psychology and Psychiatry Review*, *3*(3), 99-103.

Atzil-Slonim, D., Wiseman H. & Tishby, O. (2016). Relationship representations and change in adolescents and emerging adults during psychodynamic psychotherapy. *Psychotherapy Research, 26 (3),* 279-296.

Baranger, M., & Baranger, W. (2008). The analytic situation as a dynamic field. *The International Journal of Psychoanalysis*, *89*(4), 795-826.

Barker, C., Pistrang, N., & Elliott, R. (2002) *Research methods in clinical psychology: A introduction for students and practitioners* (2nd ed.) Chichester, England: John Wiley & Sons.

Beebe, B., & Lachmann, F. M. (1988). The contribution of mother-infant mutual influence to the origins of self-and object representations. *Psychoanalytic psychology*, *5*(4), 305-337.

Berg, J. L., Packer, A., & Nunno, V. J. (1993). A Rorschach analysis: Parallel disturbance in thought and in self/object representation. *Journal of Personality Assessment*, *61*(2), 311-323.

Bennett, A., & Elman, C. (2006b). Qualitative research: Recent developments in case study methods. *Annual Review of Political Science, 9*, 455-476.

Beresford, C., Robinson, J. L., Holmberg, J., & Ross, R. G. (2007). Story stem responses of preschoolers with mood disturbances. *Attachment and Human Development, 9*(3), 255–270.

Bergman, A. (1993). To be or not to be separate: The Meaning of Hide-and-Seek in Forming Internal Representations. *Psychoanalytic review*, *80*(3), 361.

Bezoari M. & Ferro A. (1991). A journey through the bipersonal field of analysis. From role playing to transformations in the couple. Rivista di Psicoanalisi, 37, 4-46.

Bion, W. R. (1959). Attacks on linking. *The International Journal of Psycho-Analysis*, *40*, 308.

Bion, W. R. (1962). *Learning from experience*. Jason Aronson, Incorporated.

Blatt, S. J., & Auerbach, J. S. (2001). Mental representation, severe psychopathology, and the therapeutic process. *Journal of the American Psychoanalytic Association, 49*(1), 113- 159.

Blatt, S. J., & Lerner, H. (1983). The psychological assessment of object representation. *Journal of Personality Assessment, 47*(1), 7-28.

Blatt, S. J., Tuber, S. B., & Auerbach, J. S. (1990). Representation of interpersonal interactions on the Rorschach and level of psychopathology. *Journal of Personality Assessment, 54*(3-4), 711-728.

Bonovitz, C. (2004). The cocreation of fantasy and the transformation of psychic structure. *Psychoanalytic Dialogues*, *14*(5), 553-580.

Bretherton, I., & Oppenheim, D. (2003). The MacArthur Story Stem Battery: Development, directions for administration, reliability, validity and reflections about meaning. In R. N. Emde, D. P. Wolf, & D. Oppenheim (Eds.), *Revealing the inner worlds of young children: The MacArthur Story Stem Battery and parent-child narratives.* (pp. 55-80). New York: Oxford University Press.

Bruschweiler-Stern, N., Harrison, A. M., Lyons-Ruth, K., Morgan, A. C., Nahum, J. P., Sander, L. W., Stern, D. N. & Tronick, E. Z. (2002). Explicating the implicit: The local level and the microprocess of change in the analytic situation. *The International Journal of Psychoanalysis*, *83*(5), 1051-1062.

Bruschweiler-Stern, N., Lyons-Ruth, K., Morgan, A. C., & Nahum, J. P. (2007). The foundational level of psychodynamic meaning: Implicit

process in relation to conflict, defense and the dynamic unconscious. *International Journal of Psychoanalysis*, *88*, 843.

Caspary, A. C. (1993). Aspects of the therapeutic action in child analytic treatment. *Psychoanalytic Psychology*, *10*(2), 207.

Chari, U., Hirisave, U., & Appaji, L. (2013). Exploring play therapy in pediatric oncology: a preliminary endeavor. *The Indian Journal of Pediatrics*, *80*(4), 303-308.

Chazan, S. E. (2000). Using the children's play therapy instrument (CPTI) to measure the development of play in simultaneous treatment: A case study. *Infant Mental Health Journal, 21 (3*), 211-221.

Chazan S. E. (2001). Toward a nonverbal syntax of play therapy. *Psychoanalytic Inquiry, 21* (3), 394-406.

Chazan, S. (2002). *Profiles of play: Assessing and observing structure and process in play therapy*. Jessica Kingsley Publishers.

Chazan, S. E., & Wolf, J. (2002). Using the Children's Play Therapy Instrument to measure change in psychotherapy: The conflicted player. *Journal of Infant, Child, and Adolescent Psychotherapy*, *2*(3), 73-102.

Chetnik, M. (1989). *Techniques of child therapy*. New York: The Guilford Press.

Chari, U., Hirisave, U., & Appaji, L. (2013). Exploring play therapy in pediatric oncology: a preliminary endeavour. *The Indian Journal of Pediatrics*, *80*(4), 303-308.

Churcher, J. (2008). Some notes on the English translation of The analytic situation as a dynamic field by Willy and Madeleine Baranger. *The International Journal of Psychoanalysis*, *89*(4), 785-793.

Ciaglia, D. (2010). The psychotherapy od drug dependence: Changes in core conflictual relationship themes. (Unpublished doctoral dissertation). University of Wollongong, Wollongong.

Civitarese G. & Ferro A. (2013). The meaning and use of metaphor in analytic field theory. Psychoanalytic Inquiry, 33, 190-209.

Cohen, J. (1968). Weighted kappa: Nominal scale agreement provision for scaled disagreement or partial credit. *Psychological Bulletin*, *70*(4), 213.

Crisp, P. (1987). Uncontained projective identification: The vicious circle of runaway positive feedback loops. *Psychoanalytic psychology*, *4*(4), 291.

Crisp, P. (1988). Reconstruction and repetition: The significance of time-lags in psychoanalytic psychotherapy. *The American Journal of Psychoanalysis*,*48*(4), 347-354.

Crits-Christoph, P. & Luborsky, L. (1998). Changes in CCRT pervasiveness during psychotherapy. In L. Luborsky & P. Crits-Christoph (Eds.), Understanding transference: The core conflictual relationship theme method (pp. 151-163). Washington DC, US: American Psychological Association.

DiStefano C., Zhu M., & Mindrila D. (2009). Understanding and using factor Scores: Considerations for the applied researcher. *Practical Assessment, Research & Evaluation, 14(20)*, 1-11.

Dowell, K. A., & Ogles, B. M. (2010). The effects of parent participation on child psychotherapy outcome: A meta-analytic review. *Journal of Clinical Child & Adolescent Psychology*, *39*(2), 151-162.

Downey, T. W. (2001). Early object relations into new objects. *Psychoanalytic Study of the Child*, *56*, 39-67.

Erol, N., Arslan, B. L., &Akcakin, M. (1995).The adaptation and standardization of the Child Behavior Checklist among 6–18 year-old Turkish children. In J.A. Sergeant (Ed.),*Eunethydis: European Approaches to Hyperkinetic Disorder* (pp. 97-*113). Zurich: Fotoratar.*

Erol, N., & Şimşek, Z. T. (2000). Mental health of Turkish children: Behavioral and emotional problems reported by parents, teachers, and adolescents. *International Perspectives on Child and Adolescent Mental Health, 1*, 223-247.

Fabozzi, P. (2016). The use of the analyst and the sense of being real: the clinical meaning of Winnicott's "The Use of An Object". *The Psychoanalytic Quarterly*, *85*(1), 1-34.

Faust, J., & Burns, W. (1991). Coding therapist and child interaction: Progress and outcome in play therapy. *Play diagnosis and assessment*, 663-690.

Ferro, A. (1992). Two authors in search of characters: The relationship, the field, the story. *Rivista di Psicoanalisi*, *38*(1), 44-90.

Ferro, A. (1993). The impasse within a theory of the analytic field: possible vertices of observation. *The International Journal of Psycho-analysis*, *74*(5), 917-929.

Ferro, A. (2003). *The bi-personal field: Experiences in child analysis*. Routledge.

Ferro A. & Foresti G. (2008). "Objects" and "characters" in psychoanalytical texts/dialogues. *International Forum of Psychoanalysis*, *17*, 71-81.7

Flyvbjerg, B. (2006). Five misunderstandings about case-study research. *Qualitative Inquiry*, *12*(2), 219-245.

Fonagy, P., Target, M., Cottrell, D., Phillips, J., & Kurtz, Z. (2002). What works for whom. *A critical review of treatments for children and adolescents*, 1-41.

Fonagy P., Moran G. S., Edgcumbe R., Kennedy, H. & Target M. (1993). The roles of mental representations and mental processes in therapeutic action. *Psychoanalytic Study of the Child, 48,* 9-48.

Fonagy P. & Target M. (1996a). Playing with reality I: Theory of mind and the normal development of psychic reality. *The International Journal of Psycho-Analysis, 77,* 217-233.

Fonagy P. & Target M. (1996b). Playing with reality II: The development of psychic reality from a theoretical perspective. *The International Journal of Psycho-Analysis, 77,* 459-479.

Fonagy P. & Target M. (2000). Playing with reality III: The persistence of dual psychic reality in borderline patients. *The International Journal of Psychoanalysis, 81,* 853- 873.

Fonagy P. & Target M. (2007). Playing with Reality IV: A theory of external reality rooted in intersubjectiviy. *The International Journal of Psycho-Analysis, 88,* 917-937.

Frankel, J. B. (1998). The play's the thing how the essential processes of therapy are seen most clearly in child therapy. *Psychoanalytic Dialogues, 8*(1), 149-182.

Frankiel, R. V. (1993). Hide-and-seek in the playroom: On object loss and transference in child treatment. *Psychoanalytic review, 80*(3), 341.

Freedman, N., & Lavender, J. (1996). On receiving the patient's transference: the symbolizing and desymbolizing countertransference. *Journal of the American Psychoanalytic Association*, *45*(1), 79-103.

Freedman, N., Lasky, R., & Webster, J. (2009). The ordinary and the extraordinary countertransference. *Journal of the American Psychoanalytic Association*, *57*(2), 303-331.

Freud, S. (1914). Remembering, Repeating and Working-Through (Further Recommendations on the Technique of Psycho-Analysis II). *The Standard Edition of the Complete Psychological Works of Sigmund Freud, Volume XII (1911-1913): The Case of Schreber, Papers on Technique and Other Works*, 145-156.

Gaines, R. (1995). The treatment of children. In M. Lionells, J. Fiscalini, C. H. Mann & D. B. Stern (Eds.), *Handbook of interpersonal psychoanalysis* (pp. 715-770). Hillsdale, NJ: Analytic Press.

Gilmore, K. (2005). Play in the psychoanalytic setting: Ego capacity, ego state, and vehicle for intersubjective exchange. *The Psychoanalytic study of the child*.

Gitlin-Weiner, K., & Stalker, A. (2001). Play Diagnosis and Assessment. *European Child & Adolescent Psychiatry*, *10*(4), 261-263.

Goodman, G., & Athey-Lloyd, L. (2011). Interaction structures between a child and two therapists in the psychodynamic treatment of a child with Asperger's disorder. *Journal of Child Psychotherapy*, *37*(3), 311-326.

Greenberg, J. R. (1986). Theoretical models and the analyst's neutrality. *Contemporary Psychoanalysis*, *22*, 87–106.

Gruen, R. J., & Blatt, S. J. (1990). Change in self-and object representation during long-term dynamically oriented treatment. *Psychoanalytic Psychology*,*7*(3), 399.

Grunes, M. (1984). The therapeutic object relationship. *Psychoanalytic Review*,*71*(1), 123-144.

Haaga, D. A. F., & Stiles, W. B. (2000). Randomized clinical trials in psychotherapy research: Methodology, design, and evaluation. In C. R. Snyder & R. E. Ingram (Eds.), *Handbook of psychological change* (pp. 14-39). New York: Wiley.

Halfon S., Çavdar A., & Akırmak Ü. (2015). Assessment of play activity in psychodynamic child psychotherapy. Unpublished Manuscript. Department of Psychology, Istanbul Bilgi University, Istanbul. Turkey.

Hartman, D. & Zimberoff, D. (2004). Corrective emotional experience in the therapeutic process. *Journal of Heart-Centered Therapies, 7*(2), 3-84.

Hartmann, H. P. (2007). The unconscious in self psychology. *International Journal of Psychoanalytic Self Psychology*, *2*(3), 291-313.

Horne, A. (1989). Sally: A middle group approach to early trauma in a latency child. *Journal of Child Psychotherapy*, *15*(1), 79-98.

Howe, P. A., & Silvern, L. E. (1981). Behavioral observation of children during play therapy: Preliminary development of a research instrument. *Journal of Personality Assessment*, *45*(2), 168-182.

Imber, R. R. (1990). The avoidance of countertransference awareness in a pregnant analyst. *Contemporary Psychoanalysis*, *26*(2), 223-236.

Jacobson, N. S., & Truax, P. (1991). Clinical significance: a statistical approach to defining meaningful change in psychotherapy research. *Journal of Consulting and Clinical Psychology*, *59*(1), 12.

Kachele, H. & Dengler D., Eckert, R. & Schnekenburger, S. (1990). Change of the core conflictual relationship theme by a short term psychotherapy. *Psyhotherapie, Psychosomatik, Medizinische Psychologie*, *40 (5),* 178-185.

Kelly, F. D. (1996). *Object relations assessment in younger children: Rorschach and TAT measures*. Charles C Thomas Pub Ltd.

Kernberg, P F., Chazan S. E. & Normandin L. (1998). The Children's Play Therapy Instrument (CPTI): Description, development, and reliability studies. *Journal of Psychotherapy Practice and Research, 7(3)*, 196-207.

Klein, M. (1929). Personification in the play of children. *The International Journal of Psycho-Analysis, 10,* 193-2014.

Klein, M. (1946). Notes on Some Schizoid Mechanisms. *The International Journal of Psychoanalysis, 27,* 99-110.

Klein, M. (1958). On the development of mental functioning. *The International Journal of Psycho-Analysis, 39,* 84-90.

Krimendahl, E. K. (1998). Metaphor in child psychoanalysis: Not simply a means to an end. *Contemporary Psychoanalysis, 34*(1), 49-66.

Lang, F. (2007). Play in the psychoanalytic situation. *Journal of the American Psychoanalytic Association, 55*(3), 937-948.

Loewald H. W. (1960). On the therapeutic action of psycho-analysis. *The International Journal of Psychoanalysis, 41,* 16-33.

Loewald, H. W. (1971). Some considerations on repetition and repetition compulsion. *The International journal of psycho-analysis, 52*, 59.

Luborsky, L. (1977). Measuring a pervasive psychic structure in psychotherapy: The core conflictual relationship theme. In N.

Freedman (Ed.) *Communicative structures and psychic structures* (pp. 367-395). Springer US.

Luborsky, L.A., & Crits-Christoph, P. (1998). Understanding transference: The Core Conflictual Relationship method. Washington DC: American Psychological Association.

Luborsky, L., & Diguer, L. (1998). The reliability of the CCRT: A needed update. In L. Luborsky & P. Crits-Christoph (Eds.). *Understanding transference: The Core Conflictual Relationship Theme method* (2nd. ed. pp.97-108) Washington DC: American Psychological Association.

Luborsky, L., Popp C., Luborsky E., & Mark, D. (1994). The core conflictual relationship theme. *Psychotherapy Research, 4*(3-4), 172-183.

Lyons-Ruth, K. (1999). The two-person unconscious: Intersubjective dialogue, enactive relational representation, and the emergence of new forms of relational organization. *Psychoanalytic Inquiry, 19*(4), 576-617.

Mahler, M. (1979) *The Selected Papers of Margaret S. Mahler. Vol. 2: Separation-Individuation.* New York: Jason Aronson.

Marans, S., Mayes, L., Cicchetti, D., Dahl, K., Marans, W., & Cohen, D. J. (1991). The child-psychoanalytic play interview: A technique for

studying thematic content. *Journal of the American Psychoanalytic Association*, *39*(4), 1015-1036.

Mayman, M. (1967). Object-representations and object-relationships in Rorschach responses. *Journal of Projective Techniques and Personality Assessment*, *31*(4), 17-24.

McLeod, J. (2010). *Case Study Research: In Counseling and Psychotherapy*. Sage Publications.

Midgley, N., Anderson, J., Grainger, E., Nesic-Vuckovic, T., & Urwin, C. (Eds.). (2009). *Child psychotherapy and research: New approaches, emerging findings.* Routledge.

Minnis, H., Millward, R., Sinclair, C., Kennedy, E., Greig, A., Towlson, K., Read, W. & Hill, J. (2006). The Computerized MacArthur Story Stem Battery–a pilot study of a novel medium for assessing children's representations of relationships. *International Journal of Methods in Psychiatric Research*, *15*(4), 207-214.

Mufson, L., Dorta, K. P., Wickramaratne, P., Nomura, Y., Olfson, M., & Weissman, M. M. (2004). A randomized effectiveness trial of interpersonal psychotherapy for depressed adolescents. Archives of General Psychiatry, 61(6), 577-584.

Newirth, J. (1992). An object relations perspective: The paranoid position and the development of identity. In *Spring Meeting of the American*

Psychological Association Division 39 (1991, Chicago, Illinois). (Vol. 9, No. 3, p. 289). Lawrence Erlbaum Associates, Inc.

Nourbakhsh, M. R. & Ottenbacher, K. J. (1994). The statistical analysis of single-subject data: A comparative examination. *Physical Therapy, 74 (8),* 768-776.

Ogden, T. H. (1979). On projective identification. *The International journal of psycho-analysis, 60,* 357.

Ornstein, A. (1984). The function of play in the process of child psychotherapy: A contemporary perspective. *The Annual of Psychoanalysis*.

O'Rouke N., & Hatcher L. (2013). Principal Component Analysis. In O'Rouke & Katcher (2nd Eds.) *A Step-by-Step to Using SAS for Factor Analysis and Structural Equation Modeling.* North Carolina: SAS Institute Inc.

Photos, V., Michel, B. D., & Nock, M. K. (2008). Single-case research. Hersen, M., & Gross, A. M. (Eds.),*Handbook of Clinical Psychology, Volume 2: Children and Adolescents* (Vol. 2,pp.224-245*).* John Wiley & Sons.

Piaget, J. (1962). *Play, dreams and imitation in childhood.* New York: Norton.

Robinson, J. L. (2007). Story stem narratives with young children: Moving to clinical research and practice. *Attachment & Human Development*, *9*(3), 179-185.

Robinson, J., Hérot, C., Haynes, P., & Mantz-Simmons, L. (2000). Children's story stem responses: a measure of program impact on developmental risks associated with dysfunctional parenting. *Child abuse & neglect*, *24*(1), 99-110.

Rustin, M. (2003). Research in the consulting room. Journal of Child Psychotherapy, 29(2), 137-145.

Safran, J. D. (1993). The therapeutic alliance rupture as a transtheoretical phenomenon: Definitional and conceptual issues. *Journal of Psychotherapy Integration*, *3*(1), 33.

Sandler, J., & Rosenblatt, B. (1962). The concept of the representational world. *The Psychoanalytic Study of the Child*, *17*, 128-145.

Shadish, W. R., Cook, T. D., & Campbell, D. T. (2002). *Experimental and quasi-experimental designs for generalized causal inference*. Houghton, Mifflin and Company.

Schaefer, C. E., & Kaduson, H. G. (Eds.). (2007). *Contemporary play therapy: Theory, research, and practice*. Guilford Press.

Schattner, E., Tishby, O., & Wiseman, H. (2016). Relational Patterns and the Development of the Alliance: A Systematic Comparison of two Cases. *Clinical psychology & psychotherapy*.

Schmidt, S. J., & Schimmelmann, B. G. (2013). Evidence-based psychotherapy in children and adolescents: advances, methodological and conceptual limitations, and perspectives. *European child & adolescent psychiatry*, *22*(5), 265-268.

Schneider, C. & Jones, E. E. (2004). *Child Psychotherapy Q-Set Coding Manuel.* Unpublished manuscript, University of California, Berkeley.

Shaffer, D., Gould, M. S., Brasic, J., Ambrosini, P., Fisher, P., Bird, H., & Aluwahlia, S. (1983). A children's global assessment scale (CGAS). *Archives of General psychiatry*, *40(11)*, 1228-1231

Shrout, P. E. (1998). Measurement reliability and agreement in psychiatry. *Statistical Methods in Medical Research*, *7*(3), 301-317.

Silverman, M. A. (2007). The psychoanalyst as a new old object, an old new object, and a brand new object: reflections on Loewald's ideas about the role of internalization in life and in psychoanalytic treatment. *The Psychoanalytic quarterly*, *76*(4), 1153-1169.

Slade, A. (1994). Making meaning and making believe: Their role in the clinical process. *Children at play: Clinical and developmental approaches to meaning and representation*, 81-107.

Slade, M., & Priebe, S. (2001). Are randomized controlled trials the only gold that glitters? *The British Journal of Psychiatry*, *179*(4), 286-287.

Stern, D. N. (1985). The Interpersonal World of the Infant. New York: Basic Books.

Stern, D. N. (1998). Non-interpretive mechanisms in psychoanalytic therapy: The 'something more' than interpretation. *The International Journal of Psycho-Analysis*, *79*(5), 903-921.

Tishby, O. & Raitchick, I. & Shefler G. (2007). Changes in interpersonal conflicts among adolescents during psychodynamic therapy. *Psychotherapy Research, 17 (3),* 297-304.

Tishby, O., & Vered, M. (2011). Countertransference in the treatment of adolescents and its manifestation in the therapist-patient relationship. *Psychotherapy Research, 21*(6), 621- 630.

Tronick, E., Als, H., Adamson, L., Wise, S., & Brazelton, T. B. (1978). The infant's response to entrapment between contradictory messages in face-to-face interaction. *Journal of the American Academy of Child psychiatry*, *17*(1), 1-13.

Vliegen, N. (2008). Two people playing together: some thoughts on play, playing, and playfulness in psychoanalytic work. *The Psychoanalytic Study of the Child*, *64*, 131- 149.

Waldinger, R. J., Toth, S. L., & Gerber, A. (2001). Maltreatment and internal representations of relationships: Core relationship themes in the narratives of abused and neglected preschoolers. *Social Development*, *10*(1), 41-58.

Waldinger, R. J., Diguer, L., Guastella, F., Lefebvre, R., Allen, J. P., Luborsky, L., & Hauser, S. T. (2002). The same old song?—Stability and change in relationship schemas from adolescence to young adulthood. *Journal of Youth and Adolescence*, *31*(1), 17-29.

Wilson, A., & Weinstein, L. (1996). The transference and the zone of proximal development. *Journal of the American Psychoanalytic Association*, *44*(1), 167-200.

Weinstein, L. (2001). Language, transference, and the developmental context in child analysis. *The Psychoanalytic Study of The Child*, 57, 355-373.

Weissman, M. M., Warner, V., & Fendrich, M. (1990). Applying impairment criteria to children's psychiatric diagnosis. *Journal of the American Academy of Child & Adolescent Psychiatry*, *29*(5), 789-795.

Weisz, J. R., Doss, A. J., & Hawley, K. M. (2005). Youth psychotherapy outcome research: A review and critique of the evidence base. *Annual Review of Psychology*, 56, 337-363.

Westen, D. (1991). Clinical assessment of object relations using the TAT. *Journal of personality assessment, 56*(1), 56-74.

Wilczek, A., Weinryb, R., Barber, J., Gustavsson, J. P., & Åsberg, M. (2010). The core conflictual relationship theme (CCRT) and psychopathology in patients selected for dynamic psychotherapy. *Psychotherapy Research, 10* (1), 100-113.

Winnicott, D. W. (1968). Playing; its theoretical status in the clinical situation. *The International Journal of Psycho-Analysis, 49*, 591-599.

Winnicott, D. W. (1969). The use of an object. *The International Journal of Psycho-Analysis*, *50*, 711-716.

Winnicott, D. W. (1971). *Playing and reality*. Psychology Press.

Wolf, D., & Grollman, S. H. (1982). Ways of playing: Individual differences in imaginative style. In *The play of children: Current theory and research* (pp. 46-63). Karger Publishers.

APPENDIX

APPENDIX A

The Child Behavior Checklist (CBCL)

6-18 YAŞ ÇOCUK VE GENÇLER İÇİN DAVRANIŞ DEĞERLENDİRME ÖLÇEĞİ

No:

ÇOCUĞUN ADI, SOYADI	EV ADRESİ ve TEL NO:	ANNE BABANIN İŞİ (Ayrıntılı biçimde yazınız). EĞİTİMİ (Toplam kaç yıl okula gittiğinizi yazınız) BABANIN İŞİ:.....TEL NO :.....EĞİTİMİ:.....YAŞI..... ANNENİN İŞİ:.....TEL NO :.....EĞİTİMİ:.....YAŞI.....
CİNSİYETİ: ❒ ERKEK ❒ KIZ	YAŞI:	FORMU DOLDURAN: ❒ ANNE ❒ BABA ❒ DİĞER.....ÇOCUKLA OLAN İLİŞKİSİ.....
BUGUNUN TARİHİ GÜN.....AY.....YIL.....	ÇOCUĞUN DOĞUM TARİHİ GÜN.....AY.....YIL.....	
SINIFI:---------- OKULA DEVAM ETMİYOR ❒	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 ?				*Çocuğunuz her birinde ne kadar başarılıdır?*			
	Normalden az	Normal	Normalden fazla	Bilmiyorum	Normalden az	Normal	Normalden fazla	Bilmiyorum
a._____	❒	❒	❒	❒	❒	❒	❒	❒
b._____	❒	❒	❒	❒	❒	❒	❒	❒
c._____	❒	❒	❒	❒	❒	❒	❒	❒

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

❒ Hiç yok

	Çocuğunuz her birine ne kadar zaman ayırır ?				*Çocuğunuz her birinde ne kadar başarılıdır?*			
	Normalden az	Normal	Normalden fazla	Bilmiyorum	Normalden az	Normal	Normalden fazla	Bilmiyorum
a._____	❒	❒	❒	❒	❒	❒	❒	❒
b._____	❒	❒	❒	❒	❒	❒	❒	❒
c._____	❒	❒	❒	❒	❒	❒	❒	❒

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

❒ Hiç yok

	Çocuğunuz her birinde ne kadar başarılıdır?			
	Bilmiyorum	Az Aktif	Normal	Çok Aktif
a._____	❒	❒	❒	❒
b._____	❒	❒	❒	❒
c._____	❒	❒	❒	❒

IV. Çocuğunuzun evde ya da ev dışında yaptığı işleri a, b, c şıklarına yazınız. Örneğin: Gazete alma, bakkala gitme, pazara gitme, bahçe-tarla işleri, hayvancılık, elektrik- su faturası yatırma, çocuk bakımı, sofra kurma-kaldırma, bir dükkanda çalışma gibi ödeme yapılan ve yapılmayan herşeyi katınız.

❒ Hiç yok

	Çocuğunuz her birinde ne kadar başarılıdır?			
	Bilmiyorum	Normalden Az	Normal	Normalden Fazla
a._____	❒	❒	❒	❒
b._____	❒	❒	❒	❒
c._____	❒	❒	❒	❒

6-1-01 Baskısı-201

V. 1- Çocuğunuzun yaklaşık olarak kaç yakın arkadaşı vardır?
(Kardeşlerini katmayınız) Hiç yok ❒ 1 ❒ 2 ya da 3 ❒ 4 ya da fazla ❒

2- Çocuğunuz okul dışı zamanlarda haftada kaç kez arkadaşlarıyla birlikte olur? (Kardeşlerini katmayınız) 1 den az ❒ 1 ya da 2 ❒ 3 ya da daha fazla ❒

VI. Yaşıtlarıyla karşılaştırıldığında çocuğunuzun:

	Kötü	Normal Sayılır	Oldukça İyidir	Kardeşi Yoktur
a. Kardeşleriyle arası nasıldır?	❒	❒	❒	❒
b. Diğer çocuklarla arası nasıldır?	❒	❒	❒	❒
c. Size karşı davranışları nasıldır?	❒	❒	❒	❒
d. Kendi başına oyun oynaması ve iş yapması nasıldır?	❒	❒	❒	❒

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

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

Diğer derslerde nasıldır? Örneğin: Yabancı dil, bilgisayar.
(Beden eğitimi, resim ve müziği katmayınız)

e. _____	❒	❒	❒	❒
f. _____	❒	❒	❒	❒
g. _____	❒	❒	❒	❒

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- Kaçıncı sınıfta ve nedeni _____

4- Çocuğunuzun okulda ders ya da ders dışı sorunları oldu mu?
❒ Hayır ❒ Evet- açıklayınız _____

Bu sorunlar ne zaman başladı? _____

Sorunlar bitti mi?
❒ Hayır ❒ Evet- Ne zaman?

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

❒ Hayır ❒ Evet- açıklayınız _____

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

Çocuğunuzun en beğendiğiniz özellikleri nelerdir?

Lütfen yan sayfaya geçiniz

Aşağıda çocuk ve gençleri tanımlayan maddelerin bir listesi bulunmaktadır. Her bir madde çocuğun **şu andaki ya da son 6 ay** içindeki durumunu belirtmektedir. Bir madde çocuk 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 daha çocuksu davranır

0 1 2 2. Anne babanın izni olmadan içki içer

0 1 2 3. Çok tartışan bir çocuktur

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

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

0 1 2 6. Kakasını tuvaletten başka yerlere yapar

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

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

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

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

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

0 1 2 12. Yalnızlıktan şikayet eder

0 1 2 13. Kafası karışık, zihni bulanıktır

0 1 2 14. Çok ağlar

0 1 2 15. Hayvanlara eziyet eder

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

0 1 2 17. Hayal kurar, hayallere dalıp gider

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

0 1 2 19. Hep dikkat çekmeye çalışır

0 1 2 20. Eşyalarına zarar verir

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

0 1 2 22. Evde söz dinlemez

0 1 2 23. Okulda söz dinlemez

0 1 2 24. İştahsızdır

0 1 2 25. Başka çocuklarla geçinemez

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

0 1 2 27. Kolay kıskanır

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

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

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

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

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

0 1 2 33. Kimsenin onu sevmediğinden yakınır

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

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

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

0 1 2 37. Çok kavga çıkarır, kavgaya karışır

0 1 2 38. Çok fazla sataşılır, dalga geçilir

0 1 2 39. Başı belada olan kişilerle dolaşır

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

_____

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

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

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

0 1 2 44. Tırnaklarını yer

0 1 2 45. Sinirli ve gergindir

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

_____

0 1 2 47. Geceleri kabus görür

0 1 2 48. Başka çocuklar tarafından sevilmez

0 1 2 49. Kabızlık çeker

0 1 2 50. Çok korkak ve kaygılıdır

0 1 2 51. Başı döner, gözleri kararır

0 1 2 52. Kendini çok suçlu hisseder

0 1 2 53. Aşırı yer

0 1 2 54. Sebepsiz yere çok yorgun hissettiği olur

0 1 2 55. Fazla kiloludur

56. ***Sağlık sorunu olmadığı halde ;***

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

0 1 2 b. Başağrılarından 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):

_____

Lütfen arka sayfaya geçiniz

Aşağıda çocuk ve gençleri tanımlayan maddelerin bir listesi bulunmaktadır. Her bir madde çocuğun **şu andaki ya da son 6 ay** içindeki durumunu belirtmektedir. Bir madde çocuk 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.

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0 1 2 3. Çok tartışan bir çocuktur

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

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

0 1 2 6. Kakasını tuvaletten başka yerlere yapar

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

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

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

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

0 1 2 11. Gereken gayreti göstermeden, sırtını tamamen büyüklere dayayıp herşeyi 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

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

0 1 2 19. Hep dikkat çekmeye çalışır

0 1 2 20. Eşyalarına zarar verir

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

0 1 2 22. Evde söz dinlemez

0 1 2 23. Okulda söz dinlemez

0 1 2 24. İştahsızdır

0 1 2 25. Başka çocuklarla geçinemez

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

0 1 2 27. Kolay kıskanır

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

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

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

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

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

0 1 2 33. Kimsenin onu sevmediğinden yakınır

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

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

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

0 1 2 37. Çok kavga çıkarır, kavgaya karışır

0 1 2 38. Çok fazla sataşılır, dalga geçilir

0 1 2 39. Başı belada olan kişilerle dolaşır

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

_____

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

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

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

0 1 2 44. Tırnaklarını yer

0 1 2 45. Sinirli ve gergindir

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

_____

0 1 2 47. Geceleri kabus görür

0 1 2 48. Başka çocuklar tarafından sevilmez

0 1 2 49. Kabızlık çeker

0 1 2 50. Çok korkak ve kaygılıdır

0 1 2 51. Başı döner, gözleri kararır

0 1 2 52. Kendini çok suçlu hisseder

0 1 2 53. Aşırı yer

0 1 2 54. Sebepsiz yere çok yorgun hissettiği olur

0 1 2 55. Fazla kiloludur

56. ***Sağlık sorunu olmadığı halde ;***

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

0 1 2 b. Başağrılarından 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):

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Lütfen arka sayfaya geçiniz