BASELINE PREDICTORS AND CLIENT'S PERSPECTIVES ON NON-RESPONSE IN MENTALIZATION-BASED TREATMENT FOR CHILDREN

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ABSTRACT

This study aims to examine the status of children who do not show symptomatic improvement (non-responders) in a multidimensional manner during the Mentalization-Based Child Therapy (MBT-C) process. MBT-C is a psychodynamic-based therapy model aimed at increasing the capacity of children and their parents to understand their own and others' mental states (mentalization) and to develop emotional regulation and interpersonal functioning (Midgley, 2017). The data obtained from this clinical study belonging to 86 children between the ages of 5-12 were analyzed. Within the scope of the quantitative analysis, the relationship between whether or not they respond to therapy and some child and parent characteristics was tested with logistic regression analyses. The number of traumatic experiences experienced by children, emotional regulation capacity, adaptive play capacity, and mentalization capacity and emotional regulation skills of parents were examined as independent variables. As a result of the analysis, it was found that children with high trauma history and low emotional regulation capacity were significantly more likely to not respond to therapy. In the qualitative analysis section, semi-structured interviews with parents of children who did not benefit from the therapy process were examined using thematic analysis method. Three main themes emerged: (1) Negative Feelings and Thoughts About Therapy, (2) Unmet Needs and Expectations, (3) Parental Gains. These themes revealed that some children needed longer, more structured, or more explicit therapeutic processes. This study emphasizes the importance of making adaptations appropriate to each child's individual needs in order to increase the effectiveness of MBT-C. Although it is not possible to make a clear conclusion about the benefits of therapy for children with emotional regulation difficulties and high trauma history, it is necessary to investigate these children in more detail. In addition, this study is one of the first to systematically address the concept of non-response in MBT-C, filling a unique gap in the literature

Keywords: Non-response in Child Therapy; Mentalization Based Therapy for Children; Baseline Characteristics; Therapy Experiences; Treatment Barriers

ÖZ

Bu çalışma, semptomatik iyileşme göstermeyen çocukların (yanıt vermeyenler) Mentalizasyon Tabanlı Çocuk Terapisi (MBT-C) sürecindeki durumlarını çok boyutlu olarak incelemeyi amaçlamaktadır. MBT-C, çocukların ve ebeveynlerinin kendi ve başkalarının zihinsel durumlarını anlama (mentalizasyon) ve duygusal düzenleme ve kişilerarası işlevsellik geliştirme kapasitelerini artırmayı amaçlayan psikodinamik tabanlı bir terapi modelidir (Midgley, 2017). 5-12 yaş aralığındaki 86 çocuğa ait bu klinik çalışmadan elde edilen veriler analiz edilmiştir. Kantitatif analiz kapsamında, terapiye yanıt verip vermemeleri ile bazı çocuk ve ebeveyn özellikleri arasındaki ilişki lojistik regresyon analizleri ile test edilmiştir. Çocukların deneyimlediği travmatik deneyim sayısı, duygusal düzenleme kapasitesi, adaptif oyun kapasitesi ve ebeveynlerin mentalizasyon kapasitesi ve duygusal düzenleme becerileri bağımsız değişkenler olarak incelenmiştir. Analiz sonucunda, yüksek travma geçmişi ve düşük duygusal düzenleme kapasitesi olan çocukların terapiye yanıt vermeme olasılığının anlamlı derecede daha yüksek olduğu bulunmuştur. Nitel analiz bölümünde, terapi sürecinden fayda görmeyen çocukların ebeveynleri ile yapılan yarı yapılandırılmış görüşmeler tematik analiz yöntemi kullanılarak incelenmiştir. Üç ana tema ortaya çıkmıştır: (1) Terapi Hakkında Olumsuz Duygular ve Düşünceler, (2) Karşılanmayan İhtiyaçlar ve Beklentiler, (3) Ebeveyn Kazanımları. Bu temalar, bazı çocukların daha uzun, daha yapılandırılmış veya daha açık terapötik süreçlere ihtiyaç duyduğunu ortaya koymuştur. Bu çalışma, MBT-C'nin etkinliğini artırmak için her çocuğun bireysel ihtiyaçlarına uygun uyarlamalar yapmanın önemini vurgulamaktadır. Duygusal düzenleme güçlüğü ve yüksek travma öyküsü olan çocuklar için terapinin faydaları hakkında net bir sonuca varmak mümkün olmasa da, bu çocukların daha detaylı araştırılması gerekmektedir. Ayrıca, bu çalışma MBT-C'de yanıtsızlık kavramını sistematik olarak ele alan ilk çalışmalardan biri olup, literatürdeki benzersiz bir boşluğu doldurmuştur.

Anahtar Kelimeler: Çocuk Terapisinde Yanıtsızlık; Çocuklar İçin Mentalizasyon Temelli Terapi; Başlangıç Ölçümleri; Terapi Deneyimleri; Tedavi Engelleri

To my beloved ones

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INTRODUCTION

Mentalization-Based Therapy for Children (MBT-C) is a psychodynamically based and structured therapy model that aims to develop children's capacity to make sense of their own and others' mental states (Midgley, 2017). This model has been shown to be effective in many studies on children's emotional, behavioral and interpersonal problems (Halfon et al., 2024). However, not every child benefits equally from this therapeutic approach; some children do not show clinical improvement despite completing the process. This situation is defined as "non-response" and indicates the need for research to understand why some children do not benefit from this process as well as the effectiveness of the therapeutic process.

The main purpose of this thesis is to examine the individual and contextual characteristics of children who do not respond to therapeutic treatment (non-responders) and their parents in the MBT-C application and to understand how they experience the therapeutic process. The study includes both quantitative and qualitative data collection. In the quantitative part, early indicators predicting therapeutic non-response were tested; in the qualitative part, the experiences of the process were examined in depth through semi-structured interviews with children who experienced non-response and their parents. The main questions of the research focus on which individual and environmental factors are related to this non-response of children who did not respond during the MBT-C process and how children and parents experienced this process. The interviews also aimed to reveal parent and child perspectives on the effects of therapy, the difficulties encountered and how the process could be improved.

The hypotheses developed in the quantitative part of the research are based on previous theoretical and empirical studies. In this context, it was predicted that children who showed unresponsiveness to MBT-C would have lower adaptive play capacity (Cole et al., 2004), poorer emotional regulation skills (Gross, 2002), a higher number of traumatic life experiences (Felitti et al., 1998; Dube et al., 2003), and higher prementalizing tendencies of their parents (Slade, 2005) before treatment. The

hypotheses are as follows: (1) The child's adaptive play capacity before treatment predicts non-response, (2) The child's emotional regulation capacity predicts non-response, (3) The number of traumatic life experiences predicts non-response, (4) The child's age predicts non-response, (5) The number of sessions attended predicts non-response, (6) The parent's emotional regulation capacity predicts non-response, (7) The parent's prementalizing level predicts non-response.

The theoretical framework of the study combines mentalization theory with the developmental psychopathology perspective; it evaluates multi-layered factors such as children's developmental history, parental functionality and the therapeutic relationship together. The qualitative analysis aims to reveal the subjective experiences of parents and children regarding the process under three main themes, going beyond the change in symptom level: "Negative Feelings and Thoughts Towards Therapy", "Unmet Expectations and Needs" and "Parenting Gains". In this respect, the study is one of the pioneering studies that addresses the concept of non-response in the context of MBT-C both structurally and experientially. Thesis provides a framework for understanding not only therapeutic effectiveness but also the reasons for ineffectiveness; it draws attention to the necessity of therapy practices that are sensitive to individual differences, flexible and open to development. It is expected that the findings will contribute both theoretically and methodologically to the diversification and adaptation of MBT-C practices.

LITERATURE REVIEW

2.1. The Term Non-response

Psychotherapy is a scientific and effective intervention that aims to increase the psychological well-being of individuals. There are several methods and pathways for psychotherapy work. Although psychotherapies are often evaluated with subjective or relative criteria, psychotherapy research can measure the effectiveness of therapy interventions, areas where they are beneficial, and situations where they are not beneficial. These measures contribute to the literature about the effectiveness of the therapy. Researchers expect therapies to be significantly effective for clients. Psychotherapy research in the literature is mostly focused on effectiveness. Measurements are made on effectiveness and what is effective is investigated. However, what is not effective and what prevents the effect is also an area that needs to be investigated in detail. Clients who do not end up with the expected effects after the therapy process are defined as 'non-responders', and this area is relatively less investigated in psychotherapy research (Lambert, 2013). It can also be defined as individuals who do not show a significant improvement at the clinical level or whose symptoms do not decrease at the end of therapy and afterwards. Understanding why some clients do not get expected outcomes from psychotherapy is crucial to explore what affects the effectiveness.

Research shows that approximately one third of adult psychotherapy studies have shown no benefit (Hansen et al., 2002). However, a clear prevalence rate of non-response in child therapies does not appear to be consistently reported in the existing literature. Non-response has been seen as a treatment failure (Lambert, 2010). Failure of the targeted effect to decrease clinical symptom severity to the expected level can be considered as failure in the therapy process. Failures in the therapy process cause problems for clients, therapists, the health system and the economic system (Reuter, L. et al., 2015). Clients' hopelessness about their recovery may cause therapists to question their professional competence, and the burden of recurring symptoms on the health

system and the economy can be quite high. However, it is a question mark that needs to be investigated why the symptoms of the clients who have participated in the therapy process, followed its requirements but whose symptom severity continues to be at the clinical level do not decrease. In this sense, which factors are underlying to be related to non-response and what can affect responsiveness needs to be investigated in depth.

Looking at the literature, some studies aimed to understand the effect of therapy by measuring it with self-report surveys (Krause et al., 2019, 2020), but there is not much research exploring the experiences of clients. Quantitative methods predict what may affect the outcomes by using standardized measures. While quantitative measures are useful in identifying general trends, they cannot fully explain the complex and multidimensional experiences that individuals go through. Even though these methods are faster and more convenient, they lack depth. In this context, the importance of qualitative research is increasing. Qualitative research can examine the therapy process from individuals' own perspectives and by focusing on their "lived experiences", thus illuminating elements of treatment that may be overlooked by other methods (Fiorini et al., 2024).

Although some researchers have adopted a mixed-methods approach to benefit from the strengths of both paradigms, others have conducted separate qualitative and quantitative studies. For example, Fiorini et al. (2024) conducted two distinct studies—one qualitative and one quantitative—to capture both broad patterns and rich individual perspectives. In their work, the quantitative study helped identify general trends, while the qualitative interviews provided an in-depth understanding of individuals' therapeutic experiences. This approach emphasizes that while survey data can give insight into broad associations, they may fall short in capturing nuanced personal experiences, including external factors and the therapeutic relationship.

One of the few studies using a purely qualitative approach, Mehta et al. (2023), analyzed interviews with five young people who were treated for depression using the IMPACT trial. This study provided important information about the outcomes that clients expected from therapy and the negative experiences they had. The adolescents

who did not respond to therapy stated that they believed their depression was “too severe to be cured” with therapy. They also described feeling worse as a result of therapy, such as feeling like a burden or experiencing a negative therapeutic relationship. However, some minor improvements were also noted, such as gaining greater self-awareness or feeling able to share their thoughts and feelings (Mehta et al., 2023).

These findings highlight the importance of qualitative methods in providing a deeper understanding of why therapy may not always be effective. In particular, understanding the experiences and perceptions of non-responders can inform the development of more tailored and responsive therapeutic approaches. Additionally, the results underline the need to consider individual differences and initial characteristics (e.g., symptom severity, attachment style, parental support) before initiating treatment. Such studies offer a critical framework not only for understanding successful outcomes but also for exploring unexpected or limited therapeutic effects—and the reasons behind them.

2.2. Factors Related to Non-response

There are several studies examining the factors that affect the outcomes of therapy. Research on non-responders indicates that the treatment process should be personalized and flexible (Carrington et. al., 2024). Developing methods that are sensitive to individual differences and addressing clients with their individual differences will affect the benefit they will receive from therapy. This is a strong emphasis on the fact that each individual has unique treatment needs and that different therapy methods may be more effective for different individuals (Fiorini et al., 2013; Barlow, 2010). It has also been suggested that the therapy process should be shaped based on the emotional state of the individuals, their relationship with the therapist, and their environmental conditions (Fiorini et al., 2013). In addition to individual differences, these conditions are also important factors affecting the therapy process and the effectiveness of therapy.

Procedural difficulties experienced during the therapy process, environmental conditions, and the relationship established with the therapist may be important to consider in the therapy process. For instance, Werbart et al. (2024), in their study

comparing successful and less successful psychotherapy processes, emphasized that the therapeutic alliance and therapists' early adaptation to the needs of their clients were factors in treatment outcomes. In successful cases, therapists strengthened the alliance by deeply understanding their patients' problems and repaired crises. In less successful cases, therapists had difficulty managing countertransference feelings and were unable to fully encompass the needs of their clients. These findings reveal the importance of considering individual differences in order to increase the effectiveness of therapy.

Carrington et al. (2024) emphasize that the lack of positive effects observed in therapeutic processes is closely related to individual and environmental factors. In particular, higher symptom levels, other comorbid psychological difficulties, and low alliance with the therapist have been identified as predictors of non-response. De Smet et al. (2019) suggest that the non-response state in psychotherapy for depressed clients can be understood as a psychological impasse in which individuals gain awareness and personal power but feel powerless to make practical changes. Although there was no significant reduction in symptoms, patients reported improvements in mental balance and personal power. It was observed that the clients were actually able to gain deep insight and awareness about themselves. However, they mentioned the difficulty of making changes in their lives. This study also shows that effectiveness can be measured from the individual experiences of the clients in non-response studies, and that the response may not be just symptom reduction. It may show that therapy can be effective for the client even if it is not effective in reducing symptoms. The study highlights the importance of using mixed-method research to gain a deeper understanding of treatment outcomes.

Individuals who do not respond to psychotherapy sometimes do not experience symptom reduction due to internal psychological barriers. As De Smet et al. (2019) stated, a ‘psychological impasse’ may occur; in this case, individuals may feel powerless to make changes while recognizing the difficulties they are experiencing. This situation may also be reinforced by ‘cognitive biases’; for example, ‘catastrophizing’ and seeing difficulties as insurmountable obstacles, or ‘attachment styles’ may negatively affect the therapeutic relationship. For instance, individuals with

an insecure attachment style may have difficulty establishing a secure relationship with their therapist, which may reduce the effectiveness of therapy (Carrington et al., 2024; Werbart et al., 2024). In addition, 'resistance' is an important component of therapy. Individuals with lower resistance may have difficulty coping with the emotional demands of therapy, which may lead to withdrawal or emotional avoidance from therapy (Werbart et al., 2024). These psychological and relational factors may negatively affect treatment processes. Therefore, it is emphasized that therapies for unresponsive individuals should be arranged in a personalized and flexible manner (Carrington et al., 2024).

2.3. Baseline Characteristics and Non-response

2.3.1. Adverse Childhood Experiences of Children and Non-response

In child psychotherapy, the child's individual characteristics also play an important role in the non-response. Childhood trauma is known to have negative effects on psychological health, studies by Felitti et al. (1998) and Dube et al. (2003) have shown that children who have experienced high levels of trauma are at higher risk of experiencing psychological problems. Trauma can disrupt emotional regulation processes and make it difficult to process therapeutic content. There is ongoing discussion in the literature that adolescents exposed to prolonged and intense interpersonal trauma may require interventions beyond traditional trauma-focused treatments to effectively manage their symptoms (Cloitre et al., 2011). It has been suggested that this group has persistent difficulties in the areas of emotional and interpersonal regulation, which may negatively impact participation in therapy and the development of the therapeutic alliance, leading to poor treatment response (Stein et al., 2012).

In trauma-focused therapies for children, exposure to multiple traumatic experiences is significantly associated with poor response to treatment and early withdrawal from the process. In a meta-analysis conducted by Skar et al. (2022) with 1240 children, children

who had experienced three or more different traumas were more likely to drop out of therapy or not show significant improvement. These findings emphasize the importance of in-depth assessment of trauma history before treatment. At the same time, the initial level of post-traumatic stress symptoms stands out as a factor that significantly affects therapy outcomes. It has been revealed that children with high PTSS levels are more likely to be in the non-responder group at the end of therapy. This situation shows how important it is to conduct a risk analysis at the beginning of the intervention for individuals with a heavy symptom burden. In a master's thesis written from the RCT study (Halfon, 2024), which is the data of the current study (Koç, 2024), a case study was conducted on two children with ACE scores of 4 and above, but who received two different responses to treatment. One of the children was non-responder, while the other was a responder. When the child who received a response despite the high ACE score and the non-responder child were examined, it was seen that nonverbal communication and mental state talk were the determining factors between ACE and outcome. This showed that there may be other factors effective between ACE and outcome.

2.3.2. Children's Emotion Regulation Capacity

Emotion regulation capacity of children is an important factor that affects the effectiveness of therapy. Studies by Cole et al. (2004) and Gross (2002) show that children who have difficulty regulating emotions have more behavioral problems. In the RCT study, a significant increase in emotion regulation skills was observed in children who participated in the MBT-C process at the end of therapy and this gain was maintained during the follow-up period (Halfon et al., 2024). This finding is supported by previous research showing that emotion regulation difficulties are one of the main determinants of internalizing and externalizing symptoms observed in childhood (Halfon & Bulut, 2019; Aldao et al., 2016).

The study by Fernandes et al. (2023) shows the importance that children's pre-intervention executive function levels and emotional regulation strategies may be important characteristics associated with emotional and behavioral symptoms during the intervention process. In particular, dysfunctional emotion regulation strategies such as

catastrophizing and blaming others were found to be significantly associated with emotional and behavioral symptoms. The decrease in the use of such strategies after the intervention indicates that developing emotional regulation skills contributes to the effectiveness of the intervention. These findings suggest that pre-intervention assessment of emotional regulation and executive function capacity may provide important contributions in predicting the benefits of intervention.

Another study conducted by Suveg et al. (2018), cognitive behavioral therapy (ECBT) focused on emotional regulation was compared with traditional cognitive behavioral therapy (CBT) and children aged 7-12 years who were diagnosed with separation anxiety disorder, generalized anxiety disorder or social phobia were included as a sample. The researchers tested whether pretreatment emotional dysregulation levels in particular played a determining role in which treatment would respond better. It has been suggested that ECBT may be particularly beneficial for children with high levels of emotional dysregulation because it provides children with practice regulating different emotions. However, contrary to expectations, pretreatment emotional dysregulation levels measured based on both child and caregiver reports did not significantly affect treatment outcomes. Moderator analyses revealed similar levels of improvement in the ECBT and CBT groups and no significant differences in diagnostic, severity and general developmental measures. These findings suggest that the presence of emotional regulation difficulties alone is not sufficient to predict which therapeutic approach will be more effective. Therefore, further studies are needed that examine the relationship between emotional regulation and treatment outcomes in anxious children in more detail.

2.3.3. Adaptive Play Capacity and Non-response

Play capacity is also an important characteristic of children for their development. Russ (2003) states that what really helps kids change in therapy is not just showing feelings, but also how they use play to mix feelings and imagination in a good way. Adaptive play is closely related to cognitive and emotional development. Chazan (2000) stated that children with low adaptive play capacity have difficulty processing trauma and

emotional processes. Children who participate in adaptive play appear to have more developed emotional regulation skills (Galyer & Evans, 2001). Such games serve as a means of expression through which children can express their internal conflicts (Halfon & Bulut, 2019).

Halfon and Bulut (2019) conducted a study examining the development of adherence and symbolic play capacity in psychodynamic therapy. In this study, when treatment adherence was high, symbolic play capacity increased at the beginning of treatment. Its development slowed down later in the treatment. These findings showed that symbolic play capacity can develop in psychodynamic therapy. In this study, symbolic play capacity was measured by sections taken from the sessions and coding the game. This allowed the measurement of play capacity in spontaneous sessions.

2.3.4. Children's Age

In addition to these, when the literature is examined, it has been seen that there are different factors that predict non-response. For example, it has been thought that one of the factors affecting the therapy process may be age. In childhood, each age can pass through many developmental stages and major changes. Midgeley and Kennedy (2011), and Midgely et al. (2017) stated in their studies that younger children benefit more from psychodynamic therapy. In trauma therapy, child age is a significant factor in response to treatment. A large-scale meta-analysis conducted by Skar et al. (2022) showed that older children were less responsive to treatment. This suggests that developmental differences may be related to emotional processing styles and coping strategies. Therefore, age should be taken into account when planning trauma interventions.

2.3.5. Total Sessions and Non-response

Also, a number of sessions could be effective in outcome. Some studies have questioned the assumption that more sessions lead to better outcomes in child therapy. For example, research has shown that children who received a high number of therapy sessions did

not have significantly better mental health outcomes compared to those who received very few (Andrade et. al., 2000). These findings challenge the idea of a clear and consistent dose–response effect, suggesting that session quantity alone may not be a reliable predictor of therapeutic success, and caution should be taken when using session count to guide clinical or policy decisions.

2.3.6. Parental Characteristics and Non-response

In child therapies, not only the child's process is evaluated, but often parents are also a part of the process. Evaluations and therapeutic interventions are intensively applied to both children and parents, especially in the MBT-C model. Therefore, in addition to child variables, parental characteristics and involvement are also important in terms of effectiveness. According to the meta-analytic review by Kathy A. Dowell and Benjamin M. Ogle,(2010) treatments that include parent and child involvement produce better effects than outcomes where only children are treated. In other words, therapies where the family also participates are more effective than therapies where only the child participates. This situation also emphasizes the importance of including parents and children in the process with parallel sessions in the MBT-C model.

2.3.6.1. Parental Emotion Regulation Capacity

Parents' emotion regulation skills play a critical role in the children's well-being.. A study states that parents who have higher levels of parental emotion regulation capacity are usually better at handling their child’s distress (Rutherford et al., 2013). Jones and O'Leary (2008) stated that parents' difficulty in regulating their emotions cannot provide the necessary support for the children's therapeutic process. In an outcome prediction study for youth therapy, they found that parental social role performance and interpersonal relationships significantly predicted youth treatment outcome (Packard et al., 2020), illustrating the effects of parental characteristics in work with youth (Halfon & Beşiroğlu, 2020).

In the study conducted by Zimmer-Gembeck et al. (2019) on the application of Parent-Child Interaction Therapy PCIT, improvements observed in parents' emotion regulation and reflective function skills were among the important outcomes of the intervention. In particular, the increase in cognitive reappraisal skills and the decrease in prementalization levels contributed to the improvements observed in children's behavioral and emotional symptoms. These findings may help explain why some children benefit from therapy while others remain unresponsive. It is observed that children respond more positively to therapy when therapy improves not only parenting behaviors but also the psychological capacity of the parent (e.g. emotion regulation and mentalization). In this context, the fact that such processes are not sufficiently developed at the parental level may be effective in cases of non-response.

Recent research has shown that MBT-C provides significant and sustained improvements in mothers' emotion regulation skills at the end of therapy (Halfon et al., 2024). This development is particularly significant when one considers that parental emotional regulation deficiencies are a risk factor closely related to internalizing and externalizing problems observed in children (Halfon & Bulut, 2019; Aldao et al., 2016). Therefore, supporting parents' emotional regulation capacity may pave the way for children to achieve more positive therapeutic gains; however, the mediating mechanisms of this process need to be further investigated.

2.3.6.2. Parental Reflective Functioning

Fonagy et al. (1998) and Slade (2005) emphasized that parental reflective functions are important in the development of children's emotion regulation and mentalization capacities. Higher levels of parental reflective functioning was correlated with their children's development of better emotion regulation, self-regulation capacities, and attachment security (Luyten et al., 2017). Thus, it helps to improve parent and child relationship when parental reflective functioning is improved by understanding children's feelings and thoughts better (Slade, 2005). Parents tend to talk with their children more effectively and use more positive parenting approaches when the reflective functioning is high (Rostad & Whitaker, 2016). Parental reflective functioning

(PRF) has been identified as a protective factor against both internalizing and externalizing problems in school-aged children (Taubner & Curth, 2013; Ensink et al., 2016; Benbassat & Priel, 2012). Low mentalizing capacity in parents has been reported to predict problem behaviors such as anxiety (Esbjørn et al., 2013) and conduct or oppositional defiant disorder in children (Centifanti et al., 2016). Furthermore, Sharp et al. (2006) found an inverse relationship between parents' ability to accurately predict their children's reactions and levels of psychopathology in children.

Reflective function has been studied mostly in therapies with adults in terms of outcome prediction. The predictive role of mentalization in psychoanalytic therapies with adults has been investigated, usually using the Adult Reflective Function Scale (ARFS; Fonagy et al., 1998) consisting of findings that are inconsistent. Some studies have shown that high mentalizing capacity at baseline positively affects therapy outcome (Ekeblad et al., 2016). Other studies have failed to support this relationship (Rudden et al., 2006; Taubner et al., 2011). However, Taubner et al. (2011) found that reflective function can predict reductions in general distress and improvements in the quality of the therapeutic relationship. Existing studies show that the effect of baseline reflective function (RF) in predicting therapy outcome does not vary according to the type of therapy applied (Ekeblad et al., 2016; Katznelson et al., 2019). However, it was found that the increase in RF was more pronounced in psychodynamic therapy and this increase affected therapy outcome only in this type of therapy (Katznelson et al., 2019). According to Gullestad et al.'s (2013) study, individuals with low reflective functioning levels benefited more from psychodynamic therapy compared to outpatient aftercare, especially between 8 and 36 months, while those with medium and high RF levels benefited similarly from both types of treatment, especially in the first 8 months.

Halfon and Beşiroğlu (2021) conducted a study examining the effect of both parent and child mentalization in predicting therapy outcome in psychodynamic child psychotherapy. The findings showed that mothers' reflective functioning (child-focused PRF), in particular, was associated with a decrease in problem behaviors. These results suggest that parents' mentalization capacity toward their children may be an important variable in predicting treatment response in psychodynamic child therapies. In this study,

the reflective function of the parent was coded through the parent development interview (PDI). It was examined how the mentalization capacity of parents was reflected when answering questions about their children. Halfon and colleagues conducted a Randomized Controlled Trial for Mentalization Based Treatment in Children revealed some findings (Halfon et. al., 2024). In this study, the improvement level and difference between the MBT-C group and the Parenting and Social Skills Group (PSSG) were examined. In the analyses conducted for the MBT-C group, it was found that the parental mentalization capacity did not change after therapy. In a thesis based on the same study, Özsoy (2024) found that the mentalization skills of parents in the MBT-C group did not predict child behavioral outcomes.

It should be noted that these factors can often interact in complex ways. For example, children who have experienced high levels of trauma may also have difficulties with emotion regulation and adaptive play capacities. In addition, reflective functions of the parent may reduce or exacerbate these difficulties (Slade, 2005; Halfon, 2017). Unresponsive children could have more than one of these factors, which can complicate their therapeutic progress. Since these factors are inherently interrelated, the contribution of the therapy process may contribute to the development of all factors over time or may be insufficient to resolve a complex difficulty.

2.4. Non-response in Mentalization Based Treatment

Mentalization is a capacity to understand one's own and other's mental states and underlying causes (Fonagy & Target, 1996). This capacity helps to reflect on the wishes and desires of one's own or others' and understand the meaning of actions and emotions. The capacity for mentalization varies for each individual, and may vary depending on emotional experiences, difficult situations, traumas, the type of parenting received, and genetic factors (Fonagy et al., 2002). The capacity for mentalization is not constant; it is possible for it to decrease or to be interrupted from time to time in emotionally challenging experiences (Luyten et al., 2012).

Mentalization capacity for children helps them to regulate their emotions and reduce behavioral problems (Fonagy et al., 2002). Emotion regulation is a crucial aspect of mentalization. The basis of the reaction to a situation or the symptoms that emerge are difficulties in regulating emotions and, consequently, difficulties in mentalizing (Sharp & Venta, 2012). When children's mentalization capacity is developed, they get better at managing interpersonal problems, which is associated with reduced symptoms such as anxiety and aggression (Midgley et al., 2017).

Bateman and Fonagy (2016) developed a psychodynamic therapy approach called Mentalization-Based Treatment (MBT) to enhance the mentalization capacity of adults with severe personality disorders, especially in the treatment of borderline personality disorders. This therapy method aims to understand mentalization deficits and develop capacity. Midgley and colleagues (2017) developed a manualized and time-limited psychotherapy model for children as mentalization-based treatment (MBT-C). MBT-C is a treatment approach aimed at improving their emotional and social adaptation by improving their mentalization and emotion regulation skills (Midgley et al., 2017). In this approach, therapy is conducted separately with children and parents. The process is carried out by two therapists. It consists of 15 sessions and is based on 3 mentalizing interventions: attention control, emotion regulation and explicit mentalization (Midgley et al., 2017). Attention control includes mirroring of the body language and joint attention of the therapist and the client. Emotion regulation also aims to increase emotional awareness and ensure understanding of emotions. Explicit mentalization aims to create awareness and develop the capacity to mentalize by combining the regulated emotion with situations and events.

Studies have shown that MBT-C provides improvements in children's emotional regulation, empathy development, and ability to control challenging behaviors. For example, Fonagy and colleagues (2016) stated that MBT-C provides long-term positive effects by helping children understand their internal experiences and develop sensitivity to the emotional states of others. In addition, it has been emphasized that MBT-C has positive effects on the child's general well-being, especially when combined with family therapies (Midgley & Vrouva, 2012). According to a study, mentalization-based

treatment can reduce internalization and externalization symptoms in children (Oehlman Forbes et al., 2021). In this way, it has been revealed that it can support the reduction of behavioral problems in children. Some studies conducted by Halfon and colleagues (Halfon and Bulut, 2019; Halfon et al., 2019; Halfon et al., 2020, Goodman and Halfon, 2021) investigated the relationship between treatment compliance and emotion regulation, general functioning and problem behavior in children with internalizing and externalizing problems. The results showed that when therapist adherence (adherence with mentalization principles) was high, children's emotion regulation capacity improved throughout the treatment process; when compliance was low, emotion regulation remained the same.

It has also been observed that MBT-C may not be equally effective in all children. Studies on non-responsive children show the importance of interviewing some children and families for whom therapy is not effective in reducing clinical symptoms. Such situations highlight the importance of understanding the reasons why children do not benefit from the therapeutic process and for developing innovative approaches to treatment (Carrington et al., 2024). The development of mentalization skills in children and their parents is an important factor that increases the effectiveness of MBT-C. However, the ineffectiveness of therapeutic intervention for some children indicates that research in this area needs to be conducted in more depth and the characteristics of non-responders need to be better understood. Although the study by Carrington et al. (2024) provided information on children who did not respond to therapy, there is still a need for current studies. For example, studies examining the mechanisms of change in MBT-C may be useful in understanding why these mechanisms do not help reduce symptoms to some children and families. Further studies may provide more in-depth information on this topic and help optimize treatment processes.

2.4.1. Randomized Controlled Trial (RCT)

The randomized controlled trial conducted in Turkey on the effectiveness of the Mentalization-Based Therapy (MBT-C) model applied to children was conducted by Halfon (2024). In this study, the MBT-C model was evaluated comparatively with

PSSG (Parenting and Social Skills Group), a group-based psychoeducational intervention. The interventions were structured to consist of 15 sessions; evaluations were made at the beginning, mid-treatment, end, 12th week, and 36th week follow-up points. There were no statistically significant differences between MBT-C and PSSG in reducing children's total, internalizing, or externalizing problems at 12 weeks; however, MBT-C was superior at 36 weeks on total problems with a small effect (Halfon et. al., 2024). Both mothers and children showed a significant increase in emotion regulation skills at the end of the MBT-C intervention, and this development was maintained in follow-up measurements.

The first of the theses that followed this study, Özsoy (2024), analyzed the change in parental reflective functioning using the same RCT dataset. In the study, which included 59 mother-child dyads in the MBT-C group and 58 mother-child dyads in the PSSG group, five-minute video clips taken from the first and last sessions of therapy were evaluated with the Reflective Functioning Scale (RF Scale). The findings revealed that there was an increase in the child-focused mentalization of the parents in the MBT-C group, but there was no statistically significant difference between the two groups. In addition, no significant relationship was found between parental mentalization levels and therapy outcomes.

Another study examining the relationship between model adherence and outcomes for MBT-C and PSSG interventions was conducted by Tülü (2024). In this study conducted with 189 children, 457 therapy sessions were coded with the MBT-C Adherence Scale and PSSG Adherence Scale, and children's emotion regulation skills were monitored with the Emotion Regulation Checklist based on parent reports. According to multilevel modeling analyses, overall adherence did not significantly predict emotion regulation skills. However, visual examinations revealed that children with externalizing problems showed better emotion regulation as adherence to MBT-C increased, while this group experienced a decrease in emotion regulation in PSSG. In children with internalized and comorbid problems, it was observed that emotion regulation weakened in both interventions in the case of high adherence.

Another study conducted by Özalp (2024) examined the relationship between the therapist's use of mental state talk (MST) and nonverbal coordination during the MBT-C process and children's behavioral problems. A total of 254 sessions were coded with CS-MST and a system measuring therapists' nonverbal coordination. The findings showed that therapists' use of MST significantly negatively predicted children's problem behaviors, that is, as MST increased, behavioral problems decreased. However, nonverbal coordination variables were not a significant predictor. This suggests that the therapeutic effect may depend on the meaningful verbal content established with the child and that bodily processes may have more indirect effects.

Another study examining the effect of therapists' body movement coordination on children's play and emotion regulation in the MBT-C process was conducted by Sözüer (2024). In the study involving 95 children and 16 therapists, 245 sessions were coded with CPTI (Children's Play Therapy Instrument) and the nonverbal coordination system. The findings revealed that the therapist's body movement coordination significantly positively predicted both the child's emotional regulation and harmonious play capacity. This result shows that establishing a bodily harmonious and sensitive relationship with the child can contribute to the achievement of therapeutic goals.

Finally, the case study conducted by Koç (2024) examined the relationship between nonverbal coordination and children's mental state language capacity in the MBT-C process through time-spanning patterns. In this study conducted with two children with a history of ACE (Adverse Childhood Experiences), cross-relationships between the therapist's bodily coordination and the child's MST use were evaluated using time series analyses. The findings revealed that bodily coordination was related to MST capacity in the case showing therapeutic improvement; however, this relationship could not be established in the case not showing improvement. This suggests that body language may theoretically play an important role in the development of mentalization.

2.5. Current Study

This thesis aims to examine the factors associated with treatment non-response in Mentalization-Based Therapy for Children (MBT-C) and to explore how these factors are observed in the therapy processes and outcomes of children and their families who do not respond to treatment. It is important to understand why children and families who did not observe the expected effect, namely a decrease in clinical level symptoms, did not benefit despite participating in the majority of therapy sessions and subsequent measurements within the scope of the MBT-C research conducted. Are these factors influenced by personal or environmental differences, or are the presence of different unknown factors effective? In order to understand this, the factors during and after the therapy process were examined in detail using both qualitative and quantitative methods.

The subject of this study is understanding the baseline predictors of non-response in Mentalization-Based Therapy (MBT-C) and exploring non-responder children's and their parents' experiences who participated in the therapy process but did not show improvement in their clinical symptoms. Based on the studies in the literature, the responder children are expected to have higher baseline adaptive play capacity and baseline emotion regulation skills (Cole et al., 2004; Gross, 2002), and baseline parental emotion regulation (Jones et al., 2008) compared to the non-responder group, while the number of traumatic experiences of children (Felitti et al., 1998; Dube et al., 2003) and the prementalizing scores of the parents (Slade, 2005; Halfon, 2017) are expected to be lower. Besides, the qualitative analysis method aims to provide a deeper understanding of the effective factors in cases where participants do not respond to treatment.

Some hypotheses developed in this study are considered as tentative assumptions because they are based on existing literature and theoretical foundations but have not yet been tested. Since the research is exploratory in nature, especially in terms of examining possible relationships between early developmental indicators and socio-cognitive outcomes at later ages, these hypotheses aim to reveal certain trends and patterns. In this context, the findings of the study will not only evaluate the validity of

these pre-hypotheses but also have the potential to provide theoretical and methodological contributions to future research.

Hypotheses for quantitative analyses are listed below:

Hypothesis 1: Baseline child adaptive play capacity will predict non-response.

Hypothesis 2: Baseline emotion regulation capacity of children will predict non-response.

Hypothesis 3: Baseline adverse childhood experiences of children will predict non-response.

Hypothesis 4: Children's age will predict non-response.

Hypothesis 5: Baseline parental emotion regulation will predict non-response.

Hypothesis 6: Baseline parental prementalizing will predict non-response.

2.5.1. Qualitative Research Question

In the qualitative part of this study, interviews will be conducted only with children and their parents who do not respond to therapy. The aim of the study is to deeply understand the factors that lead to unsuccessful results in the therapeutic process and to develop suggestions for improving these processes. The research will focus on the following basic questions:

1. How did children and parents experience the therapy process and what difficulties did they encounter during this process?

2. How do children and parents define the main factors that affect their therapeutic process?

3. How do children and parents perceive the effects of therapy on their lives and what suggestions do they make to improve the process?

In line with these questions, semi-structured interviews will be conducted with children and their parents who did not respond to therapy. The interviews will focus on understanding the parents' expectations, experiences, difficulties they experienced

during the therapy process, the effects on their children and the therapist-parent-child relationships. The interviews with the children will provide information about what the therapy process was like for them, the emotional difficulties they experienced, the role of the therapist and how they felt affected by the process.

The questions asked to the children will aim to understand their experiences during the therapy process. Children will be asked questions about how they experienced the therapy process, whether their expectations about therapy were met, what they liked and disliked the most about therapy, the difficulties they experienced during the therapy process, and the relationship the therapist established with them. The aim is to understand how therapy affected their lives from the children's own perspective and whether these effects continue after therapy. Children's views will reveal more clearly the benefits that therapy has provided them, as well as the difficulties and their development during the therapy process.

The aim of interviews will be conducted with parents and children to obtain information about important elements in the therapy process, how children benefit from therapy, the difficulties they encounter, the relationship they establish with the therapist, and the ongoing effects after therapy. In this way, the differences between children who respond to therapy and those who do not can be revealed in order to make therapeutic processes more effective. Factors such as the emotional difficulties experienced by children during the therapeutic process, the relationship they establish with the therapist, and the effects that remain after therapy can provide important information about the treatment processes of individuals who do not respond to therapy. The perspective of the parents will also provide valuable clues about the child's therapeutic experience and how they can contribute to therapy. This information aims to develop an in-depth understanding of how the therapy process can be improved and which factors prevent a response to therapy. Ultimately, it will help develop strategies and interventions that will make the therapy process more effective.

METHOD

3.1. Randomized Controlled Trial (RCT)

This thesis aims to explore the factors that predict non-response in child psychotherapies and the experiences of parents and children in child psychotherapies that resulted in non-response outcomes. In this context, this thesis was conducted based on the data of the Randomized Controlled Trial (RCT) study named "The Effectiveness and Change Mechanisms of Mentalization Based Therapy for Children (MBT-C)" received ethical approval (no: 2021-40024-48) conducted at Istanbul Bilgi University. The randomized controlled trial measured the effectiveness of MBT-C by comparing it with the Parenting and Child Social Skills Group Intervention (PSSG).

Mentalization Based Therapy for Children (MBT-C) is 15-weeks of treatment that is designed for both parents and children. children and parents participate in parallel sessions with two therapists who interact and cooperate with each other throughout the sessions. MBT-C includes 12 individual 3 family sessions. At the end of the treatment, parents were referred to long term therapy if it was necessary. During the therapy process, various standardized measures were administered. Following the completion of therapy, follow-up assessments were conducted, and progress reports were prepared for the families, outlining the developmental changes observed over the course of treatment.

In this randomized control trial, MBT-C was conducted by 16 therapists who were experienced for 1 - 5 years (M = 2.96), 90% of them were women, and their age varied between 25 and 41 (M = 29). They completed a MBT-C training given by Anna Freud Center and the instructors/ supervisors were Dr. Emma Morris and Dr. Holly Dwyer Hall.

3.1.1. RCT Sample

The sample started to be collected as of March 2022. The announcements of the study were made through the social media posts of Istanbul Bilgi University Psychotherapy

Research Center. A total of 644 families participated in the initial screening and the participants were selected according to the inclusion and exclusion criteria.

Children between the ages of 5 and 12 showing clinical-level problems based on the Turkish version of Child Behavior Checklist (CBCL; Erol & Şimşek 1995) were included in this study. Children between the ages of 5-12 who demonstrated clinically significant internalized, externalized, or total (both internalized and externalized) problems were sufficient to meet the inclusion criteria. Those excluded from the study included children with autism spectrum disorder, severe intellectual disability, psychotic disorder, severe behavioral disorder, severe substance abuse, and those at risk of harming themselves or others as screened by the Schedule for Affective Disorders and Schizophrenia for School-Age Children (K-SADS; Gökler et al., 2004), Kaufman Brief Intelligence Test (KBIT-2; Kaufman and Kaufman, 1990). According to the KBIT assessment results, the mothers' average Total Intelligence Score was 100.35 (SD = 11.70), while the fathers' average score was 101.99 (SD = 11.13). The children assessed in the study had a higher mean Total Intelligence Score of 103.57 (SD = 17.24).

Additionally, children in crisis situations requiring immediate intervention were also excluded. Exclusion criteria for parents included those at risk of psychosis, severe intellectual disability, severe substance abuse, and those at risk of harming themselves or others and determined by the Turkish versions of Brief Symptom Inventory (BSI; Şahin and Durak, 1994) and BAPIRT Alcohol and Substance Scales (Ögel et al., 2017). In addition, parents in need of immediate crisis intervention were also excluded from the study.

A total of 222 clients met the eligibility criteria and were subsequently randomly allocated to one of two groups, with stratification based on age, gender, and problem type. Of these, 111 clients (50%) were assigned to receive the MBT-C intervention, while the other 111 (50%) were placed in the PSSG active control condition. After assignment, 11 participants (5 from the MBT-C group and 6 from the PSSG group) chose not to initiate treatment. As a result, the final sample included 106 clients in the MBT-C intervention group and 105 clients in the PSSG control group (Appendix B)

3.1.2. RCT Data Collection

Before the treatment began, demographic information was collected from the clients. Details regarding the child's age, gender, history of therapy, as well as the family's socioeconomic background, marital status, and educational attainment of the family members were gathered as part of the demographic data collection. Baseline measures were collected before the initiation of therapy at Time Point 0, while outcome measures were gathered at Time Point 2, corresponding to the end of the treatment. Throughout the therapy process, all sessions were both visually and audibly recorded. Baseline observational measures were extracted through coding of the session recordings by trained research assistants. Sessions were excluded from the analysis if any data regarding observational measures were missing at the start.

3.2. Participants of the Current Study

Following the İstanbul Bilgi University Ethics Committee's approval, the primary investigator (PI) used purposive sampling to reach potential participants. Participants were selected from individuals who have undergone therapy as part of the Mentalization-Based Interventions research conducted at Bilgi University. This study included two steps, combining quantitative and qualitative methods respectively. Within the scope of the research examining the effectiveness of the MBT-C therapy process, the quantitative data already collected in the study was used as archive data. For the first step of the current study, the archive data was analyzed. Among 106 participants, 86 participants completed the treatment phase and their questionnaires at the end of the therapy. These participants divided into two groups by using CBCL scores at the end of the treatment;: those who show nonclinical and borderline symptoms (internalizing, externalizing and total) at post-treatment (classified as 'responders') (n= 55), and those who show clinical level symptoms at post-treatment (classified as 'non-responders') (n= 31). Participants were grouped based on the level of symptom reduction as measured by the Child Behavior Checklist (CBCL). Given that families primarily sought therapy due to behavioral problems, and that the study aimed to examine the

effects of MBT-C on these behavioral difficulties, the use of the CBCL was considered appropriate for evaluating treatment outcomes.

For the second step of the thesis, nonresponder group was those who completed the therapy process, and participated in follow-up evaluations at the end of therapy, and were willing to participate in interviews with those with clinical levels of internalizing, externalizing or total symptoms at the end of therapy according to their CBCL scores were selected. Children were ranked from oldest to youngest according to their age groups, and 8 pairs of children and parents were invited for an interview. Participants were contacted via phone by the researcher. Among the 20 families contacted, 8 agreed to participate in the interviews, 7 did not respond to the calls, 3 declined due to scheduling difficulties, and 2 explicitly stated they did not want to contribute because they were highly dissatisfied with the treatment process.

3.3. Assessment and Outcome Measures

All quantitative measures were used previously in the main study. The archive data were collected by using the measures below. Quantitative part of the study was analyzed by using these measures.

3.3.1. Child Behavior Checklist (CBCL)

Behavioral and emotional difficulties in children were assessed using the Child Behavior Checklist (CBCL), developed by Achenbach (1991). This tool is a validated instrument available in two versions: one for ages 1.5–5 (99 items) (Appendix C) and another for ages 6–18 (112 items) (Appendix D). Parents complete the checklist based on their child's behaviors, covering externalizing problems (such as aggressive behaviors), internalizing issues (such as anxiety), and total problem behaviors, scored on a 3-point Likert scale (0 = not true, 1 = somewhat or sometimes true, 2 = very or often true). The Turkish adaptation of the Child and Adolescent Behavior Checklist (CBCL) for the age group of 6-18 was made by Erol and Şimşek (2010). In this

adaptation, the internal consistency coefficients of the scale (α = .87, .90 and .94, respectively) and test-retest reliability (r = .93) were analyzed to be sufficient (Erol & Şimşek, 2010). The internal consistency coefficients of the CBCL 6-18 form used in this study were found to be quite high. Cronbach's alpha value was calculated as .95 for the total score of the scale, .87 for the internalizing subscale, and .92 for the externalizing subscale. These findings show that the internal consistency of the scale in our study was high. Therapy outcomes were determined as non-response and response by using CBCL total problem scores. In this thesis, raw scores for total problems subscale were converted to standardized T-scores (Achenbach, 1991) and children who scored above 65 were classified as clinical level, 60 and 65 T-scores were classified as borderline clinical level.

3.3.2. Adverse Childhood Experiences Inventory (ACE)

The number of adverse childhood experiences of the children was assessed by using a parent-report, the Adverse Childhood Experiences Inventory (ACE) (Appendix E). This scale is used to determine the number and type of early adverse childhood experiences of individuals. Each "Yes" response is calculated as one point, and the total score ranges from 0 to 10, with higher scores indicating more adverse childhood experiences. The scale does not have a specific cut-off value. The scores varied between 0 and 10, with a score of 10 indicating complete exposure. The previous findings showed good consistency and reliability (Dube et al., 2003). The Turkish adaptation of the ACE Scale was conducted by Gündüz et al. (2018). The internal consistency of the Turkish version was found to be α = .92, demonstrating adequate reliability. The Cronbach alpha coefficient calculated for the Childhood Adverse Experiences Questionnaire (ACE) used in this study was found to be .75.

3.3.3. Emotion Regulation Checklist (ERC)

Children's emotion regulation capacities were measured using the Emotion Regulation Checklist (ERC) (Appendix F). This scale evaluates children's emotional awareness and

self-regulation ability. The Emotion Regulation Checklist is a 24-item parent-report measurement tool assesses children's emotional regulation skills through two subscales: The Emotion Regulation Sub-scale measures characteristics such as situationally appropriate emotional responses, empathy, and emotional self-awareness, while the Lability/Negativity Subscale assesses characteristics such as difficulty regulating negative emotions, mood swings, and lack of flexibility (Shields & Cicchetti, 1997). The scale is rated by parents on a 4-point Likert format ranging from "1" (never) to "4" (almost always). The internal consistency of the original scale is high for both subscales (Cronbach's alpha ranges from .83 to .96, respectively). The Turkish adaptation of the scale (Batum & Yağmurlu, 2007) also demonstrated adequate internal consistency, with alpha values ranging from .73 to .75. When the internal consistency coefficients of the scale used in this study were examined, the Cronbach alpha value for the total score was found to be .63. Alpha was calculated as .64 for the emotion regulation subscale and .70 for the lability/negativity subscale.

3.3.4. Difficulties in Emotion Regulation Scale (DERS)

Parents' emotion regulation capacities were assessed using the Difficulties in Emotion Regulation Scale (DERS; Gratz & Roemer, 2004)) (Appendix G). Difficulties in Emotion Regulation Scale (DERS) is a scale developed by Gratz and Roemer (2004) and used to assess the difficulties experienced by individuals in the emotion regulation process. The scale consists of 6 sub-dimensions: Nonacceptance of emotional responses, difficulty engaging in goal-directed behavior, impulse control difficulties, lack of emotional awareness, limited access to emotion regulation strategies and, lack of emotional clarity. This scale, consisting of a total of 36 items, is scored with a 5-point Likert-type rating system (1= almost never, 5= almost always). High scores indicate difficulty in emotion regulation. The short version of the Difficulty in Emotion Regulation Scale (DERS-16) was developed by Bjureberg and colleagues (2016). The 'Awareness' sub-dimension in the original scale was removed and the number of items was reduced from 36 to 16. DERS-16 has high internal consistency and good reliability (α = .92, r = .93) (Bjureberg et al., 2016). The Turkish adaptation of the scale was made

by Yiğit and Guzey Yiğit (2019). In this adaptation, the internal consistency of the scale for the total score was found to be sufficient (α = .92) (Yiğit & Guzey Yiğit, 2019). In the Turkish sample, sub-dimensions showed good internal consistency (α = .84, .87, .87, .78), respectively. In this study, the total DERS score was calculated by summing the sub-dimension scores. In this study, the internal consistency coefficients of the subscales were found to be .70, .86, .89, .89 and .79, respectively. The Cronbach alpha coefficient for the total score of the scale was .94. These results show that the scale has sufficient internal consistency both at the general level and on the basis of subdimensions.

3.3.5. Parental Reflective Function Questionnaire (PRFQ)

Parents' prementalizing mode levels were assessed using one of the subscales of the Parental Reflective Function Questionnaire (PRFQ) (Appendix H). The Parental Reflective Functioning Questionnaire (PRFQ) was used to assess the reflective functioning capacity of parents. This measurement tool, developed by Luyten et al. (2017), was created to assess parents' ability to understand and interpret their children's mental states, i.e., their reflective function levels. The scale, consisting of a total of 18 items, covers three main dimensions: prementalizing mode, the level of interest and curiosity in the child's mental processes, and the sense of certainty regarding these processes. These subscales, each consisting of 6 items, are assessed on a 7-point Likert-type scale based on the parents' statements (1 = "completely disagree", 7 = "completely agree"). While high scores from the prementalizing mode dimension indicate that the parent has a low level of mentalization capacity, high scores from the interest-curiosity and certainty subscales indicate a stronger reflective function capacity. The reliability of the scale is sufficient: Cronbach's alpha value was found to be .70 for prementalization, .74 for interest and curiosity, and .82 for certainty regarding mental states.The Turkish version of the scale has been demonstrated to be both valid and reliable for use with Turkish populations (Arıkan et al., 2020). The internal consistency coefficients of the subtests of the parent mentalizing scale used in this study were found

to be .65 for prementalizing, .69 for certainty about mental states, and .68 for interest and curiosity in mental states.

3.3.6. Children's Play Therapy Instrument (CPTI)

Children's adaptive play capacities were measured through the analysis of video recordings using the CPTI (Appendix I). CPTI is a play assessment tool used to code children's adaptive play processes and imaginative play skills. Children's Play Therapy Instrument (CPTI), introduced by Kernberg et al. (1998), segments children's session activities into categories such as interruption, longest play activity, pre-play and play. The Turkish adaptation of the CPTI has shown high levels of internal consistency and good inter-observer reliability for gaming profiles (Halfon, 2017). CPTI has demonstrated good inter-rater reliability (Kernberg et al., 1998) and is considered sensitive to changes during therapy (Chazan, 2000) with high convergent and predictive validity in associating play characteristics with behavioral issues (Halfon, 2017) and strong discriminant validity in identifying play associated with trauma (Cohen et al., 2010). Each level consists of a variety of scales and items rated by reliable coders. The rating is based on a 5-point Likert-type scale (5 = prominent features, 4 = considerable evidence, 3 = moderate evidence, 2 = minimal evidence, 1 = no evidence). For each play profile, a mean score is calculated by summing up specific items. The final level, functional analysis, includes two scales: coping and defensive strategies and awareness of the play activity. Based on the functional analysis, children's play behavior is divided into four profiles: Adaptive, Inhibited, Impulsive, and Disorganized play profiles. The Adaptive Play Profile refers to fluent, integrated, and progressive play activities in which the child can symbolically represent disturbing experiences. The Inhibited/Conflictive Play Profile is characterized by rigid, solitary, and quiet play activities reflecting the child's internal conflicts. The Impulsive/Aggressive Play Profile includes intermittent and aggressive play behaviors that are directed toward action in order to cope with disturbing emotions but lack symbolic representation. The Disorganized Play Profile describes disorganized, regressive, and traumatic play activities that reflect fear of being overwhelmed by intense emotions. In this study,

scores from the adaptive play profile were used to assess children's play capacity. High scores in the adaptive play profile indicate good play capacity.

Seven research assistants, all of whom were master's-level clinical psychologists, participated in a 7-hour training session conducted by Selin Kitiş. Selin Kitiş herself had previously completed CPTI training under the supervision of Sibel Halfon, who was trained by Saralea Chazan. Following the training, the research assistants worked in pairs, reviewing training videos and coding play segments until they achieved an inter-rater reliability (ICC) of at least 0.70. Once this threshold was reached, independent coding of the child sessions was carried out in pairs. The inter-rater reliability during the coding process ranged from .70 to 1.00 (M = .94)

3.4. Procedure

For the second step of the study, interviews were conducted with 12 participants who voluntarily agreed to participate in 11 interviews (3 child interviews, 8 parent interviews with 8 mothers and 1 father). Number of participants was decided according to a qualitative research source written by Braun and Clarke (2013). Following 8- parent interviews, it was determined that sufficient thematic saturation had been reached; therefore, no further participants were contacted.

Participants were contacted via their contact information as they have previously participated in the therapy sessions at Istanbul Bilgi University Psychological Counseling Center and completed the process. Participants who agreed to participate were given detailed information about the study. Parental consent was obtained for child participants, along with the child's assent to participate. Consent forms were sent via digital forms using Google Forms. Children’s assent were taken via phone call before scheduling an interview and were repeated in interviews. Following verbal assent and written consent, a suitable date for the interview were determined. Among 8 families, four children showed an interest in the study, three children provided verbal assent and participated in the interview; one child chose to withdraw their participation.

An interview guide was followed through the interviews (Appendix J & K). The interview guide has been developed based on studies (Carrington et. al., 2024; De Smet, M. M., 2019) and evaluated by thesis advisors. Following ethical approval, a pilot interview was conducted to test the appropriateness of the questions. The online interviews were conducted in a secure environment. Participants were advised to join the sessions from a private and distraction-free setting. The interviews conducted with both children and their parents were recorded and analyzed after being transcribed. The interviews took approximately 30- 40 minutes with parents and 10 - 20 minutes with children.

During the parent interviews, a brief introduction was followed by questions intended to help parents recall the therapeutic process (e.g., the therapist's name, year of participation, the child's age at the time). A set of 10 pre-prepared, semi-structured interview questions was used, and follow-up prompts were introduced when necessary to explore relevant areas in greater depth. The interviews focused on understanding the parents' expectations, experiences, difficulties they experienced during the therapy process, the effects on their children and the therapist-parent-child relationships. The objective of the interviews with the children was to provide information about what the therapy process was like for them, the emotional difficulties they experienced, the role of the therapist and how they felt affected by the process. Parents were asked questions about how therapy went, the impact of the process on their and their children's lives, the difficulties they encountered during therapy, and the results they achieved after therapy.

The questions asked to the children aimed to understand their experiences during the therapy process. Children were asked questions about how they experienced the therapy process, whether their expectations about therapy were met, what they liked and disliked the most about therapy, the difficulties they experienced during the therapy process, and the relationship the therapist established with them. The aim is to understand how therapy affected their lives from the children's own perspective and whether these effects continue after therapy. Children's views will reveal more clearly the benefits that therapy has provided them, as well as the difficulties and their development during the therapy process.

In the qualitative dimension of the study, it was planned to conduct individual interviews with both parents and children. In this context, short, structured interviews were also conducted with some of the children participating in the study (n=3). However, most of the responses received from the children during the data collection process remained very short, general and limited in content (for example: “we were playing, it was nice”, “it happened a lot, I forgot” etc.). This situation is thought to be due to the children’s age and difficulty in remembering the therapeutic process as time passed.

Therefore, the interview data obtained from the children were not included in the qualitative analysis process and were only taken into account at the level of the researcher’s observations. In order to obtain richer data from children in future studies, it is anticipated that giving priority to age-appropriate projective techniques, play-based interview methods or interviews conducted immediately after therapy will yield more meaningful results.

3.5. Data Analyses

For the first step of the study, logistic regression analysis was used to analyze the differences between nonresponder and responder groups according to various variables. Since the children's therapy response (responder vs. nonresponder) was defined as a binary variable, logistic regression analysis was preferred to analyze the effect of independent variables on this result. Logistic regression is an appropriate method to model the effects of independent variables on the probability of belonging to this variable when the dependent variable is categorical. Considering the sample size and variable characteristics of the study, logistic regression analysis was evaluated as an appropriate method in terms of both statistics and application. The dependent variable was defined as group (responder or nonresponder); while the independent variables were adverse childhood experiences (ACE score), children's emotion regulation capacity (ERC score), parents' emotion regulation capacity (DERS score), parents' prementalizing mode (PRFQ sub-dimension), and children's adaptive play capacity (CPTI subscale) and children’s age by controlling for total sessions attended by children.

The analysis was performed using SPSS software and the significance level was accepted as $p < .05$.

For the second step of the study, a thematic analysis method was used to examine the data. Thematic analysis is a flexible and robust qualitative analysis method that allows for the identification, analysis and interpretation of common themes and differences in the experiences of participants (Braun & Clarke, 2006). The research was conducted with a thematic analysis approach in order to examine the experiences of children and their families whose symptoms continue at a clinical level after the end of the therapy. This method aims to deeply understand the perceptions of the participants regarding the therapy process and how they are affected by this process.

MAXQDA software was used for the organization and systematic analysis of the data. The qualitative findings obtained from thematic analysis were integrated with the quantitative results, thus providing a comprehensive understanding of the therapy process and its effects. This approach will provide an important basis for better understanding groups that do not respond to treatment and improving therapy processes.

The data were analyzed using the six-step reflexive thematic analysis framework described by Braun and Clarke (2006). First, audio recordings of the interviews were transcribed word by word. The transcripts were read multiple times to develop familiarity with the material, during which early notes and reflections were written to follow initial thoughts and emerging patterns.

In the second step, the principal investigator (PI) systematically coded the data using line-by-line coding in MAXQDA. Each meaningful segment of text was coded with caution for staying close to the participant's language. Codes such as “i needed a map,” “what was the problem,” and “therapy not tailored to our needs” were among the examples that emerged during this phase.

Once initial coding was completed, codes were put together based on conceptual similarity and recurring content to generate early themes (Step 3). The PI reviewed high-frequency codes and grouped them under broader conceptual categories. For instance, codes such as feedback needed and not getting sufficient feedback were

grouped under a theme reflecting need for feedback, while codes describing parental development or learning about problems were explored under themes of parental awareness. As analysis progressed, some candidate themes evolved, merged, or were discarded to reflect a more accurate and coherent representation of the data.

In the fourth step, the thematic structure was reviewed and refined. Themes were assessed in relation to the coded data and the entire dataset to ensure consistency and internal coherence. During this process, certain initial themes were either divided into sub themes or restructured under different overarching categories. For example, one initial theme on “limited time” was later reframed into two sub themes such as starting point and insufficient time.

In the fifth step, final themes and subthemes were clearly defined and named. Their scope and conceptual boundaries were clarified, with representative quotes selected for each to ground the findings in participants’ voices. The final step involved writing the analytical narrative. The themes were organized into a storyline that corresponded to the original research aims and offered a meaningful interpretation of the participants’ experiences with MBT-C. Throughout reporting, all participants were assigned numerical identifiers to protect confidentiality and ensure anonymity.

To ensure the trustworthiness of the analysis, it was reviewed in collaboration with the thesis advisor. Throughout the research process, ongoing consultations with the advisor took place, allowing for triangulation. Additionally, reflexivity was applied through field notes and discussions with the advisor. The To ensure trustworthiness, member checking was employed, where participants review and validate the findings. In this way, the experiences of individuals who do not have symptom change for their child in therapy were addressed better. This approach contributes to understanding the factors affecting therapy outcomes and to clarifying why MBT-C is not effective for some individuals.

3.6. Researcher’s Position and Reflexivity

The researcher's perspective should be understood in the study and the data should be interpreted accordingly. The researcher is a child and adolescent therapist and occasionally uses the MBT-C model in her clinical studies. The lack of symptomatic change in the sessions was also considered as unhelpful for the researcher. For this reason, when starting the study, the expectation in the qualitative interviews was that the majority of the participants would talk through their negative feelings about the process. Realizing this before the process, she tried to control this limitation and make sense of positive and negative experiences together. The researcher realized that she included too much of her own clinical comments about the participants in the process and stepped back and adopted the principle of interpreting only what the participants mentioned. The researcher has no connection with her own life in this study, but this process helped the researcher to learn that change cannot remain fixed with symptoms.

RESULTS

4.1. Results of Quantitative Analysis

4.1.1. Descriptive Statistics

Descriptive statistics were calculated for all continuous variables and presented by group. The mean age of the children in the responding group (n = 54) was 7.94 (SD = 1.83), while the mean age in the non-responding group (n = 31) was 8.16 (SD = 2.30). The number of therapy sessions attended by the children was similar across groups, with a mean of 13.26 (SD = 1.85) in the responding group and 13.35 (SD = 1.54) in the non-responding group. ACE scores were lower in the responding group (M = 0.78, SD = 1.13) and higher in the non-responding group (M = 1.77, SD = 1.71). Adaptive play capacity (CPTI) was found to be 3.71 (SD = 0.60) on average in the responder group (n = 46) and 3.65 (SD = 0.84) in the non-responder group (n = 25). Difficulties in emotional regulation (DERS) were lower in the responder group (M = 33.39, SD = 11.92) and higher in the non-responder group (M = 39.29, SD = 10.73). Child emotion regulation scores (ERC) were found to be 64.98 (SD = 6.17) on average in the responder group and 58.81 (SD = 5.88) in the non-responder group. Finally, parent pre-mentalization scores (PRFQ) were measured as 15.63 (SD = 5.72) in the responder group and 19.23 (SD = 6.91) in the non-responder group (Table 3.1.).

Table 3.1. Descriptive Statistics for Variables by Response Group

Variable	Response			Non-response		
	n	M	SD	n	M	SD
ACE Total	54	0.78	1.13	31	1.77	1.71
Total Sessions	54	13.26	1.85	31	13.35	1.54
Child's Age	54	7.94	1.83	31	8.16	2.30
CPTI Adaptive	46	3.71	0.60	25	3.65	0.84
DERS Total	54	33.39	11.92	31	39.29	10.73
ERC Total	54	64.98	6.17	31	58.81	5.88
PRFQ Prementalizing	54	15.63	5.72	31	19.23	6.91

Note. M = mean; SD = standard deviation. Groups are defined by therapy response. ERC = Emotion Regulation Checklist; PRFQ = Parental Reflective Functioning Questionnaire; DERS = Difficulties in Emotion Regulation Scale; CPTI = Child Play Therapy Inventory.

4.1.2. Assumptions

To assess the assumption of multicollinearity among the independent variables, a linear regression analysis was conducted with ACE scores as the dependent variable. Tolerance and Variance Inflation Factor (VIF) values were examined for all predictors.

The results indicated that all VIF values were below the commonly used cut-off of 5 (range: 1.06 to 1.43), and all tolerance values were above .2, suggesting that multicollinearity was not a concern in this model.

To assess the assumption of linearity between continuous predictors and the logit of the dependent variable, log-transformed interaction terms (i.e., IV * ln(IV) were included in the logistic regression model. This included log-terms for age, PRFQ, ERC, DERS, CPTI, ACE, and total sessions. Due to the 0 scores in the ACE scores, this variable was calculated with the formula IV * ln(IV+1).

Two of the log interaction terms, namely for DERS ($p = .086$) and ACE ($p = .062$), approached statistical significance, suggesting potential non-linearity in their relationship with the log odds of treatment response. Although these findings did not reach conventional significance thresholds ($p < .05$), they indicate that the linearity of

the logit may be violated, particularly for emotion regulation of parents and adverse childhood experiences of children. All other log interaction terms, including those for age, PRFQ, ERC, CPTI, and total sessions, were not statistically significant ($p > .10$), indicating that the linearity assumption was likely met for those variables.

These results suggest that while the assumption of linearity generally holds, caution is warranted when interpreting the effects of DERS and ACE scores due to potential deviations from linearity. Interpretations involving these variables were made cautiously in light of this finding.

For possible outliers, z-scores of independent variables were taken. According to the results, a z-score above ±3 was detected in the 'Total number of child sessions' variable of one participant (total number of attended sessions: 8) , but it was not deemed necessary to remove it due to its minimal impact on the overall results and it was decided to keep it in the analysis.

4.1.3. Binary Logistic Regression Analysis

A binary logistic regression was conducted to examine whether adverse childhood experience scores, total number of child sessions as a control variable, children's age, child adaptive play scores (CPTI), child emotion regulation score (ERC), parental emotion regulation (DERS), and parental prementalizing mode (PRFQ) predicted treatment non-response in children receiving mentalization-based therapy (MBT-C).

The overall model was statistically significant, $\chi^2(7) = 25.25$, $p < .001$, indicating that the set of predictors distinguished between non-response and response. The model explained between 29.9% (Cox & Snell R^2) and 41.2% (Nagelkerke R^2) of the variance in treatment response status. The Hosmer and Lemeshow goodness-of-fit test was non-significant, $\chi^2(8) = 5.32$, $p = .723$, suggesting an adequate model fit. According to the classification table, the model identified 60.0% of non-response and 87.0% of response, with an overall classification accuracy of 77.5%.

Among the predictors, two variables came out as statistically significant: **ACE scores** negatively predicted treatment response (B = –0.59, Wald = 4.85, p = .028, OR = 0.55), indicating that children with higher levels of adverse childhood experiences were more likely to have non-response in therapy. **Emotion Regulation** Capacity of Children (ERC) was positively associated with treatment response (B = 0.15, Wald = 5.81, p = .016, OR = 1.17), suggesting that higher levels of emotional regulation capacity of children can predict response in therapy. All other predictors, including attended session numbers, age, adaptive play capacity, DERS scores, and PRFQ scores, were not significant (p > .05). These findings indicate that child- level factors contribute to the likelihood of non-response from MBT-C. In particular, adverse childhood experiences and low emotional regulation capacity of children appear to be key predictors of non-response (Table 3.2).

Table 3.2 Results of Binary Logistic Regression Analysis

Predictor	B	SE	Wald	OR	CI for OR
ACE Total	-0.59	0.27	4.85	**0.55***	.33 - .94
Total Sessions	-0.04	0.18	0.06	0.96	.68 - 1.36
Child's Age	-0.14	0.22	0.39	0.87	.56 - 1.34
CPTI Adaptive	0.28	0.45	0.39	1.33	.54 - 3.23
DERS Total	-0.02	0.03	0.40	0.98	.93 - 1.04
ERC Total	0.15	0.06	5.81	**1.17***	1.03 - 1.32
PRFQ Prementalizing	-0.06	0.06	0.86	0.95	.84 - 1.06
Constant	-5.99	5.08	1.39	0.003	

Note. b = unstandardized coefficient; SE = standard error; OR = odds ratio. CI = confidence interval. 0 = Non-response, 1 = response. *p < .05.

4.2. Results of Qualitative Analysis

The qualitative data obtained in this study were analyzed using the thematic analysis method developed by Braun and Clarke (2006). In the analysis process, data obtained from eight interviews conducted with 9 parents, 8 mothers and 1 father, who participated in child-focused therapy were evaluated. In the initial planning of the study, it was planned to include the interviews conducted with the children in the qualitative

analysis. However, since the content of the data obtained from the children was limited and not deep enough for analysis, these interviews were not included in the analysis part of the study.

As a result of the analysis of the data obtained from the parent interviews, three main themes and subthemes related to them were created. The main themes reflect the experiences of the parents regarding the therapy process and the emotional, relational and cognitive transformations they experienced during this process. The subthemes are structures that represent different aspects of each main theme and are derived from common meaning patterns. Detailed explanations of the themes are presented in the following sections together with the relevant participant statements (Table 3.3).

Table 3.3 Themes, Sub-themes, and Illustrative Quotes from Parental Interviews

Themes and sub-themes	Example quote
Negative Feelings and Thoughts About Therapy	*"But something like this happened, we could not get any feedback from there and it ended abruptly. There is such a problem, I think the main problem here is that having a project is good, it can be, but I think the problem here is that when the project is finished, its data is also confidential, and it is cut off without giving clear information to the other party." (F)*
Therapy Brought Out Anger in the Parent	
Abrupt Ending	
The Process Being a Research Project	
Inadequate Changes in Symptoms	
Unmet Needs and Expectations About Therapy	*" Well, as I said, I felt like I was completing a pattern, I felt like I was wasting time. I felt like I was not heard. I think I am clear but I wasn't, I mean what is the problem, why are we complaining, I mean they say X can't stop, can't X? That's it. They say he is very irritable, is he irritable? Because we don't see it. Because it's really not like that inside the house, the teacher was describing it to us in a completely different way." (D)*
Inadequate Feedback	
Limited Time	
Father Refusal	
Individual Needs	
Parental Gains	

Parental Awareness Parent Develops Then Child Develops Learning About the Child Psychology Doing Something for the Problems Empathic Attitude	*"I mean, just because of your guidance, I got a little closer to the child. I got closer to his feelings. How can I say that? I understood him more. I got more positive, not with prejudice, but more positive. Because they were telling me that, you know, empathize. They were constantly telling me that, I empathize, I guess that was the effect a little more." (B)*

4.2.1. Theme 1: Negative Feelings and Thoughts About Therapy

A common theme in parents' thoughts about the therapy process was related to negative feelings and thoughts. The issues that parents thought were negative according to their experiences were combined into 4 subthemes. The subthemes were: therapy brought out anger in the parent, abrupt ending, the process being a research project, and inadequate changes in symptoms.

4.2.1.1. Therapy Brought Out Anger in The Parent

Three of the parents mentioned that parents sometimes became more angry during the therapy process. Some parents stated that they became more and more angry as they felt guilty while trying to understand themselves in this process, while others felt that they were compromising themselves while trying to keep up while going and coming alone, which caused them to become even angrier, and their anger increased as their children behaved more daringly from time to time. One of the parents stated that it did not feel good to see and express the mistakes that they made in the areas they tried to fix and cared about during the therapy process, that this process was like a mosaic and that they needed to see the good parts in it:

"We are already doing as much as we can. Sometimes we do it with good intentions and we may do something wrong, but we are already doing something that will be a journey and if we are trying to do it consciously, it is especially tiring. Apart from that, when someone comes up to us and says that what we did was wrong, a huge anger is released. In other words, the parent is like, no, even if what you did was wrong, there were many

right pieces there. In other words, I worked very hard for that. There were things that I knew from the information given theoretically and there were things that you paid attention to, but this is a very mosaic puzzle, it makes you do wrong in some places. It seems very cruel to say that what you did was wrong. Because there is a lot of effort." (A)

"Zaten elimizden geldiğince bir şey yapıyoruz. Bazen iyi niyetle yapıyoruz ve yanlış bir şey de yapabiliyor olabiliriz ama çok fazla zaten yolcu olacak bir şey yapıyoruz ve bunu bilinçli şekilde yapmaya çalışıyorsak özellikle bu çok yorucu.Onun dışında birisi karşımıza gelip de bu yaptığımız yanlış denildiği zaman çok büyük bir öfke açığa çıkıyor.Yani .Ebeveynin sanki yaptığınız yanlış da ,hayır o yanlış bile olsa orada çok doğru parça da vardı. Yani ben ora için çok çabaladım. Hani teorik olarak verilen o bilgilerden bildiğim şeyler de vardı ve dikkat ettiğin şeyler de vardı ama çok mozaikli bir puzzle bu, bazı yerlerde yanlış yaptırıyor. hani yaptığınız yanlış demek çok acımasızca gibi geliyor. Çünkü çok uğraş var yani." (A)

One of the parents mentioned that the parent sessions left negative feelings on her during the therapy process. She stated that as someone who often finds herself guilty, looking back on her own childhood and seeing her own side only made her feel more angry and guilty. She also said that she needed to focus on the future rather than looking at the past, and that it was already difficult to continue doing this and that it was not good to dig into it:

"She asks about your childhood and your mother, you have to talk about things that you don't want to talk about, and when you talk, no matter what, I already know myself, I always tend to feel like blaming myself, when I was with my mother, I used to say, I should be understanding towards my mother. So I find it in myself again. So this is a constant conflict, for example, did I really need it, I was already trying to continue there. Was this really necessary? There was also a place where I couldn't get any results, I mean, the diagnosis of this child is not there, we do not know what we are, I said to myself at the end of the account, I went for so many months, I tortured myself so much, I was always at fault, and that turned out to be a mess, there was no need for all this torture, you know." (D)

“Hani çocukluğuna dair annene dair bir şey soruyor bahsetmek istemediğim konuşman istemediğin şeyleri konuşman gerekiyor ve konuşurken de ne olursa olsun ben zaten kendimi biliyorum sürekli kendimi suçlamak hissi eğilimindeyim annemleyken şöyle diyordum anneme karşı anlayışlı olmalıyım Yani yine kendimde buluyorum Yani sürekli böyle bir çatışma yani ona mesela ihtiyacım var mıydı gerçekten hani ben zaten orayı sürdürmeye çalışıyordum. Hani bu gerçekten gerekli miydi kısmında orada bir de hani benim verim alamadığım bir yer yani Bu çocukların tanısı Ortada değil ne olduğumuzu bilmiyoruz kendime hesabın sonunda şey dedim bunca ay gittim bunca kendimi eziyet ettim Hep hatalı Sendin o da fos çıktı Hiç gereği yokmuş bu kadar işkencenin hani.” (D)

4.2.1.2. Abrupt Ending

Four of the parents shared their feelings about the end of the therapy process. Some parents thought that the therapy process went well but ended badly, that the effect wore off when it ended, that they could not get help during the process, that they immediately went back to their old ways when the therapy ended, that they could not get any results, that nothing happened during the process. Some participants stated that the process was left unfinished, that it ended suddenly, and that they were left unaware when it ended. One participant described the abrupt end of the process, that they did not understand anything, and that they were left unaware as follows:

“But something like this happened, we could not get any feedback from there and it ended abruptly. There is such a problem, I think the main problem here is that having a project is good, it can be, but I think the problem here is that when the project is finished, its data is also confidential, and it is cut off without giving clear information to the other party.” (F)

“Ama şöyle bir şey oldu, yani biz oradan geri bildirim alamadık ve çat diye bitti. Böyle bir sıkıntı var bence temel problem burada proje olması güzel, yani olabilir ama burada bence sıkıntı proje bittiği anda şimdi onun verileri de gizli olduğu için karşı tarafa net bir bilgilendirme yapmadan onun kesilmesi.” (F)

The same participant detailed her experience in this way:
"Not met (Expectations). In other words, it seemed like it would be met, we were saying it was going well because X also liked it, something had happened. In other words, it created a relief in him, but as I said, it was like something was left there without finishing." (F)

"Karşılanmadı (Beklentiler) .Yani karşılanacak gibi geliyordu, güzel gidiyor sanki diyorduk çünkü X de seviyordu bir şey olmuştu. Yani onda bir rahatlama yarattı ama dediğim gibi yani bir şeyin bitmeden orada kalması gibiydi." (F)

One of the parents stated that her daughter was happy during the process and enjoyed going, but other than that, nothing happened and when the process was over, everything returned to normal and she did not observe any change:
"She probably liked it. That's why she was coming with love and running. I mean I think she loved it. There is nothing else. Later in our lives, as I say, there was no result to this. As long as we continued at that moment, it was good. After that moment, we returned to our normal, same life after that environment." (G)

"Hoşuna gidiyordu muhtemelen. Ondan dolayı severek ve koşarak geliyordu. Yani hani sevdiğini düşünüyorum. Başka bir şey yok. Daha sonrasında hayatımızda hani bir diyorum ya buna bir sonuç olmadı. O an devam ettiğimiz sürece iyiydi. O an o ortam yaptıktan sonra sıradaki hayatımıza normal, aynı şeye döndük." (G)

4.2.1.3. The Process Being A Research Project

Four of the parents shared their thoughts about this being a research project; the recurring themes of the parents were that it was a project and therefore had a structure that had to be adhered to; individual needs could not be adequately met; the data was confidential because it was a project and therefore the process was suddenly cut short and no guidance was given; the duration was limited. At the same time, since this is research, it is tiring to fill out surveys and tests continuously. Afterwards, they thought

that they would get feedback at any time on the given tests and that they were done, but they could not get enough feedback during this process. One of the parents stated that this was a project, and there were some parts that needed to be followed, so what she said was not heard enough, it was not a scheme that met her needs, it was just done and passed like a task:

"It is so obvious that I turned into a complete fool and I am in a cage, but everyone has a goal in their mind that they want to reach. Everyone does not pay attention to what I say while going to that goal, it is not my need. This is a project, today these things need to be done. We did it, we did it, that was the situation, I saw this, that's why these projects seem a little funny to me. Because everyone is up to what needs to be done in those templates there, not their needs." (D)

"O kadar belli ki benim tam bir Aptala döndüğüm bir kafesin içinde olduğum fakat herkesin kafasında ulaşmak istediği bir hedef var Herkes o hedefe giderken benim ne dediğimde dikkat etmiyor benim ihtiyacım değil Bu bir proje bugün Bunlar yapılması lazım Biz yaptık mı yaptık durum buydu ben bunu gördüm yani bu projelerde bana o yüzden birazcık Komik geliyor Çünkü herkes oradaki o şablonlardaki yapılması gerekenlere kalmış ihtiyaçları değil." (D)

One of the parents stated that it was nice to participate in projects or to carry out projects and that this process was beneficial, but after the project was over, the participants were left behind, the needs or the efforts made were not seen, and there was no continuity at the center or in any other way, and that the support they could provide as much as the project was not enough:

"It is nice to have a project, I mean it can be, but I think the problem here is that when the project is finished, its data is also confidential, and it is cut off without giving clear information to the other party. It could work like this, that is, the project information may not be given, but even if the information is not the same people. It can be continued by transferring it to another person with the data. Oh, this is over, what are we going to do, there is a queue here too, there is no room, we will put you in the normal queue. Whenever it comes in 1-2 years, it is not like this but we are left like this." (F)

“Proje olması güzel , yani olabilir ama burada bence sıkıntı proje bittiği anda şimdi onun verileri de gizli olduğu için karşı tarafa net bir bilgilendirme yapmadan onun kesilmesi. Şöyle bir işleyiş olabilir, yani projenin bilgisi verilmeyebilir ama yine bilgide aynı kişiler olmasa bile. Verilerle birlikte başka bir kişiye devrederek devamı sağlanabilir. Ha bu bitti, he napacağız biz yani işte burada da sıra var yer yok artık sizin normal sıraya sokacağız. Ne zaman gelirse 1-2 sene sonra ya böyle değil de biz böyle kaldık.” (F)

4.2.1.4. Inadequate Changes in Symptoms

Six of the parents stated that their symptoms did not completely go away during and after the therapy process, some symptoms did not go away at all, some symptoms got worse, and some symptoms got a little better. One of the common thoughts among the parents was about the worsening of the symptoms. For some parents, some of the symptoms eased during that period but then returned to normal. One of the parents reported that they came to therapy during the summer and that she observed that she was a little better in the next class. In fact, on the contrary, her behavior increased and she became more talkative:

“So it was a little better in the 4th grade. We had come in the summer anyway. So it was a little better but it was like that again, he was a little shy but nothing left in middle school anyway. I don't know if he is interested in aging. We don't really have such a problem right now. In fact, on the contrary, he tries to laugh with his friends, talk in lessons, etc.” (B)

“Yani 4. sınıfta bir tık daha iyiydi. Zaten yazın gelmiştik. Yani bir tık daha iyiydi ama gene böyle biraz şeydi çekingendi ama zaten ortaokulda hiçbir şey kalmadı. Onun yaşlama ilgisi var bilmiyorum. Pek şu anda yaşamıyoruz öyle bir sıkıntı. Hatta tam tersi arkadaşlarıyla böyle gülmeye çalışıyor, konuşmaya çalışıyor derslerde falan.” (B)

Another parent stated that some symptoms had decreased and were getting better, but some symptoms had not changed at all and were still the same, and had even started to have a little more difficulty:

"He had an addiction to phone time. I can say that we solved it a little during X's therapy this term. In other words, it has decreased a lot. It has decreased to the point of almost nothing? Other than that, some of his behaviors can continue. He still has some obsessions sometimes. He is a child who cries so irritably. They can continue. Other than that, there were those times too. Problems with homework and studying etc. They can still continue a little bit, his reluctance." (H)

"Telefon süresinde bağımlılığı vardı Bu dönem ali'nin terapi süresince onu birazcık çözümledik diyebilirim. Yani o bayağı bir azaldı. Yok denecek kadar baya azaldı yani? Onun dışında yani bazı davranışları devam edebiliyor. Hâlâ biraz bazen takıntıları. Böyle hırçın ağlamakta bir çocuk yani. Onlar devam edebiliyor. Onun dışında işte o zaman da vardı. Ödev ders yapma problemleri falan. Onlar da yine hala birazcık devam edebiliyor, isteksizliği." (H)

Another parent from the process at İstanbul Bilgi University stated that the symptoms got worse after the process started and ended, and that the therapy process started to trigger the child and the mother, and that the child's symptoms got worse with the encouragement he received from the therapists:

"It turned our time at Bilgi University into a time when we were triggered. In other words, our graph showed us, according to what we said, there was a graph, we started here. It increased here. They gave us feedback in 3-month periods, we did something again, we filled out the test, etc. After the therapy was over, we were still inside." (A)
"We are back to where we started but during the therapy process we have risen higher, in other words he has not fallen, he has risen higher against each other." (A)

"Bizim Bilgi Üniversitesi'ndeki geçirdiğimiz süreyi çok fazla. Daha tetiklendiği imiz bir zamana çevirdi. Yani bizim grafiğin bizi bize göre yani söylediklerimize şey bir grafik vardı, şurada başlamışız.Buraya yükselmiş. Hani 3 aylık dilimlerde geri bildirim yaptılar işte tekrar şey yaptık, test doldurduk, vesaire terapi bittikten sonraki içeride biz

gene başladığımız yere dönmüşüz ama terapi sürecinde biz daha yükselmişiz yani birbirimize karşı o inmemiş, daha yükselmiştir." (A)

One of the parents who spoke positively about the therapy process stated that the change in symptoms was not surprising and that symptoms may increase as difficult emotions are worked on. The more they talk in the sessions, the more difficulty the child experiences sometimes increases. Therefore, the sessions end with more intense symptoms than when they started:

"As I said, the effects of therapy there, at first it was like this, let's say the obsession level was 6 out of 10, with the start of therapy it went up to 7s or 8s, in the process it went down to 7 while I was at Bilgi University, in other words we may have left it at a higher level there, well, after that it continued at 7 or maybe 8 for a long time, it was not this intense before it started, it became an obsession that gradually intensified." (C)

"Dediğim gibi terapinin etkileri orada ilk başta X'in şöyle oldu diyelim ki 10 üzerinden 6 takıntı seviyesi terapinin başlamasıyla bir 7lere 8lere çıktı devam eden süreçte bilgi üniversitesindeyken belki 7 ye düştü yani daha yüksek seviyede bırakmış olabiliriz orada işte sonrasında da 7de belki uzunca 8de devam etti başlamadan önce bu kadar yoğun değildi giderek yoğunlaşan bir takıntı durumu oldu." (C)

Another parent talked about the symptoms her child was experiencing and stated that she had not observed any change in them and that her child was still experiencing the same behaviors:

"So X normally withdraws into himself and does not show his feelings very much. He does not talk in front of people outside. He was playing and talking to the people there. But other than that, I could not make any progress, any development. Nothing happened. In other words, there was no different situation." (G)

"Yani X normalde hani böyle içine kapanıp çok duygularını belli edemedi. Dışarıda insanların yanında konuşmayan. Oradaki kişilerle hani o oyunda oynuyor ve konuşuyordu. Ama onun dışında hani bir ilerleme, bir gelişme kaydedemedim. Bir şey olmadı. Yani sadece değişik bir durum olmadı." (G)

4.2.2. Theme 2: Unmet Needs and Expectations About Therapy

Another theme that emerged during the interviews with parents was unmet needs and expectations about therapy. . Parents conveyed the issues they wanted to change or be different during the therapy process in 4 sub-themes: inadequate feedback, limited time, father refusal and individual needs.

4.2.2.1. Inadequate Feedback

A common theme regarding parents' experiences during the therapy process was inadequate feedback. 5 out of 9 of the parents stated that the feedback they received about their children during and after the process was inadequate, that they wanted to understand what was wrong with their child but could not get clear feedback. Some parents stated that therapists gave vague answers, did not clarify the problem, and a parent said, *"Tell me about the problem, why is my child constantly getting complaints at school?" (D)*

Some participants stated that they thought they were doing well during the therapy process, but realized that feedback was insufficient after the therapy was over. Some parents stated that they still thought they would receive more feedback at some point during the process and during follow-ups. When the process was over, they stated why they were not given enough information, that they filled out many tests and forms, and that they gave a lot of data for their children, but the feedback was not enough:
"But something like this happened, we couldn't get feedback from there and it ended abruptly. I think there is such a problem, the main problem here is that having a project is good, it can happen, but I think the problem here is that when the project is finished, its data is also confidential, so it is cut off without giving clear information to the other party. It can work like this, that is, the project information may not be given, but again, even if the people involved are not the same. It can be continued by transferring it to another person with the data." (F)

"*Ama şöyle bir şey oldu, yani biz oradan geri bildirim alamadık ve çat diye bitti. Böyle bir sıkıntı var bence temel problem burada proje olması güzel , yani olabilir ama burada bence sıkıntı proje bittiği anda şimdi onun verileri de gizli olduğu için karşı tarafa net bir bilgilendirme yapmadan onun kesilmesi. şöyle bir işleyiş olabilir, yani projenin bilgisi verilmeyebilir ama yine bilgide aynı kişiler olmasa bile.Verilerle birlikte başka bir kişiye devrederek devamı sağlanabilir." (F)*

A parent stated that the process was only good at that moment, that their child enjoyed playing and going there, that it was like an activity. However, they could not understand why they had these difficulties during and after this process, and that they could not receive feedback, and that this part of the process was insufficient:

"She was playing and talking to the people there in that game. But other than that, I couldn't make any progress or development. Nothing happened. I mean, there was no different situation. But, for example, after this, at the end of this study, I wasn't told that this happened to me, because of this or that you have to act like this. Actually, no conclusion was made clearly. Why? Was it his character or was he affected by something? No such thing was said….. Of course, I would like to reach a conclusion. It would make me happier to know how to act, what we have to do." (G)

" Oradaki kişilerle hani o oyunda oynuyor ve konuşuyordu. Ama onun dışında hani bir ilerleme, bir gelişme kaydedemedim. Bir şey olmadı. Yani sadece değişik bir durum olmadı. Ama hani bunun, mesela sonrasında bu çalışmanın sonunda da hani bana şöyle oldu, bundan dolayı veya şöyle davranmanız gerekiyor diye bir şey de söylenmedi. Sonuç yapılmadı aslında net olarak. Neden kaynaklı? Karakteri mi yoksa bir şeyden mi etkilendi? Böyle bir şey söylenmedi…… Tabii ki ben bir sonuç almak isterdim. Nasıl davranacağımızı, ne yapmamız gerektiğini bilmek daha çok mutlu ederdi." (G)

One participant added the following to her thoughts about the inadequacy of feedback:

"I mean, there is something in you, there is something called making things felt. I learned that. I mean, the psychologist, you will understand it yourself, he will ask you, you will understand it yourself, but when a person is lost in something and especially when you are in a panic of 'I am lost, I have to get out of here', that meaning, it suffocates the process even more." (D)

"Yani sizlerde şey var, sezdirme diye bir şey var. Ben onu öğrendim. Yani psikoloğun hani sen kendin anlayacaksın o sana soracak sen kendin anlayacaksın ama insan bir insanı yani bir şeyin içinde kaybolmuşken ve özellikle de ben kaybım benim buradan çıkmam lazım telaşına yani o anlamı süreci.Daha çok boğuyor." (D)

This parent mentioned that the lack of clarity, uncertainty, and vague feedback from therapists during the therapy process were not good for her as a parent. Besides, three out of nine parents stated that the feedback during the process was sufficient, that they were able to learn more about their children and get to know them better. One parent stated that she also received feedback about herself and understood what she needed to do accordingly.

4.2.2.2. Limited Time

The common opinion of 6 parents was that therapy processes were very long processes, but the fact that MBT therapy consisted of 15 sessions was insufficient for the process for some parents. Some saw it as a beginning, some saw it as a seed planted, but some saw it as related to their needs not being met. There have been those who thought that the therapy process would not be sufficient in 15 sessions. There have been parents who thought that some issues could not be deepened in this process and could only be touched upon the surface, but the problems were not on the surface.

One of the parents who expressed their satisfaction with the therapy process stated that while they focused on the emotional aspects of the process, they were not able to touch on the academic difficulties at all, that this process was very long and that they needed continuity and even continued with therapy:

"Well, our initial focus was of course on the reason for these obsessive behaviors and how to solve them. So the academic part was in the background, it didn't even get that far. Anyway, it was a study with a certain time period and it wasn't very enough for psychological support. It was actually a non-existent time, but it was still useful in terms of creating awareness. So, the beginning was like this, those were the reasons in the beginning." (C)

“Hani amacımız başlangıçta odağımız tabii ki bu takıntılı davranışlarının sebebi ve nasıl çözüleceği ile ilgiliydi. Yani akademik kısmı ikinci plandaydı oraya çok sıra gelmedi bile. Zaten hani şey bir çalışmaydı belli bir zaman aralığı olan ve psikolojik destek için de çok yeterli değil. Olmayan bir zaman aslında ama yine de işte bir şekilde bir farkındalık yaratması açısından faydalı oldu. Yani başlangıç bu şekilde sebepleri buydu en başta.” (C)

One of the parents who stated that they did not get any benefit from the therapy process stated that before starting therapy, everyone around them thought that the therapy would be very long and that it would take a long time and that they should allocate resources accordingly. However, according to the client, this period was defined as much longer than she could imagine. She stated that they continued therapy after the therapy ended and that she still continues with her child today and will continue to do so. This is nothing and they have a long way to go:

“There is also something, my friends who had previously applied to a psychologist for their children told me that the process was long. I had sat down and made money calculations etc. I understood that the process was long anyway. Then when your friends said that it could last until September or October, I said to myself yes, it was long. But. Well, this period is actually very short. This is just the introduction. Actually, I couldn't grasp anything. I couldn't grasp it.” (D)

“Bir de şey var, yani daha önceden çocuğuyla ilgili psikologa başvuran arkadaşlar bana süreç uzun demişlerdi. Ben oturup para hesapları falan yapmıştım. Sürecin uzun olduğunu anladım zaten. Sonra sizin arkadaşlarınız da bu eylüle ekime kadar sürebilir dediğinde de evet uzun oluyormuş ya falan dedim kendi kendime ama.Hani.Bu süre aslında çok kısa. Bu sadece giriş.Aslında bu hiçbir şeyi idrak edemedim. idrak edemedim.” (D)

One of the parents stated that she saw the therapy process as a companion and that she would like to continue this every week if she had the opportunity, and that it would be good for her child to be able to play and talk to someone every week:

"If I had the means, I would take him somewhere like that for the rest of his life and let him play with him, talk to him for an hour. I would want something like that. Maybe everyone has a sense of trust in someone from the outside. They enjoyed it, played games with him. We just went through such a process. It was short. It was a short time, not a very long time." (G)

"Hani imkanım olanlar olsa hani ömrünün sonuna kadar hep onu götürüp öyle bir yerde o bir saatse bir saat onunla oynasın, konuşsun. Öyle bir şey isterdim yani. Belki herkeste güven duymak dışarıdan birine işte bir güven oluştu. Onunla bir keyif aldı, oyun oynadı. Öyle bir süreç geçirdik sadece. Kısa oldu. Kısa bir süreydi yani çok uzun bir süre değil." (G)

4.2.2.3. Father Refusal

Three of the parents mentioned the difficulty of attending therapy alone, that fathers were resistant to therapy and did not want to attend, and that they were tired and angry about going through the whole process alone. One of the parents stated that the father did not want to participate, that the road was far and that it was difficult to come and go alone, that she was angry to do everything alone:
"The father was not a participant and I would come there, taking on all the difficulties and saying okay, I'll handle it etc. Throughout the whole therapy, I had the perception that it was going to be me again, I mean I'm doing it again." (A)

"Baba katılımcı değildi ve bütün zorluğu göğüsleyerek ya tamam, ben hallediyorum falan diyerek ben oraya geliyordum.Bütün terapi boyunca gene benden gidiyor algısı oluştu bende yani gene ben yapıyorum." (A)

One parent could not recall parenting sessions and stated that it would be good if parents were involved, but also thought it would be helpful if the father could attend:
"Maybe they can call my husband too. It might be good to talk to the family. These are." (B)

“Belki eşim de çağırabilirler. Aileyle de görüşülmesi iyi olabilir. Bunlar yani.” (B)

4.2.2.4. Individual Needs

Three of the parents mentioned their individual needs that were different from the ones mentioned above. For example, some parents stated that they needed clarity in the processes, it is stated that they needed the process to be more clear and understandable. At the same time, some parents stated that this was not their routine, that they continued their normal lives outside of therapy and that therapy did not reflect the general situation and therefore did not affect their lives. One of the parents stated that she did not receive clear feedback about the process, but she thought that she had expressed herself clearly and that this process was a project and did not address her individual needs:

“Yes, I have, I am more open and clear. I wish he had spoken. I mean. I said, but that person constantly questions herself, my husband tells me that I am too insistent. Right now, that is going on in my head, but I am saying, you are not clear. If you had spoken more clearly. In this state, you would have been too insistent. (D) Well, as I said, I felt like I was completing a pattern, I felt like I was wasting time. I felt like I was not heard. I think I am clear but I wasn't, I mean what is the problem, why are we complaining, I mean they say X can't stop, can't X? That's it. They say he is very irritable, is he irritable? Because we don't see it. Because it's really not like that inside the house, the teacher was describing it to us in a completely different way.” (D)

“Evet var ben daha açık net.Konuşsaydı mışım.Yani.Dedim ama ya o insan sürekli kendini sorguluyor ya eşim bana çok ısrarcısın diyor. Şu anda da beynimde o dönüyor ama esrin diyorum. Daha net konuşsaydın. Bu halde çok ısrarcı olacaktın. (D) Ya işte şey dediğim gibi ben bir şablonu tamamlıyor muş gibi hissettim ben zaman kaybettiğimi hissettim. Duyulmadığını hissettim. Kendimi net zannediyorum ama değildim demek ki yani sorun neymiş, niye şikayet ediliyormuşuz yani X duramıyor diyorlar duramıyor mu X?işte.Çok hırçın diyorlar hırçın mı Çünkü biz görmüyoruz Çünkü gerçekten evin içinde öyle değil öğretmen bize bambaşka tasvir ediyordu.” (D)

The same parent stated that the therapy process was not a simple process for her. She did not come there just to chat. She stated that she wanted to see some benefit and that it was a cry for help. However, she felt that this was not heard and that her individual needs were not put before the project:
“I mean, I am not coming here for pleasure. I did not come here randomly, saying, "Oh, there is a study, let me join." I really came there because of a need.” (D)

“Yani buraya bir keyif için gelmiyorum. A bir çalışma varmış, hadi katılayım. Deyip rastgele gelmedim. Ben gerçekten ihtiyaç için geldim oraya.” (D)

Another one stated that the time the baby spent with his son there did not represent their life in general, that it was different there, that the problems in their normal daily lives continued in the same way and that he felt that she was not understood enough.
“We can spend time there. Yes, there are many places we spend time but it is not the general part of our lives. I mean when you go on a holiday, we can have a very busy, very good time for a week but when we go home, for the next year or two, we will live normally again, oh what a great time we had. It is not like we are actually having a very good time, you know.” (A)

“Hani orada vakit geçirebiliriz. Evet, vakit geçirdiğimiz çok yer var ama o bizim hayatımızın geneli gene olmuyor. Yani bir tatile gittiğiniz zaman da bir hafta boyunca çok yoğun, çok güzel vakit geçirebiliriz ama evimize döndüğümüz zaman e önümüzdeki bir yıl boyunca 2 yıl boyunca biz artık gene normalimizde yaşamaya ay ne güzel vakit geçirmiştik. Ya biz aslında çok güzel vakit geçiriyoruz gibi olmuyor yani hani.” (A)

The same parent stated that she thought that the lack of depth in her own processes and the lack of sufficient sessions did not benefit her child enough. She stated that she felt individually that the problems were not too surface level and that there was a need for depth. She stated that if she felt good, her child could feel good as well. For this reason, she thought that maybe not every therapy would appeal to everyone:
“It is like we cannot understand him without understanding me. Naturally, this therapy process is also on his mind. It probably does not appeal to everyone, it may appeal to some people, but. It probably does not appeal to everyone, because of the result. It

seems like it is not that superficial. I mean, we cannot say that this is it, okay, clean the rocks at the end, this place will be cleaned, like cleaning rocks, but there are also things deeper and actually the reasons are maybe those deep things, in other words, the main reasons." (A)

"Şöyle yapmamak lazım. Işte illa yani beni anlamadan onu anlayamıyormuşuz gibi bir şey oluyor. Doğal olarak bu terapi süreci de aklında. Herkese hitap etmiyor herhalde birilerine hitap edebilir ama.Herkese hitap etmiyor herhalde, çünkü sonuç.O kadar yüzeyde değildir gibi geliyor. Yani hani bu kadar işte tamam uçtaki taşları temizlersek burası temizlenir gibi bir şey demiyormuşuz gibi taş temizleme gibi o yani ama daha derinlerde de bir şeyler var ve aslında sebepler belki o derindeki şeyler yani hani esas sebepler." (A)

4.2.3. Theme 3: Parental Gains

Another common theme that emerged during interviews with parents was parental gains. This theme was divided into 5 different subthemes. The subthemes were parental awareness, parent develops then child develops, learning about the child psychology, doing something for the problems, and empathic attitude.

4.2.3.1. Parental Awareness

Parents stated that parental involvement in the therapy process was beneficial. 6 out of 9 parents stated that they benefited from parental awareness. These parents stated that they gained awareness in understanding their children and themselves. One parent stated that during this therapy process, they got to know their child again and saw aspects they had never seen before. The majority of the parents stated that they gained information about their own parenting, some awareness about their own motherhood, and that they treated their children in a way they saw and understood from the therapists. One parent stated that it helped them see the problem better.

One parent stated that although she did not use the awareness she gained in therapy on the child she brought to therapy, she applied it and modeled it for her other child:
"I had a little girl at that time, she had just been born, in my relationship with her I actually progressed a little more under the guidance of therapists. I mean, not in a very conscious way. Not in an internalized way. Not like they said this, I should do it like this, but come on, from there, from there, this is what you have to do at home with X. I took it a little bit from there. I mean, I think I took it from there. You know, by modeling it for them. I didn't do it very consciously, but I shared it with them. For example, I realized that I was approaching my daughter like you. I realized myself. I'm doing it like them, etc. Maybe just witnessing it a little bit may have helped me take it as a model." (A)

"Benim küçük kızım vardı işte o zaman daha yeni doğmuştu, onunla olan ilişkide aslında birazcık daha terapistlerin yani rehberliğinde gibi ilerledim. yani şey çok bilinçli bir şekilde değil. İçselleştirilmiş bir şekilde değil. Hani yoksa böyle demişlerdi böyle yapayım gibi bir şekilde değil ama hadi, oradan işte X'e karşı falan evde böyle yapmak gerekiyormuş. Oradan birazcık birazcık aldım. Yani bence oralardan aldım diye düşünüyorum. Hani onları modelleyerek diyeyim. Bunu çok bilinçli bir şekilde yapmadım ama onlara da paylaştım. Mesela kızıma sizin gibi yaklaştığımı fark ettim. Kendimi fark ettim. Onlar gibi yapıyorum falan gibi. Birazcık belki sadece tanık olmak bile model almamı sağlamış olabilir." (A)

A mother stated that in addition to the awareness she gained about her child, she also gained awareness about her own identity and behavior as a mother and as an individual:
"Yes, yes, yes, not only with my mother, I mean as a woman myself until I became a mother, the things I experienced during my marriage, the things I experienced before, etc. How it affected my life, how it was reflected in my motherhood, there was also guidance regarding this." (C)

"Evet, evet, evet, sadece annemle de değil yani anneliğime gelene kadar kendim bir kadın olarak da hani evliliğimde yaşadığım, öncesinde yaşadığım şeyler vesair. Hayatımı nasıl etkilediği onun evet anneliğime nasıl yansıdığı, bununla ilgili de bir yönlendirme oldu." (C)

4.2.3.2. Parent Develops Then Child Develops

Another sub theme that parents saw as a gain in the therapy process was parent develops then child develops. Three of the parents thought that there was a connection to co-development. The common thought of the parents was that as the parent develops, the child develops. The parents stated that the development of their own parenting skills during the therapy process will also affect the development of the child and that it is important to be involved in the process as a parent.

One of the parents stated that she thought it was beneficial to be involved in the process together and that her child benefited from it as she developed:

"Since we came as a mother and a child, it affected both of us, but of course if I am not affected, I cannot be useful to my child, and of course there is such a thing in psychology, you are such a mother and you live in the same house, I think it was good for us." (E)

"Anne ve çocuk olarak geldiğimiz için ikimizi de etkiliyordu ama tabii ben etkilenmezsem çocuğuma faydalı olamıyorum bir de tabii böyle bir şey var psikolojide öyle bir annesin aynı evde yaşıyorsun bence iyi oldu bizim için." (E)

4.2.3.3. Learning About The Child Psychology

Another sub-theme from the parents' gains was learning about the child. 4 out of 9 parents stated that they learned new things during the process and found it useful. Parents stated that they learned how to play games with their children, how to understand the game, the language of communication, or the correct answers to the questions they thought were wrong. One of the parents stated that they learned that the restrictive themes of their child's games and toys, which indicated aggression, were actually useful. She stated that what surprised her the most during the process was that war games played with toys such as guns would not actually be harmful:

"We did this because I don't know, in order not to raise the child as a militarist (laughs) the authorities didn't have a toy like a gun or something that could harm a living being. So, you know, so that he could release his anger etc. They even said we could buy a gun,

I was shocked :) For example, it seemed very interesting in reverse there. Still, we didn't do much at home, but she said we could play games like this for a while." (G)

"Bunun biz çünkü ne biliyim çocuğu militarist yetiştirmemek için (gülüyor) öyle ne silah bi şey canlıya zarar verebilecek bir oyuncağı olmadı yetkinin. Öyle olunca hani içindeki şeyleri atabilmesi için öfkeyi vesaire diye. Hatta silah alabileceğimizi falan söylediler ben şok olmuştum :) orada mesela çok enteresan gelmişti tersinden . yine de öyle çok şey yapmadık hani evde ama bi süre mesela böyle oyunlar oynayabileceğimizi söyledi." (G)

4.2.3.4. Doing Something For The Problems

Another thing that parents saw as a gain during the therapy process was doing something for the problems. 4 out of 9 parents stated that being able to do something for their children was a step for them, a start to the process, and that doing something had a relaxing effect on them. In this process, parents received support on issues they had difficulty with regarding their children, and experienced the comfort of taking at least a step and being in safe hands. On the other hand, parents stated that doing something was a good experience for them, as it relieved their guilty feelings and relaxed them during the therapy process. The opinion of one of the parents was as follows regarding the effect of being able to take a step towards the problem they are experiencing, being safe and being able to do something:

"I mean, it made me feel good as a mother. I mean, my child has a problem and I was finally able to take a concrete step towards it. We are doing something, we are safe now, I mean, there is something I couldn't handle on my own. There are really professional people, they know what to do. It's something like this will work out eventually. The feeling of trust is at the top." (C)

"Yani anne olarak iyi hissettirdi. Yani çocuğumun bir problemi var ve sonunda buna somut bir adım atabildim. Bir şeyler yapıyoruz, artık güvendeyiz yani şey var tek başıma başa çıkamadım. Gerçekten profesyonel birileri var, onlar ne yapacaklarını biliyor. Bu iş eninde sonunda yoluna girecek diye bir şey. Güven duygusu en başta." (C)

4.2.3.5. Empathic Attitude

Another sub-theme regarding the parents' gains was about empathic attitudes. 4 of the parents stated that they started to empathize with the feelings their children were experiencing and that they realized that the issues they initially considered as spoiled were actually feelings they had difficulty with. They stated that when parents started to empathize with their children, they relaxed, they started to understand their children better, they started to approach them more positively, and they tried not to approach them with anger. Some of the parents stated that the stress they experienced when they started the process was eased by feeling the support of the therapists, and they realized that they could empathize better because of this. One of the parents described her experience this way:

"I mean, just because of your guidance, I got a little closer to the child. I got closer to his feelings. How can I say that? I understood him more. I got more positive, not with prejudice, but more positive. Because they were telling me that, you know, empathize. They were constantly telling me that, I empathize, I guess that was the effect a little more." (B)

" Yani sadece hani beni yönlendirmelerinizden kaynaklı çocuğa biraz da şey yaklaştım. Hani daha duygularına şey yaklaştım. Hani nasıl diyeyim. Daha onu anlar gibi. Hani daha böyle pozitif, daha böyle hani ön yargıyla değil de daha pozitif yaklaştım hani. Ya onu söylüyorlardı çünkü hani siz hani empati kurun. Hani bana sürekli onu diyorlardı, hani empati kurdum yani biraz daha fazla herhalde etkisi bu oldu." (B)

DISCUSSION

5.1. Current Findings

In this study, it was investigated whether various individual and parental factors had an effect on the response to therapy in order to examine the characteristics of children who did not show symptomatic improvement during the MBT-C process (non-responders). In the scope of the study, it was hypothesized that individual factors such as the number of traumatic life events of the child, emotional regulation capacity, play capacity and age at which therapy began, as well as the parent's emotional regulation and mentalization skills, could predict the response to therapy while controlling for the duration of therapy (total number of sessions). As a result of the analyses, it was seen that only the traumatic experiences experienced by the children and the emotional regulation capacity significantly predicted the non-response status. Other variables such as play capacity, age, number of sessions and parental characteristics did not have a significant effect on the response to therapy. In this section, the findings are discussed by comparing them with similar studies in the literature and possible explanations are presented.

The first hypothesis was that baseline adverse childhood experiences of children would predict non-response. In the analyses conducted, it was seen that it predicted non-response. Baseline adverse childhood experiences significantly predicted treatment non-response. These findings are directly related to the findings in the meta-analysis of Skar et al. (2022). Skar et al. (2022) suggested that three or more traumatic experiences may cause drop out and non-response. Our study also obtained findings that support this. In the literature, it is thought that childhood traumas and PTSS levels affect the course of treatment, so more precise methods may be needed while working in this area (Cloitre et. al., 2011; Skar et. al., 2022). These findings support that as the intensity of the negative effects of trauma on the child increases, the rate of response to treatment decreases.

The second hypothesis was that children's baseline emotion regulation capacity would predict non-response. As a result of the analysis, it was seen that the initial emotion regulation capacity predicted the outcome at the end of the treatment. While high emotion regulation capacity was associated with response, low emotion regulation capacity was associated with treatment non-response. These findings showed that emotion regulation skills may be a protective factor in the therapy process. Similarly, in Fernandes et al.'s (2023) study, children's executive functions and emotional regulation strategies before the intervention were found to be significantly associated with emotional and behavioral problems during the intervention process. In particular, high levels of dysfunctional strategies such as catastrophizing and blaming others were associated with problem behaviors; the decrease in these strategies during the therapeutic process was considered an indicator reflecting the effectiveness of the intervention. Both studies show that the pre-intervention assessment of emotional regulation skills plays a critical role in predicting how children will benefit from the therapeutic process.

On the other hand, the findings obtained in this study contradict the findings of Suveg and colleagues (2018). In Suveg's study, emotional regulation levels measured based on reports from children and parents did not show a significant predictive or moderating effect on treatment outcomes. This difference may primarily be due to theoretical differences in the measurement approaches used. Suveg and colleagues assessed emotional regulation skills with more strategy-based measurement tools (e.g., specific coping strategies such as suppression and reappraisal). In contrast, scales such as the ERC (Emotion Regulation Checklist) used in this study measure broader dimensions such as general emotional regulation capacity and emotional awareness.

Secondly, sample differences may also be effective. Suveg's study was conducted with children with anxiety disorders, thus the relationship between emotional regulation and internal symptoms may have become more complex. This study, on the other hand, has a more heterogeneous clinical sample and includes external problem behaviors. Finally, the difference in the applied treatment models may also contribute to the contradiction between these findings. While CBT (Cognitive Behavioral Therapy)-based

interventions were used in the study by Suveg et al., a psychodynamic and relationship-based model such as MBT-C was applied in this study. Emotional regulation is seen as tightly linked to the child's mentalization capacity within the framework of MBT-C, and its development is addressed more in the context of relationships. Therefore, the meanings and intervention mechanisms that different theoretical models attribute to the concept of emotional regulation may also cause differences in comparative findings. For all these reasons, multidimensional and theoretically different definitions are needed to better understand the relationship between emotional regulation and therapeutic response.

This study also investigated whether children's pre-therapy play capacity (measured with CPTI) could predict whether they would respond to treatment. Considering that play capacity reflects the child's capacity to represent internal conflicts and express emotional processes, it was suggested that children with higher play capacity would respond more positively to therapy. However, the analyses showed that the initial level of play capacity did not significantly predict non-response.

In the psychoanalytic-based study of Halfon and Bulut (2019), it was similarly observed that symbolic play capacity increased at the beginning of therapy, especially in cases where treatment compliance was high, but this increase slowed down over time. This suggests that play capacity is not a fixed trait; it may be a dynamic process (state) shaped by relationships, attachment, and therapeutic environments. Therefore, levels measured only before therapy may be insufficient to explain therapeutic change.

Secondly, the fact that CPTI assessments were taken very early in the therapy process may reflect a stage where the child's play capacity was not fully demonstrated. The first sessions, when the therapeutic alliance was not yet developed and the child did not fully trust the therapist and the environment, may have limited the true reflection of play capacity. This may have made the initial measurement of play capacity an "instantaneous performance" rather than an "underlying capacity." Thirdly, in measurements based on observational coding such as CPTI, limitations such as the limited interpretative power of the therapist and the coder's inability to directly know the child's inner life may have created measurement errors in play capacity data.

In this study, no significant relationship was found between the age at which the child started therapy and the response to treatment. This finding seems to contradict some previous studies. For example, Midgley and Kennedy (2011) stated that psychodynamic therapies are more effective for younger children; they emphasized that therapeutic gains decrease with increasing age. Similarly, a large-scale meta-analysis by Skar et al. (2022) showed that age has an effect on treatment response, especially in trauma-based interventions, and that therapeutic effects decrease as age increases.

However, the fact that this relationship was not found in the current study can be explained by the nature of the MBT-C model and its application method. MBT-C is a modular and manual-based approach based on adapting therapeutic interventions to age-appropriate levels (Midgley, 2017). The therapy process is structured according to the child's developmental level; techniques such as play, emotion recognition, and relational representations are selected according to age. In this way, interventions suitable for the emotional processes and mentalization development of older children can be provided. In other words, the differences that may increase with age can be compensated for within the flexible application structure of MBT-C.

Therefore, this finding does not indicate that the age factor is ineffective, but that its effect can be limited in models sensitive to developmental level such as MBT-C. In addition, it is necessary to evaluate the effect of age on treatment outcomes not alone, but together with other characteristic and environmental factors. Therefore, it is important to conduct multivariate analyses in larger and heterogeneous samples to reveal the effect of the age variable on therapeutic response.

In this study, the total number of sessions received by children was included in the model as a control variable. No significant relationship was found between the total number of sessions received by the children and non-response to treatment. This finding questions the widespread assumption that the number of sessions will directly increase therapeutic benefit. Indeed, the study by Andrade et al. (2000) also revealed that there was no significant difference in the mental health outcomes of children who received a high number of sessions compared to those who received fewer sessions. This suggests that a direct and consistent dose-response relationship between the number of sessions

and the results is not always valid. The fact that the finding in this study was not significant indicates that the number of sessions alone is not a sufficient variable to determine the success of treatment and that deeper process variables such as the nature of the treatment process, the child's motivation, and the therapeutic alliance should be taken into account. In addition, it was thought that the absence of very high variances in the number of sessions attended in the sample and the similarity of participation rates may have caused the absence of a significant difference.

Another hypothesis was that the parent's baseline emotion regulation capacity would predict treatment non-response. However, as a result of the analyses, baseline parental regulation did not predict treatment outcome. The study by Zimmer-Gembeck et al. (2019) showed that the emotional regulation skills developed by parents during the therapy process were associated with improvements in children's behavioral and emotional symptoms. In particular, it was stated that the increase in cognitive restructuring skills and the decrease in prementalization levels were associated with children responding more positively to treatment. Similarly, in the MBT-C-focused study by Halfon et al. (2024), significant improvements were found in mothers' emotional regulation skills at the end of therapy. These findings suggest that increases in parental psychological functioning may contribute to children's well-being. In contrast, in this study, parents' pre-therapy emotional regulation levels did not play a significant role in predicting treatment response. This difference suggests that parental factors may depend on the dynamics of change in the therapeutic process and may not always be captured by fixed (trait) level measurements.

In a similar study to ours, in a master's thesis Özsoy (2024) examined the changes in emotional regulation and parental stress levels in parents who applied MBT-C and evaluated whether parental reflective functioning was associated with these variables. In the study, a decrease in the stress levels of parents in both the MBT-C group and the control group was observed, but the PRF level was not significant as a predictive factor for this decrease. This result also suggests that parental emotion regulation capacity may be a fixed trait and may not be open to change during short-term therapy interventions. In this context, Özsoy's study also supports the findings of the current study; since in

this study, the parent's emotion regulation capacity before therapy did not significantly predict the response to treatment. When both studies are evaluated together, it is understood that the effect of parental factors on the therapeutic process can only be measured by long-term changes or developments within the process; fixed characteristics at the initial level may have a limited effect on treatment outcomes.

It has been hypothesized that baseline parental prementalizing mode, measuring the parent's difficulty in making accurate attributions about the child's feelings, thoughts, and behaviors (Luyten et. al., 2017), will predict treatment non-response in children. When the relationship between baseline parental mentalization and treatment non-response was examined, it was found that parental prementalizing mode did not predict non-response. In the data obtained from the RCT study, mothers' PRF did not improve during the therapy process (Halfon, 2024). These results showed that MBT-C parental mentalization did not change during the therapy process and was not associated with outcome measures. In our study, it was seen that it did not predict treatment response from a similar perspective.

The findings from Halfon and Beşiroğlu (2021) showed that mothers' baseline child focused parental reflective functioning predicted a decrease in children's problem behavior. The findings obtained in this study did not overlap with the findings of Halfon and Beşiroğlu (2021). This difference may be largely due to the measurement method used. Halfon and Beşiroğlu (2021) used a narrative method, such as the Parent Development Interview (PDI), to measure parental mentalization, where open-ended questions based on qualitative data are evaluated by coders. This method evaluates in depth and in context how parents understand their children's inner world and the extent to which they can distinguish complex patterns of emotion and thought.

In contrast, the Parental Reflective Functioning Questionnaire (PRFQ) used in this study is a self-report measurement tool. Self-report tools are based on the individual's own insight and awareness; therefore, there may be limitations regarding how participants perceive themselves. Self-report methods may have validity limits, especially when measuring psychological capacities such as mentalization, which mostly operate at an

unconscious and relational level. This means that narrative-based measures should be made more in-depth and reliable in assessing mentalization capacity.

5.2. Discussion of Qualitative Analysis

The qualitative analyses conducted in this study show that the experiences of parents who participate in child-focused therapies can be emotionally intense, multidimensional, and sometimes contradictory. The fact that parents simultaneously voice both positive and negative themes about therapy reveals that parental involvement in child therapies is not merely an administrative or supportive function, but an active process that has a therapeutic effect in its own right. In line with the basic principles of the MBT-C approach, these findings show that approaching the parent's emotional process with sensitivity can contribute to the psychological development of the child.

As a result of the qualitative analysis conducted in this study, three main themes emerged to understand the experiences of parents regarding the child-focused therapy process: negative feelings and thoughts about therapy, unmet needs and expectations, and parental gains. These themes reveal the multilayered and sometimes contradictory experiences of parents regarding the therapy process; on the one hand, they indicate feelings of disappointment, anger, or inadequacy, while on the other hand, they also indicate areas of awareness, insight, and development.

5.2.1. Negative Feelings and Thoughts About Therapy

The first theme, negative feelings and thoughts about therapy, includes the intense emotional difficulties experienced by some parents during or after the therapy process. Some participants stated that therapy triggered negative feelings such as anger or disappointment in them. This is a process that is frequently encountered, especially in psychodynamic or mentalization-based therapies, because such interventions can bring to the surface the individual's internal conflicts, defenses, and emotional regulation styles (Bateman & Fonagy, 2016). In this context, the expressions of anger,

disappointment, and the failure to achieve the expected change from therapy in the theme of "negative feelings about therapy" reveal that parents have internalized the process and are deeply affected emotionally. Some parents stated that therapy created feelings of anger in them, and that this was not due to a negative attitude towards therapy, but rather due to having to confront unresolved feelings from their childhood. This emotional burden increased, especially when they had difficulty coping with the child, and caused temporary disconnections and burnout in some parents. Therefore, it is important for therapists to realize that parents also need to be heard and understood, and to provide a framework that normalizes and holds such reactions. At the same time, it is difficult to mentalize the child when the parent's needs are also intense (Midgley et al., 2017). In this sense, it is also possible for parents to feel forced to understand the child. Some participants stated that seeing mistakes in what they did for the better also made them angry. While trying to do something with great effort, seeing their mistakes caused them to feel angry about the effort they put in. Therefore, we think that it would be important for future studies to make their strengths visible while giving feedback to parents.

As stated in the MBT-C manual (Midgley,2017), some families may have different needs and expectations about the therapy process. In such cases, the therapist clearly stating the therapeutic goals, holding regular feedback sessions with the parent, and transparently explaining within which boundaries the therapy process will operate can contribute to maintaining the therapeutic alliance. In addition, it should not be forgotten that some parents may expect a more direct, structured, and informative approach; stretching the intervention style appropriate to this need can facilitate the parent's emotional regulation.

5.2.2. Unmet Needs and Expectations

The second theme, unmet needs and expectations, emphasizes the parents' more structural and relationship-based needs for therapy. Some participants expressed that the number of sessions was insufficient, individual needs were not met, or the process was not handled holistically because only the mother participated in the therapy. The lack of

"father participation" in particular is important not only in this study but also in child therapies in general (von Klitzing & White, 2020). The statements in this theme show that parents want not only the child's but also their own experiences and expectations to be heard. Indeed, the active participation of parents in the therapy process and the need to be seen individually are meaningful not only for the child but also for the family system. The points mentioned in the theme of “unmet needs and expectations”, such as the insufficient number of sessions and feedback, the participation of only mothers in the process, or the ignoring of individual needs, indicate that child therapies should be structured with a more holistic approach to the family system. The MBT-C model (Midgley et al., 2017) allows the practitioner to stretch the framework and structure it according to the family; individual sessions where the parent can carry the emotional burden, father-child sessions or paired feedback sessions are possible within the model. However, in cases where this flexibility is not sufficiently used or structured in practice, it may be inevitable for parents to feel excluded and unseen. Indeed, one of the important principles of the guide is the principle that “the child cannot be understood unless the parent is understood.” This principle states that the parent should be recognized as a subject who is a part of the change, not just someone who receives session information.

Feedback has been an important point for parents in the therapy process. Some parents stated that they needed more, clearer or more appropriate feedback. Similar thoughts can be found in the literature. However, the quality of the feedback given by the therapist and the way they interact with the parent also play a critical role. The subtheme Inadequate Feedback reflects the feeling that parents do not receive sufficiently structured, timely, and emotionally sensitive feedback during the therapy process. Participants stated that they expect therapists to share the changes in their children and the course of the process more openly, clarify their expectations, and allow space for their own emotional processes. This situation is not only an individual experience, but also a clinical need supported by the literature. In the systematic review by Gondek et al. (2016), it was shown that measurement-based feedback used in the therapy process increases therapeutic effect, especially for individuals who do not respond to treatment. Providing feedback to both the therapist and the client increases

cooperation and process awareness; however, findings regarding when, for whom, and in what context feedback is effective are still variable.

Similarly, in a randomized controlled study conducted by de Jong et al. (2018) in a child psychiatry sample, it was observed that feedback-focused intervention (FIT) increased the quality of life in children, but did not cause a significant change in symptom severity. This suggests that the therapeutic benefit of feedback may be effective not only at the symptom level, but also through the parent's processes of making sense of the process, carrying hope, and developing commitment.

Therefore, therapeutic feedback is not only a technical part of the process, but also an important building block that strengthens the parent's emotional involvement and ensures the sustainability of the process. Therapists should provide feedback not only on the child's symptoms but also on the parent's emotional experience, and should regularly examine what they feel, how they make sense of the process, and what they need. Otherwise, the idea that the process is only "about the child" can lead parents to feel excluded, worthless, and misunderstood.

In a study conducted by Barnett et al. (2015) focusing on this issue, it was found that the therapist's in vivo (instant) feedback techniques during the Parent-Child Interaction Therapy (PCIT) applications directly affected the parent's participation in the process and skill acquisition. The study showed that parents who received more responsive and empathic coaching acquired child-focused parenting skills faster and remained committed to therapy for longer. In contrast, families where more directive, repetitive and rigid techniques were used had higher rates of early dropout. This finding may help us understand why some parents in the current study tended to disengage from the process or why they "felt like a research project" and "received insufficient feedback." Interaction styles where the parent is immediately heard and responded to, and their needs are met in a way that is appropriate for them, increase therapeutic commitment; standardized, superficial approaches can prevent the parent from emotionally owning the process.

Therefore, in child-focused therapies, especially from the first sessions, actively listening to the parent's experience, regularly examining their needs, and providing feedback both openly and sensitively can contribute to making the process more sustainable for both the parent and the child. This approach is an important clinical practice that can transform the quality of parental involvement not only within the framework of MBT-C, but also in all child-centered therapeutic interventions.

Fathers' refusal to participate in the therapy process also emerged as a sub-theme. The majority of the process fell on the shoulders of the mothers, and the fathers' failure to participate in the process led to feelings of exhaustion and loneliness in the mothers. Conducting the therapy process, which was emotionally and physically difficult, as a single parent was a challenging experience and even increased their anger. In our study, we observed that a significant number of people were involved in the process as single parents. Although the MBT-C model supports parental involvement with its flexible structure, these findings suggest that fathers should be included in the process more systematically and consciously. This situation is not limited to this sample; the literature also consistently reports that fathers participate in child therapy at much lower rates than mothers. For example, Phares et al. (2005) emphasized that factors such as social roles, temporal and spatial barriers, therapists' lack of direct invitation, and discomfort with being in emotional spaces underlie the low representation of fathers in child and family-based therapies. This study presented both clinical and research-based strategies to engage fathers in the process: flexible scheduling, direct invitation, and sensitivity to father-specific concerns are among these practices.

Similarly, in a mixed-method study conducted by Klein et al. (2022) on Parent-Child Interaction Therapy (PCIT), it was found that fathers' regular participation was achieved only 61% of the time, and the only significant factor predicting this participation was the strategies implemented by the therapist to increase father involvement. In qualitative interviews, therapists stated that they encountered systemic obstacles but were highly motivated to ensure father involvement. The findings show that father involvement is not spontaneous but possible through structured and persistent therapist efforts.

When all these findings are evaluated together, the lack of father involvement in the current study points to a broader problem not only in the individual family structure but also in the general structure of the therapeutic system. In MBT-C and similar child-centered interventions, practices such as special invitation methods for fathers, flexible participation models, and recognition of the co-parenting structure can be developed to prevent the burden on a single parent in the process. In this sense, perhaps future studies could examine the effects of differences in this involvement on outcomes. Future studies should investigate how we can ensure the active participation of fathers in the process; they should also focus on systemic, cultural or structural barriers.

In another subtheme, Limited Time, several parents felt that the number of sessions was too few for meaningful change, and that more time was needed to explore both the child's and their own processes. The inadequacy of this process for some participants was due to the shortness of the process and the fact that radical changes could not occur in such a short time. At the same time, some participants thought that their children were still continuing therapy today, that the process was a beginning, and that the current changes could be related to the path covered in so much time. However, even if they realized that they needed more therapy, it was a disappointment that they could not continue due to the nature of the study.

The MBT-C intervention implemented in this study included a time-limited structure. Within this framework, a predetermined number of sessions (usually 12 sessions), a clear calendar, focus formulation, and parallel parent work were planned with the family at the beginning of the therapeutic process. The mentalization-based approach sees this framework not only as a structural necessity but also as a part of the mentalizing stance. According to the MBT-C model , this transparent structuring at the beginning of the process supports a sense of trust and cooperation for both the child and the parent (Midgley et al., 2017). Due to the nature of this time-limited structure, some basic processes—for example, the development of the child's and parent's mentalizing capacity or the establishment of epistemic trust—may not be fully completed. However, such time-limited interventions still have the potential to be an orientation, a first step, or a mental space opening regarding these capacities. Although this limitation was

structurally conveyed at the beginning of the therapeutic process, the findings show that some parents approached therapy with the expectation of a complete and visible change. This constitutes one dimension of the disappointment experienced at the end of the process.

5.2.3. Parental Gains

The theme of “parental gains” shows that the therapeutic process can create insight and awareness in parents. Expressions such as “First I changed, then my child changed” suggest that the parent experiences a transformation in their self-representation and that this transformation is reflected in the child. This situation directly overlaps with one of the basic assumptions of MBT-C, which is that “the mental transformation in the parent will contribute to the child’s well-being.” Some parents re-evaluated their children’s emotional needs, their own parenting styles or family interaction patterns during the therapy process, and this evaluation turned into a behavioral change.

In the theme of Parental Awareness, many parents stated that they felt the need to look not only at the child but also at their own parenting attitudes when faced with their child's problems. This indicates that the parent develops an internal observation position while trying to make sense of visible problems on the outside. Especially when evaluated in the context of mentalization capacity, these moments of awareness suggest that the parent begins to attribute mental meanings not only to the child's behavior but also to their own emotions, expectations, and reactions (Midgley et al., 2017). Such a change in the level of representation shows that the therapeutic process can have transformative effects not only for the child but also for the parent's self-perception.

The theme of Parental Awareness shows that parents do not only focus on their children during the therapy process, but also review their own parenting attitudes, emotional reactions, and behavioral patterns. This insight is related to the parent's involvement in therapy not as a passive observer, but as an active and thoughtful participant. In fact, in a comprehensive review study conducted by Haine-Schlagel and Escobar Walsh (2015), it was revealed that not only the parent's participation in the sessions but also their

active participation in the session at a mental, emotional and interactional level were more directly related to therapeutic outcomes. The researchers emphasized that parental participation was limited to the "attendance" criterion in many studies; however, real interactional participation, that is, the parent's emotional and cognitive involvement in the process, created effects that supported the child's mental well-being.

These findings theoretically support the theme of Parental Awareness in the current study. Parents' awareness of their own internal processes allows them to develop a more inclusive and regulating view of the child. Therefore, in child-focused therapeutic models, positioning the parent as a partner who not only provides information but also emotionally participates can significantly increase therapeutic effectiveness.

The experiences expressed in the sub-theme Parent Develops Then Child Develops show that therapeutic change is not one-way but has a relational structure. Some parents stated that their children's development was only possible with their own transformation; they even associated the change in the child's behavior with their own internal awareness and regulatory capacities. This supports the perspective that development in parental functioning directly contributes to the child's well-being, which is one of the basic assumptions of MBT-C (Midgley et al., 2017). The change here points to a deep restructuring not only in observable behaviors but also in the mental relationship the parent establishes with the child. The awareness that the parent develops regarding his/her own parenting style, emotional reactions, and relationship with the child, seen in this theme, shows that not only the child but also the parent is emotionally and mentally involved in the therapeutic process. This finding is also consistent with previous research showing that the active participation of the parent in child-centered interventions strengthens the therapeutic effect.

In fact, a meta-analytic review of 48 studies conducted by Dowell and Ogles (2010) showed that therapeutic models conducted with the parent as a child-parent are more effective than individual child therapy alone. This finding shows that including the parent in therapy as a co-participant in the therapeutic process, rather than just as an "informant" or "accompanying", can increase both trust in the process and the child's behavioral and emotional gains. In the same study, although the effectiveness of

individual therapies without parental involvement in cognitive-behavioral approaches was found to be high, it was emphasized that parental involvement generally made a significant contribution to therapy outcomes. In this context, the insight observed in this theme shows not only individual awareness, but also a transformation process and co-development that has constructive effects on the child's development.

The subtheme Learning About the Child Psychology revealed that parents approach the therapy process more equipped and confident when they acquire new information about their children's development, emotional processes, and behavioral patterns. This finding shows that parents experience therapy not only as an "intervention area," but also as a psychoeducational learning process.

One of the studies supporting this situation, Martinez (2015), showed that the frequency with which the therapist uses psychoeducational strategies in therapies conducted for behavioral disorders in children positively affects the level of parental participation in therapy. In particular, talking to parents about the causes of behavioral problems, justifying intervention methods, and explaining these processes with concrete examples makes it easier for parents to both understand the process and commit to the process. This finding directly coincides with the fact that some parents in the current study realized their children's emotional needs for the first time thanks to the therapy process and stated that gaining information on these issues strengthened them. Therefore, it can be said that psychoeducation is not only a tool that conveys information, but also an important therapeutic element that supports the parent's mentalization capacity and helps them develop a more holistic representation of their child.

In the subtheme of Empathetic Attitude, it was stated that the empathetic approach seen from the therapist or the empathetic relationship exemplified in the sessions contributed to the parent taking a more compassionate and understanding position towards their own child. These observations suggest how learning through modeling works in the therapeutic context and that the parent's mentalizing style can develop indirectly. This situation shows that one of the main goals of MBT-C, which is to increase the parent's capacity to think about the child's internal states, can be supported not only by direct psychoeducation but also through relationship patterns and emotional experience.

These findings also overlap with the developmental and therapeutic literature on empathy. Barish (2023) stated that the child's need for empathetic responses is as basic and vital as physical contact; he emphasized that empathetic responses occur not only in moments of comforting the child, but also when playing together, sharing his curiosity or accompanying his enthusiasm. According to Barish, such empathetic responses allow the child to feel “understood” and form the basic building blocks of emotional health. In this context, the therapist’s empathetic stance serves not only as immediate emotional support but also as a model that can transform the parent’s relationship with the child.

5.3. Clinical Implications

5.3.1. Clinical Implications for Quantitavite Analysis

In light of all this information, the findings should be interpreted with caution and careful consideration. Although some children were initially perceived as non-responders at the end of therapy, follow-up data suggest that meaningful improvements often emerged over time (Halfon, 2024). The effects of MBT-C may not be immediately visible at the conclusion of treatment, as core therapeutic gains—such as enhanced reflective functioning and emotional insight—require time to be internalized and expressed in daily life. In many cases, the true impact of the therapy appeared more clearly in the long term.

It is also important to note that the outcome measures used in this study were collected immediately after the end of therapy. Previous research has shown that MBT-C is not only effective in the short term but also produces stronger effects compared to active control groups in the long term. Therefore, the immediate post-treatment assessments may underestimate the true impact of the intervention. However, in this study, long-term follow-up data were not used, as many families experienced significant individual and familial life events, and several environmental disruptions—such as natural disasters—occurred in the surrounding context and country. Since it was not possible to

adequately control for the impact of these external factors on outcomes, only the assessments conducted immediately after therapy were included in the analysis.

In this study, ACE predicted non-response and the literature includes similar studies. In this case, we can think that children with high traumatic experiences are at risk for non-response in therapy. This information shows that traumatic experiences should be learned in detail in the first evaluation when starting the therapy process and perhaps the therapy process should be customized according to the child's experiences. It is important for therapists to know that traumatic experiences may be associated with non-response when starting therapy. If therapists are aware of this during this process, they can prepare therapeutic approaches in this direction and consider a longer and more intensive therapy program. Of course, this relationship is not linear; some factors can mediate this relationship for therapists and families. For example, Koç's study (2024) examined two children with a similar number of traumatic experiences and found the mediating effect of nonverbal communication and mental state talk. Some protective and mediating factors changed the course of therapy. Therefore, it would be wrong to evaluate the abundance of traumatic experiences as a direct non-response, but it is useful in terms of being aware of the process and following a path accordingly. Considering that trauma has negative effects on coping mechanisms, providing new coping skills for these children may also be effective in the process.

Finding this relationship and being on the same level with the literature was very important for this study. Although the effects of trauma on children are known, it has also been shown in therapy. Before reaching this point, it is obvious that there is a need for supportive factors in the therapy process in preventive programs.

In addition, perhaps the number of traumatic experiences is effective, but the type of traumatic experience may also be effective in this regard. An analysis was made on the numbers in this study, perhaps important results could have been obtained if it was looked at in terms of different subcategories. Future studies on the type of trauma may reveal various elements such as which categories are more at risk and which ones have more negative effects together. Future studies may examine which categories can cause

a more challenging process and which other factors can moderate and mediate this relationship in case studies, which will be useful for the literature.

The findings obtained in this study show that children's baseline emotion regulation capacities significantly predict treatment outcomes. While children with stronger initial emotion regulation skills benefited more from therapy, children with lower regulation capacity tended to remain non-responsive to treatment. These results reveal that emotion regulation skills are not only a therapeutic target but also a potential protective factor that can predict the course of the treatment process.

First of all, these findings emphasize the importance of assessing emotion regulation skills before therapy in child and adolescent psychotherapy. The extent to which a child is open to therapy may be directly related to their capacity to regulate their inner lives. Therefore, attention should be paid not only to the level of symptoms but also to how the child experiences emotional experiences, the intensity of the emotions they express, and their coping styles. In this context, in addition to standard scales such as the Emotion Regulation Checklist (ERC), therapeutic observation-based assessments may also be useful in initial interviews.

Secondly, for children with low emotional regulation capacity, preparatory or constructive interventions that can be carried out before therapy or in parallel with therapy may be beneficial. Especially for children who suppress their emotions, over-externalize them or tend to avoid them, acquiring emotional awareness and basic regulation skills before switching to a mentalization-based approach may be preparatory to the therapeutic process. In the early stages of therapy for these children, it would be appropriate to focus more on lower-level skills such as recognizing and naming emotions, noticing physical symptoms and basic relaxation strategies.mentalization-based therapy actually advocates this method (Midgley, 2017). In this therapy method, emotion regulation and attention control constitute the first steps. After these develop in the process, mentalization comments are made.

Thirdly, this study shows that emotion regulation is not a fixed but a dynamic process. The therapy process of children with low emotional regulation capacity may progress

more fluctuating, a rapid change in symptom levels may not be observed and a longer period of time may be required to achieve therapeutic goals. Therefore, therapists need to adjust expectations, explain the process and support the emergence of therapeutic gains in order to ensure the sustainability of the alliance they establish with both the parent and the child. In addition, monitoring progress in emotion regulation skills throughout therapy can guide treatment planning and process evaluation.

These findings are also partially consistent with previous studies in the literature. For example, Fernandes et al. (2023) reported that dysfunctional strategies used by children before intervention (such as catastrophizing and blaming others) were associated with behavioral problems and that the decrease in these strategies during the therapy process reflected the effectiveness of the intervention. In the current study, a significant relationship was found between general emotion regulation capacity and therapy response. This suggests that the quality of the strategies used by children and general regulation capacity should be considered together. In contrast, Suveg et al. (2018) found no significant moderator effect of emotion regulation level on treatment outcomes. This difference may be due to the type of measures used (strategy-based vs. general capacity), clinical characteristics of the sample, or differences in the therapy models applied. Therefore, the relationship between emotion regulation and treatment outcomes needs to be examined in a multidimensional manner in further studies.

In conclusion, this study highlights the need for individualized interventions based on emotion regulation in child psychotherapy. In mentalization-based models such as MBT-C, it is thought that the therapeutic process can be more effective and sustainable when both the assessment and intervention processes are structured in accordance with the child's current regulation capacity. Early emotional regulation assessments and flexible intervention planning, especially in children at risk of not responding to treatment, are among the strategies that can increase clinical success.

In this study, it was found that play capacity measured with CPTI did not show a significant relationship with non-response to therapy. Most studies in the literature treat play capacity more as a developmental indicator; they examine the causal relationship of this capacity with dynamic outcomes such as response to therapy in a more limited

way. Our current findings show that play capacity may not be a factor that directly and solely determines response to therapy. This suggests that play capacity may be a contextual and processual feature that is shaped during the therapy process and can develop together with the therapeutic relationship, rather than a fixed characteristic.

Accordingly, although play capacity is an important resource in clinical practice in understanding and formulating the emotional content of children, it should be kept in mind that assessments made on a single measurement before therapy may be insufficient to understand children's potential for change. In the first sessions of therapy, children may not have developed sufficient confidence yet; this may cause play behaviors to be observed below their potential. In this context, repeating the assessments made with tools such as CPTI after the establishment of the therapeutic alliance or monitoring the change in play capacity over time can reveal more clearly how this skill interacts with therapeutic change.

In addition, the fact that play capacity alone does not explain non-response shows that therapeutic outcomes should be considered together with multidimensional factors such as not only the child's characteristics but also parental involvement, emotional regulation capacity, the quality of the therapeutic alliance and continuity in the therapy process. Therefore, if play capacity is to be used as an assessment tool, especially in mentalization-based therapies such as MBT-C, it should be interpreted together with qualitative data such as the child's representational capacity as well as the extent to which he or she participates in the process, the relationship he or she establishes with the therapist and the depth of symbolization.

The findings of this study reveal that play capacity alone may be limited in predicting therapeutic change; however, it is an area that develops and can be supported during the therapy process. In clinical practice, instead of evaluating play capacity as a fixed characteristic, viewing it as a skill that is open to development, can be monitored over time, and is sensitive to intervention will provide a more holistic approach. In future studies, monitoring the change in play capacity over time may provide more explanatory data on how this capacity interacts with therapeutic change.

In this study, no significant relationship was found between the age at which the child started therapy and whether or not he/she responded to treatment. This finding seems to contradict previous studies (e.g., Midgley & Kennedy, 2011; Skar et al., 2022) suggesting that younger children benefit more from psychoanalytic and mentalization-based therapies. However, the sample of the current study is limited to the 5–12 age range and does not contain high variance in terms of age. In addition, since the sample size is relatively limited, the statistical power to determine the effect of age may not have been fully achieved.

This suggests that the effect of age on therapeutic outcomes should not be evaluated alone, but together with other contextual factors such as the child's developmental level, type of problem, type of participation in therapy, and characteristics of the applied model. Especially in models structured with developmental sensitivity such as MBT-C, therapeutic techniques should be shaped according to the child's emotional capacity, mentalization skills, and relational participation rather than age, which may make it difficult to directly observe the effect of age.

From a clinical perspective, this finding suggests that therapists should not plan interventions based solely on the child's calendar age. Two children of similar age may have significantly different levels of emotional regulation, reflective functioning capacity, or relationship building styles. Therefore, age alone should not be considered a deciding variable in assessment and intervention processes; instead, the child's developmental needs, relationship building styles, and emotional involvement in therapy should be taken into account. Moving forward, studies covering wider age ranges and with larger and more heterogeneous samples are needed to more clearly understand the effect of age. These studies can model the effect of age on response to therapy not only as a developmental but also as a contextual and process-based variable.

No significant relationship was found between the total number of sessions received by the children and the lack of response to treatment. This finding questions the widespread clinical assumption that therapeutic benefit will automatically increase as the number of sessions increases. Consistent with the findings of Andrade et al. (2000), a linear and consistent "dose-response" relationship was not observed in this study.

Various factors may have played a role in explaining this situation. First of all, the fact that all children participating in the study attended approximately the same number of sessions for a similar duration may have reduced the statistical variance and prevented differences between the groups. The fact that the sample was not normally distributed in terms of the number of sessions and had a low variance made it difficult to test the effect of the number of sessions statistically.

This finding shows that focusing only on the number of sessions is insufficient when evaluating the effectiveness of the therapy process. Process variables such as the quality of the therapeutic relationship, the child's motivation, the strength of the therapeutic alliance, and emotional involvement may be much more decisive than the number of sessions. Therefore, decisions regarding session duration should be made according to the individual needs of the child. While some children achieve significant gains with a few sessions, others may require longer and more structured interventions.

As a suggestion for future studies, comparisons can be made between different intervention duration groups in order to more clearly evaluate the effect of the number of sessions. For example, one group can receive a short-term intervention of 15 weeks, while the other group can receive a long-term process of 30–45 weeks. Such a design may allow for more clear observation of the effects of therapy duration on therapeutic response. This finding reveals that the "more sessions, more effect" approach is not always valid in both clinical practice and research planning, and emphasizes the importance of focusing on the qualitative depth of the therapeutic process, individual differences, and process monitoring.

At the same time, parents' pre-therapy emotion regulation skills did not significantly predict whether children would respond to treatment. However, this difference paves the way for important clinical interpretations regarding the nature of emotion regulation capacity and how it is measured.

Emotion regulation is a capacity that operates at both individual and relational levels and can change over time during the therapy process. Therefore, a fixed (trait) level measurement made before therapy cannot always be expected to accurately reflect the

potential for change that will emerge during the therapy process. In structured, process-oriented, and developmentally sensitive models such as MBT-C, change often develops through relational dynamics such as establishing the therapeutic relationship, touching the child's emotional content, and the parent's beginning to approach the child's emotions differently. At this point, observing and monitoring emotion regulation capacity during the therapy process may be more functional than one-time measurements.

In addition, the emotion regulation measurement tool (DERS - Brief Form) used in the study is a self-report-based scale and is based on the parent's insight, awareness, and statement regarding their own regulation. However, some parents, especially parents of children experiencing psychological difficulties, may have difficulty describing or expressing their own internal processes. This may affect the validity of the measurement. Therefore, more meaningful results can be produced when such emotion regulation variables are assessed with multiple methods, both based on self-reporting and supported by in-session observation. This finding suggests that it may not be sufficient to predict whether the child will respond to therapy by looking at the parent's level of emotion regulation before therapy, but rather how this capacity changes during the therapy process. In clinical practice, supporting parental emotion regulation skills requires planning holistic approaches that are not only child-focused but also family-focused.

Prementalization levels, which measure parents' mentalization capacity before therapy, did not significantly predict whether children would respond to treatment. First, in our study, parental mentalization was assessed using the self-report PRFQ scale and only the prementalization subscale. Although this approach measures the parent's tendency to make false attributions about the child's internal states, it may not fully reflect the complex and multidimensional nature of mentalization. Indeed, in studies such as Halfon and Beşiroğlu (2021), parental mentalization was measured by evaluating narratives obtained via the PDI (Parent Development Interview) by expert coders, and significant relationships were found with child behavioral problems. This method may

be a more sensitive tool because it allows the parent to assess not only what they think, but also how they express it, their narrative style, and emotional nuances.

Second, the effects of mentalization often operate indirectly and contextually. A parent's ability to make accurate attributions about their child is related not only to having this skill at a cognitive level, but also to being able to apply it in a real relational context. How this capacity changes during the therapeutic process, how much it is activated, and how it is reflected in the child's behaviors may not be fully captured with a fixed measurement before therapy.

Finally, the failure to determine the relationship between the PRF variable and therapy outcomes suggests that this variable may be a structure that acts together with other factors in the process rather than a direct effect. For example, the parent's mentalization capacity may facilitate the establishment of a therapeutic alliance in the interaction with the child, but it can gain meaning when evaluated together with the child's individual regulation skills, symptom profile, and level of participation in therapy. Therefore, in future studies, addressing the change in parental mentalization during the process, the relationship with the therapist, the ways in which the child responds to emotional needs, and intra-session patterns with multi-layered methods will contribute to a more accurate understanding of the therapeutic effects of this variable.

5.3.2. Clinical Implications for Qualitative Analysis

The interviews with families in this study were conducted in April 2025, approximately two to three years after the completion of therapy. Given this time gap, the outcomes derived from these interviews should be interpreted in light of possible memory distortion, intervening life events, and the evolving parental perspectives on therapy. Over the two years following therapy, children's developmental stages advanced, and parents' concerns may have shifted accordingly. Their current recollections during the interviews may reflect more recent frustrations or developmental challenges rather than the immediate outcomes of therapy.

Nevertheless, many of the observed changes are likely rooted in the therapeutic foundations laid during MBT-C. Families were provided with written feedback reports at the end of the therapy process, outlining the child's progress; however, in some cases, these may have been insufficient for families to fully make sense of the changes that occurred. Some parents expressed confusion or dissatisfaction during the interviews, which may reflect a mismatch between their expectations and the delayed nature of therapeutic change.

The perception of therapy as "a research project" or unexpected level of change in symptoms suggests that there is a mismatch between the parents' expectations from therapy and the process offered by therapy. At this point, clearly stating the goals and boundaries at the beginning of the therapeutic process can ensure that the process progresses more transparently. At the same time, while it may not be a problem for parents to have a research project at the beginning, the intensity of the measurements during the process, the physical effort and the burden of the therapy may have been a challenge for parents. In such studies, even if the parents have consented, when what is desired within the scope of the research and what the parents gain from the therapy are different, we can think that their experiences are negative. In connection with this issue, one of the parents stated that the therapists were there for the research and did not see the client's needs because they thought they were filling in the templates that needed to be done.

Some parents stated that the end of therapy was abrupt and that they did not feel ready for the process to end. The limited nature of the therapy process due to the research-based structure caused a process that parents thought would continue to end early. This situation created a feeling of emotional incompleteness in some parents. Therefore, clearly discussing the therapy goals, duration and possible outcomes from the beginning can prevent such uncertainties. At the same time, continuing to collect data for the research but not receiving sufficient feedback also made the end of this process abrupt. On the other hand, while doing in-depth work, ending therapy before the needs were met may have made one think that it was a meaningless end. Perhaps in such in-depth

work, it would be good for parents to be prepared for closure and to have periodic interim meetings afterwards.

In particular, the fact that some parents perceive therapy as a "research project" or do not see sufficient changes in the child's symptoms suggests that expectations from therapy and the process presented may be incompatible. This situation shows that the therapeutic framework should be shared openly and clearly at the beginning and that it is important to inform families about the process.

Some parents interpreted the fact that the child's symptoms did not change as a failure. However, it should be kept in mind that the change process in mentalization-based therapies is long-term and may not be observed immediately. Therefore, drawing a clearer framework about "what can change" at the beginning of the therapeutic process ensures that the process progresses in harmony with the families' expectations. It may also have been interpreted in connection with the intensity of the symptoms or the family's need for help. While some parents have seen some change but have stated that they have not seen any change in some areas, some parents have emphasized that they have not seen a complete change and have even gotten worse from time to time. Perhaps the parents' needs in this regard should be addressed more clearly.

The metaphor of the “magic wand” expressed by some participants is striking in terms of understanding this situation. Although parents knew on a logical level that such an intervention was unrealistic, they internally hoped for a rapid and transformative effect. This situation suggests that, especially in families where the mentalization capacity is still developing, the expectation is focused solely on the child’s change and the more complex, relational nature of the process is not internalized. Therefore, it is clear that in time-limited therapies, not only the technical framework but also psychoeducation about the nature of change and expectation adjustment should be an important part of the therapeutic process.

In the theme of Doing Something for the Problems, it is quite significant that some parents stated that taking action against their child's problems reduced their feelings of guilt and increased their sense of hope. In these families, starting the therapy process

provided a kind of transition to action and control, even if there were no major changes on the surface. Regular participation in therapy contributed to the organization of not only the child but also the entire family system, and the feeling of "I'm not doing anything" was replaced by a sense of active effort. This is an important gain that strengthens the parent's sense of internal agency and can be the primary motivation for therapeutic change in some cases.

It is also important to emphasize that not every non-response outcome implies therapeutic failure. In some cases, families may not observe immediate symptomatic change, but the therapy still plants important seeds for emotional development and reflection. These gains can shape parenting dynamics and foster delayed therapeutic effects. When these three themes are evaluated together, it can be seen that the therapy process can be both a challenging and a developing experience for parents. While the process created disappointment for some parents due to the failure to meet expectations or the structural limits of the process, it opened the door to meaningful insights for others. Therefore, viewing parental involvement in child-focused therapies not only as a supportive element but also as an area of intervention can increase the effectiveness of the therapeutic process. This suggests the importance of restructuring the therapeutic framework in a way that more explicitly considers parental needs and motivations

However, all these clinical observations should also be evaluated within the temporal context of the study. In this study, interviews with parents were conducted two to three years after the end of the therapy process. During this period, many changes may have occurred in the families' lives. For example, symptoms may have re-emerged in some children or different problems may have developed; this may have led to a more critical and disappointing perspective on the effect of therapy in retrospect. At the same time, some parents' feelings about the therapy process may have changed over time; they may have begun to evaluate a process that they initially found meaningful or supportive as inadequate over time. In this context, it should be noted that the themes obtained are shaped not only by the therapy process but also by the experiences and re-interpretations brought about in the years following therapy.

This observation also brings to the agenda the need for post-therapy support structures in child therapies. These structures, referred to as "booster sessions" in the MBT-C manual (Midgley et al., 2017), can be implemented in the form of follow-up interviews with parents after therapy, sessions organized at certain intervals, or counseling sessions, aiming to recognize the changing needs of parents and support the sustainability of the child's psychological well-being. Such a structure can help parents make sense of the disappointment they experience with the process, and help them recognize and intervene in potential problems early. In line with the findings of this study, in child-focused therapies, the parent should be considered not only as a person who assumes an "instrumental role" but also as an emotionally active, meaningful, and developmental subject. An approach that regularly monitors what the parent feels, what they expect, and to what extent they are understood, is structured according to need, and can be flexible when necessary, will strengthen the parent's commitment to the therapeutic process and support the child's development more directly.

Studies should also investigate how to facilitate more equitable parental involvement. In light of the theme Father Refusal, future interventions can benefit from designing engagement strategies specifically tailored to increase father participation, including scheduling flexibility, male therapist representation, or sessions that directly address paternal roles and resistance. Regarding the theme of Abrupt Ending, research should explore how termination is experienced and processed by families, especially in therapy structures defined by external constraints (such as research protocols). Developing best practices for termination that support emotional closure may prevent dropout or therapeutic disengagement.

In addition, the long-term impact of non-response in therapy should be examined more closely. The findings related to Doing Something for the Problems and Parental Awareness suggest that non-response in terms of symptom change does not equate to therapeutic failure. Future studies should focus on delayed or indirect therapeutic benefits and how families construct meaning from therapy even when measurable change is limited. Finally, developing follow-up or booster sessions, parent consultation tracks, and post-therapy outreach efforts may help address the evolving perceptions and

needs that emerge after the end of treatment, especially given the time gap reported in this study.

In addition to these, one of the most striking and powerful contributions of this study to the literature is that it provides both a quantitative and qualitative analysis of the phenomenon of therapeutic non-response, in light of the data obtained from the first randomized controlled trial (Halfon et al., 2024) on mentalization-based child therapy (MBT-C). This first RCT study conducted by Halfon and colleagues demonstrated the effectiveness of MBT-C. This study also constituted a starting point for the literature in that it included the first systematic non-response analysis conducted with this approach. The results obtained in this study clearly show that therapy does not work in the same way for everyone and that some children do not benefit sufficiently from MBT-C. However, this study helped us understand what can be changed and improved.

The current thesis study, following these important findings, proposes a research model to understand the characteristics of children who do not benefit sufficiently from MBT-C (non-responders), the experiences of their families, and their experiences regarding the process. In particular, the fact that 31 of the 86 children who participated in the RCT study still showed symptoms at a clinical level immediately after therapy reveals that the issue of therapeutic ineffectiveness (non-response) is an important issue that cannot be ignored. This rate should direct both clinicians and researchers to examine the characteristics of this group more closely and to develop intervention plans specific to their needs.

One of the most valuable aspects of the study is that it does not leave this non-response phenomenon only at a numerical level, but also allows the therapeutic process to be analyzed qualitatively. Because classical effectiveness studies mostly answer the question of “how much does it work?” while leaving the questions of “how does it work?” or “why does it not work for whom?” unanswered. This study addresses this gap and provides clues on how the MBT-C approach can be made more effective by making sense of situations where the therapeutic process is ineffective.

The findings obtained from the qualitative analysis revealed that, especially for some families, the therapeutic process requires longer time, clearer guidance, the involvement of both parents, more direct feedback, and needs to be structured by considering more individual needs. However, it was observed that some children were not emotionally ready for therapy, some parents had difficulty making sense of the process, and in some cases, the child-therapist relationship did not deepen sufficiently.These findings suggest that even within the MBT-C model, known for its flexible structure, more specific adaptations may be required for the needs of some families. Particularly for children who have experienced severe trauma and have difficulty regulating emotions, adaptations such as greater involvement of parents in the process, more frequent family meetings, or increased psychoeducational support for caregivers may increase therapeutic gains. What is suggested here is not a rigid intervention protocol; it is the use of the already existing flexible structure of MBT-C in a way that is more appropriate to the needs and capacities of each family.

At the same time, learning that there are parental gains and that the child's symptoms do not change completely but are somewhat better also shows that conducting effectiveness research based on one-dimensional symptom change can be misleading. In qualitative interviews, there were participants who talked about their negative experiences as well as parents who saw the process as a turning point that gave positive meaning or said that they had taken a step. This brings us to the question of whether we can call this situation completely non-response even if there is no symptomatic change. Perhaps future studies should not evaluate non-response only in terms of symptom change in outcome when defining it, but should also consider that the process is multidimensional and how gains are achieved from other perspectives.

This study points to the importance of identifying children with high trauma histories and significant emotion regulation difficulties early in the planning of the therapy process. While MBT-C is a developmentally appropriate and flexible model, the findings suggest that some children—especially those with high emotional reactivity—may benefit from additional or adapted support structures. These preliminary findings suggest that more individualized treatment with detailed assessments at the beginning of

the therapy process may be clinically valuable. For example, increasing the number of individual sessions for some children, working more intensively with parents in some families, or adding preliminary interventions that support emotion regulation skills may have a positive effect on the process. In addition, spending time at the beginning of the process to address parental needs and expectations and ensuring that they feel heard may also contribute. Although randomized controlled trials follow certain structures, these findings point to the clinical value of a flexible approach that is sensitive to individual needs in the therapy process. However, since this study was conducted with a limited sample, the results obtained should be interpreted with caution, and these trends should be systematically examined in larger and more diverse samples.

In conclusion, this thesis study provides a comprehensive perspective not only on the effectiveness of MBT-C, but also on the limitations of this approach, its improvable aspects, and how it can be adapted for different client profiles. Understanding why the therapeutic process does not work for some children is of great importance not only in terms of clinical practice but also in terms of ethical responsibility. Thanks to this thesis, we can now talk not only about who benefits, but also about who does not benefit and why. Thus, an important step has been taken towards a more inclusive, more flexible, and more individualized structure for child therapies.

5.4. Strengths and Limitations

This study has presented us with which baseline characteristics are more prone to non-response and how these can be intervened at the beginning of the process. While revealing the change in children's symptom levels with quantitative analyses is valuable in terms of determining which children do not benefit from therapy, qualitative analyses make visible the reasons behind this lack of change, the clients' experiences and experiential patterns regarding the process. This synthesis allows therapeutic processes to be evaluated not only with their outcomes but also with their dynamics. Thus, not only effectiveness but also the "conditions of effectiveness" are understood more clearly.

When this study is considered as a whole, there are strengths and limitations for both qualitative and quantitative studies. One of the most important strengths of this study is that it is the first study to our knowledge that examines the non-response through the effectiveness of MBT-C therapy. Many studies have looked at variables that predict outcome, but listening to parents' experiences and examining them together is a very important part of this study. At the same time, the experiences of the participants of the first RCT study investigating the effectiveness of MBT-C conducted in Türkiye were examined in depth. Adding the needs and experiences of parents to the literature will also guide future MBT-C therapies.

This study addresses an area that has not been sufficiently studied in the literature on child therapy. Although there are many studies focusing on the effectiveness of psychotherapies, it is largely unclear which children do not benefit from therapy and why. This study contributes to the development of more individualized and flexible intervention models by focusing on subjective experiences of the therapy process as well as changes in symptom levels. The research findings offer meaningful implications for clinical practice. The data obtained may help therapists predict which children may need a longer, more structured, or more feedback-oriented process. In this context, the study has the potential to develop practical recommendations that can contribute to the more sensitive and effective structuring of MBT-C practices.

However, some limitations of the study should be taken into consideration when interpreting these findings. The sample size was limited both for general analyses and for comparison of subgroups. The small number of non-response groups in particular made it difficult to achieve statistical significance. In addition, some variables used (e.g. PRFQ sub-dimensions) were based on self-reports, and it should be noted that parents' responses may be biased by social desirability or awareness levels. Some measures, such as children's play capacity, were not supported by more comprehensive methods that track changes over time, thus reflecting the dynamic nature of the variable in a limited way. The Cronbach alpha coefficients obtained in the sub-dimensions of some scales used in this study create limitations in terms of internal consistency of the

measurements. This situation indicates that the findings obtained with these sub-scales should be interpreted with caution and that the results have limited generalizability.

Some of the parents reached during the qualitative data collection process refused to be interviewed or could not be reached for various reasons. This created a tendency in the study sample for participants to participate by their own choice. In particular, parents who felt more disappointment, anger, or insecurity about their child's therapy process may not have participated in the study because they had difficulty coping with these feelings. Since participation requires emotional dedication and a desire to return to the process, individuals who feel less negative feelings or are more at peace with the process may have been more likely to participate.

Therefore, not being able to hear the experiences of parents who could not participate in the study should be considered as a factor that limits the full representation of the analyzed themes. In families that could not be reached, there may be much deeper structural obstacles, psychological fractures or patterns of insecurity. In this context, the findings of the study are based on the experiences of individuals who still have the emotional space to remember and tell the process, especially after therapy; this causes a certain perspective to come to the fore. In future studies, using different data collection methods (such as anonymous written statements, interviews with a consultant) that will make it easier to reach such families can create a more comprehensive data structure.

All these clinical observations should be evaluated within the temporal context of the study. In this study, interviews with parents were conducted two to three years after the end of the therapy process. During this period, many changes may have occurred in the families' lives. For example, symptoms may have re-emerged in some children or different problems may have developed; this may have led to a more critical and disappointing perspective on the effect of therapy in retrospect. At the same time, some parents' feelings about the therapy process may have changed over time; they may have begun to evaluate a process that they initially found meaningful or supportive as inadequate over time. In this context, it should be noted that the themes obtained are shaped not only by the therapy process but also by the experiences and re-interpretations brought about in the years following therapy.

In the initial planning of the study, there was a goal of conducting a more holistic analysis by including the children's experiences with therapy. However, the content obtained from the interviews was insufficient in terms of reaching the necessary findings for analysis. Therefore, the interviews conducted with children were not included in the qualitative analysis part of the study. However, this process provided important observations regarding the methodological difficulties of interviews conducted with children and had a developing function for future studies.

One of the main reasons for this limitation is that the verbal expression skills of the children interviewed are limited due to their age. The verbal expression, insight and abstraction skills necessary to describe an abstract, emotional and internal experience such as the therapeutic process are still not sufficiently developed in many children. In addition, there is an average time difference of 2 to 3 years between the therapy process and the interviews conducted with children. During this period, the fact that the children had both grown older and progressed to different developmental stages made it difficult for them to remember emotional and relational details about the therapy period. Some children were able to recall their past therapy experiences very briefly and superficially during the interview, while others described the process as a “playing” experience and could not make sense of it contextually. This situation was related to remembering the therapy process and processing it emotionally, not only with age, but also with the time elapsed and their ability to express it.

The ages at which the children interviewed started the therapy process (for example, between the ages of 5 and 7) coincide with a period when their capacity to structure and describe their own emotional experiences was still developmentally limited. Therefore, although they were older at the time of the interview, what they remembered and could describe about that period remained mostly superficial and was not developed enough to detail relational or internal processes. It was also thought that they had difficulty expressing their feelings because they had not met the researcher and had no alliance. These findings show that conducting qualitative interviews with children is not only a technical skill, but also a process that should be carefully structured in terms of developmental appropriateness, timing and method. Using creative methods such as

play-based methods, projective techniques, story completion, drawing pictures or dramatic role-play as an alternative to verbal interviews may be more effective, especially in expressing subjective experiences regarding the therapy process.

Understanding the child's perspective on the therapy process should be evaluated not only in terms of producing clinical knowledge, but also as an ethical responsibility that focuses on the subjective experiences of children. In future studies, children's developmental capacities, interview timing and expression styles should be addressed in a more holistic manner, paving the way for their participation in the process as meaningful narrators.

In addition, one of the important methodological limitations of this study is the lack of a control group. Since there was no comparison group, causal inferences cannot be made about whether MBT-C is effective or ineffective for certain subgroups. The relationships and patterns obtained are descriptive and exploratory; they do not provide definitive results. Future randomized controlled trials are needed to test these relationships and to better understand the contributions of MBT-C to therapeutic change.

In conclusion, this study provides preliminary but valuable findings about the phenomenon of non-response to therapy in the context of MBT-C. By combining quantitative symptom data with in-depth qualitative narratives of caregivers, it contributes to a more holistic understanding of how the therapeutic process is experienced and in which areas difficulties are experienced. Although methodological limitations, such as limited sample size, reliance on self-reports, and lack of a control group, limit the generalizability and causal interpretation of the findings, the study provides clinically meaningful suggestions for individualizing interventions and increasing therapeutic engagement. It also highlights the importance of incorporating children's voices into future research in developmentally sensitive and creative ways.

CONCLUSION

In conclusion, this study makes significant contributions to the literature in the field of mentalization-based therapy for children (MBT-C); it sheds light on the specific needs of this group by examining the characteristics of children who do not benefit sufficiently from therapy (non-responders). The study examined the effects of variables such as childhood negative life experiences, emotional regulation difficulties and parental mentalization capacity on therapy response using logistic regression analysis, and also evaluated the experiences of families regarding the process using thematic analysis through qualitative interviews.

The study shows that the reasons why some children do not benefit from therapy to the expected level, despite similar initial symptom levels, are due to inadequate fixed structures, inappropriate feedback processes and, in some cases, the need for longer-term intervention. These findings draw attention to the fact that therapies should be individualized by considering the child's developmental characteristics, past traumas and family dynamics. In addition, this study is one of the first in the literature to qualitatively examine the issue of non-response within MBT-C practices, and by providing insights into “why ineffective therapeutic processes do not work,” it provides important clues about how existing interventions can be improved.

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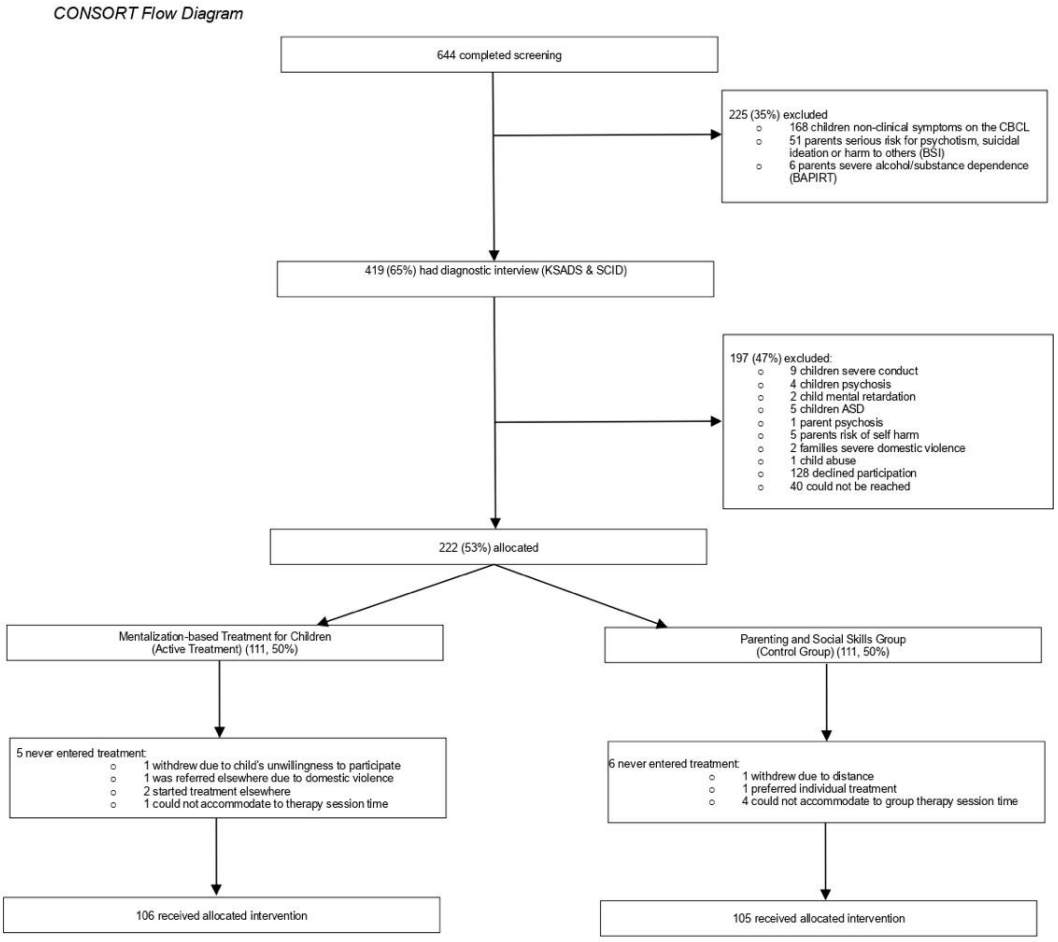
APPENDICES

Appendix A. Result of the Evaluation by the Ethics Committee

Result of the Evaluation by the Ethics Commitee is available in the printed version of this dissertation.

Appendix B. Consort Flow Diagram



Appendix C. Consent Form for Interviews

BİLGİLENDİRİLMİŞ ONAM FORMU

Bu çalışma İstanbul Bilgi Üniversitesi Klinik Psikoloji Yüksek Lisans Programı öğrencisi Aysu Aydın tarafından Doç. Dr. Sibel Halfon danışmanlığında yüksek lisans tezi kapsamında yürütülmektedir. Bu çalışma, çocuklar ile gerçekleştirilen terapi süreçlerinin etkilerini anlamayı ve bu süreçlerde etkili olan veya etkili olmayan faktörleri incelemeyi amaçlamaktadır. Elde edilen bulgular, terapi süreçlerini daha verimli hale getirmek ve danışanlara sağlanan desteği artırmak fayda sağlayabilir.

Araştırma kapsamında çevrim içi platform üzerinden görüşmeler planlanacaktır. Görüşmeler çocuğunuz ve sizinle ayrı ayrı yapılacak ve benzer sorular sorulacaktır. Her bir görüşme yaklaşık 45-60 dakika sürecek ve ses kaydı alınarak yazıya dökülecektir. Görüşmeler, çevrenin sessiz ve internet bağlantısının sabit olduğu bir ortamda gerçekleştirilmelidir.

Bu araştırmaya katılımın sizin veya çocuğunuzun fiziksel ya da ruhsal sağlığı üzerinde olumsuz bir etkisi olacağı öngörülmemektedir. Ancak herhangi bir rahatsızlık hissetmeniz durumunda, bizimle iletişime geçebilir ve süreci sonlandırabilirsiniz. Katılım tamamen gönüllülük esasına dayalıdır ve istediğiniz zaman çalışmadan çekilebilirsiniz.

Araştırmada elde edilen bilgiler, kişisel gizlilik ilkelerine uygun olarak korunacaktır: Veriler, kimlik bilgilerinizden arındırılarak anonim hale getirilecek ve numaralandırılarak saklanacaktır. Hiçbir kişisel bilgi, üçüncü şahıslarla ya da kurumlarla paylaşılmayacaktır. Görüşmelerden elde edilen ses kayıtları, analiz tamamlandıktan sonra güvenli bir şekilde silinecektir.

Araştırmaya katılım tamamen gönüllülük esasına dayanmaktadır. Katılmayı kabul ettikten sonra, herhangi bir aşamada çalışmadan ayrılma hakkına sahipsiniz. Ayrılmanız durumunda, o ana kadar toplanan bilgiler araştırmada kullanılmayacaktır.

Araştırma hakkında sorularınız olduğunda ya da desteğe ihtiyaç duyduğunuzda, aşağıdaki iletişim bilgilerini kullanarak bizimle iletişime geçebilirsiniz:

Psikolog Aysu Aydın

Bilgi Üniversitesi Klinik Psikoloji Programı:

E-posta:

Telefon:

Bilgilendirme mektubunda detayları açıklanmış olan araştırma projesine

Katılmak istiyorum □ Katılmak istemiyorum □

Çocuğun adı soyadı:

Ad Soyad:

Telefon numarası:

İmza:

Çocuklar için Sözlü Onam Formu

Merhaba!

Burada, daha önce terapiye katılmış çocukların ve ailelerin yaşadıkları süreçleri daha iyi anlamak için bir araştırma yürütüyoruz. Bu çalışmada, terapi deneyimlerini ve bu deneyimlerin çocuklar ile aileler üzerindeki etkilerini öğrenmeyi hedefliyoruz. Araştırmamız, sizlere ve sizin gibi diğer çocuklara daha iyi nasıl destek olabileceğimizi anlamamıza yardımcı olacak.

Eğer bu çalışmaya katılmayı kabul edersen, seninle çevrim içi bir görüşme yapacağız ve bu görüşmeyi sesli olarak kaydedeceğim. Görüşme sırasında sana bazı sorular soracağım ve bu sorular, terapi sürecinle ilgili deneyimlerini anlamaya yönelik olacak.

Senden aldığımız bilgiler, yalnızca araştırma ekibindeki birkaç kişi tarafından görülecek ve analiz edilecek.

Bize anlattıkların diğer katılımcılardan alınan bilgilerle birleştirilecek, böylece kimse bu bilgilerin senden geldiğini bilmeyecek. Ayrıca, adını ya da seni tanıyabilecek herhangi bir bilgiyi çalışmada paylaşmayacağım. Tüm bilgiler, gizlilik kurallarına uygun şekilde korunacaktır.

Eğer bu çalışmaya katılmak istemezsen ya da fikrini değiştirip çalışmadan ayrılmak istersen, istediğin zaman bunu yapabilirsin. Bu tamamen senin kararın ve katılmaman ya da ayrılman durumunda kimse sana kızmayacak ya da üzülmeyecek.

Annen bu çalışmaya katılmana izin verdi, ancak bu senin tercihin. Eğer herhangi bir sorunun ya da anlamadığın bir şey varsa bana sorabilirsin.

Eğer bu çalışmaya katılmaya karar verirsen, lütfen aşağıdaki uygun seçeneği belirt.

Bu çalışmaya katılmaya karar verdim. _____

Bu çalışmaya katılmak istemiyorum. _____

Çocuğun Adı:

Tarih:

Appendix D. Child Behavior Checklist For Ages 1.5-5 (CBCL/1.5-5)

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

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

0 1 2 1. Ağrı ve sızıları vardır (tıbbi nedenleri olmayan).

0 1 2 2. Yaşından daha küçük gibi davranır.

0 1 2 3. Yeni şeyleri denemekten korkar.

0 1 2 4. Başkalarıyla göz göze gelmekten kaçınır.

0 1 2 5. Dikkatini uzun süre toplamakta ya da sürdürmekte güçlük çeker.

0 1 2 6. Yerinde rahat oturamaz, huzursuz ve çok hareketlidir.

0 1 2 7. Eşyalarının yerinin değiştirilmesine katlanamaz.

0 1 2 8. Beklemeye tahammülü yoktur, her şeyin anında olmasını ister.

0 1 2 9. Yenmeyecek şeyleri ağzına alıp çiğner.

0 1 2 10. Yetişkinlerin dizinin dibinden ayrılmaz, onlara çok bağımlıdır.

0 1 2 11. Sürekli yardım ister.

0 1 2 12. Kabızdır, kakasını kolay yapamaz (hasta değilken bile).

0 1 2 13. Çok ağlar.

0 1 2 14. Hayvanlara eziyet eder.

0 1 2 15. Karşı gelir.

0 1 2 16. İstekleri anında karşılanmalıdır.

0 1 2 17. Eşyalarına zarar verir.

0 1 2 18. Ailesine ait eşyalara zarar verir.

0 1 2 19. Hasta değilken bile ishal olur, kakası yumuşaktır.

0 1 2 20. Söz dinlemez, kurallara uymaz.

0 1 2 21. Yaşam düzenindeki en ufak bir değişiklikten rahatsız olur

0 1 2 22. Tek başına uyumak istemez.

0 1 2 23. Kendisiyle konuşulduğunda yanıt vermez.

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

0 1 2 25. Diğer çocuklarla anlaşamaz.

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

0 1 2 27. Hatalı davranışından dolayı suçluluk duymaz.

0 1 2 28. Evden dışarı çıkmak istemez.

0 1 2 29. Güçlükle karşılaştığında çabuk vazgeçer.

0 1 2 30. Kolay kıskanır.

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

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

0 1 2 33. Duyguları kolayca incinir.

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

0 1 2 35. Çok kavga dövüş eder.

0 1 2 36. Her şeye burnunu sokar.

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

0 1 2 38. Uykuya dalmakta güçlük çeker.

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

0 1 2 40: Başkalarına vurur.

0 1 2 41. Nefesini tutar.

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

0 1 2 43. Hiçbir nedeni yokken mutsuz görünür.

0 1 2 44. Öfkelidir.

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

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

0 1 2 47. Sinirli ve gergindir.

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

0 1 2 49. Aşırı yemek yer.

0 1 2 50: Aşırı yorgundur.

0 1 2 51. Hiçbir neden yokken panik yaşar.

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

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

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

0 1 2 55. Cinsel organlarıyla çok fazla oynar.

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

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

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

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

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

0 1 2 61. Yemek yemeyi reddeder.

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

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

0 1 2 64. Gece yatağına gitmemek için direnir.

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

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

0 1 2 67. Sevgiye, şefkate tepkisiz görünür.

0 1 2 68. Sıkılgan ve utangaçtır.

0 1 2 69. Bencildir, paylaşmaz.

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

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

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

0 1 2 73. Çekingen ve ürkektir.

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

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

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

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

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

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

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

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

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

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

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

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

0 1 2 86. Temiz, titiz ve düzenlidir.

0 1 2 87. Çok korkak ve kaygılıdır.

0 1 2 88. İşbirliği yapmaz.

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

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

0 1 2 91. Çok gürültücüdür.

0 1 2 92. Yeni tanıdığı insanlardan ve durumlardan çok tedirgin olur. (açıklayınız): _____

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

0 1 2 94. Geceleri sık sık uyanır.

0 1 2 95. Alıp başını gider.

0 1 2 96. Çok ilgi ve dikkat ister.

0 1 2 97. Sızlanır, mızırdanır.

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

0 1 2 99. Evhamlıdır.

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

0 1 2_____

0 1 2_____

0 1 2_____

LÜTFEN TÜM MADDELERİ YANITLAYINIZ.

SİZİ KAYGILANDIRAN MADDELERİN ALTINI ÇİZİNİZ.

Child Behavior Checklist For Ages 6-18 (CBCL/6-18)

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

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

0 1 2 1. Yaşından çok çocuksu davranır.

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

0 1 2 3. Çok tartışan bir çocuktur.

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

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

0 1 2 6. Kakasını tuvaletten başka yerlere yapar.

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

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

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

_____

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

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

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

0 1 2 12. Yalnızlıktan şikayet eder.

0 1 2 13. Kafası karışık, zihni bulanıktır.

0 1 2 14. Çok ağlar.

0 1 2 15. Hayvanlara eziyet eder.

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

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

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

0 1 2 19. Hep dikkat çekmeye çalışır.

0 1 2 20. Eşyalarına zarar verir.

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

0 1 2 22. Evde söz dinlemez.

0 1 2 23. Okulda söz dinlemez.

0 1 2 24. İştahsızdır.

0 1 2 25. Başka çocuklarla geçinemez.

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

0 1 2 27. Kolay kıskanır.

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

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

(açıklayınız): _____

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

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

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

0 1 2 33. Kimsenin onu sevmediğinden yakınır.

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

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

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

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

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

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

0 1 2 39. Başı belada olan kişilerle dolaşır.

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

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

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

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

0 1 2 44. Tırnaklarını yer.

0 1 2 45. Sinirli ve gergindir.

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

0 1 2 47. Geceleri kabus görür.

0 1 2 48. Başka çocuklar tarafından sevilmez.

0 1 2 49. Kabızlık çeker.

0 1 2 50: Çok korkak ve kaygılıdır.

0 1 2 51. Başı döner, gözleri kararır.

0 1 2 52. Kendini çok suçlu hisseder.

0 1 2 53. Aşırı yer.

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

0 1 2 55. Fazla kiloludur.

56. **Sağlık sorunu olmadığı halde;**

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

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

0 1 2 c. Bulantı, kusma duygusu olur

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

(açıklayınız): _____

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

0 1 2 f. Mide-karın ağrısından şikayet eder

0 1 2 g. Kusmaları olur

0 1 2 h. Diğer (açıklayınız): _____

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

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

0 1 2 58. Burnunu karıştırır, derisini ya da vücudunu yolar, saç ve kirpiğini koparır.

(açıklayınız): _____

0 1 2 59. Herkesin içinde cinsel organıyla oynar.

0 1 2 60. Cinsel organıyla çok fazla oynar.

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

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

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

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

0 1 2 65. Konuşmayı reddeder.

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

(açıklayınız): _____

0 1 2 67. Evden kaçar.

0 1 2 68. Çok bağırır.

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

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

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

0 1 2 72. Yangın çıkartır.

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

0 1 2 74. Gösteriş meraklısıdır, maskaralık yapar.

0 1 2 75. Çok utangaç ve çekingendir.

0 1 2 76. Diğer çocuklardan daha az uyur.

0 1 2 77. Gece ve/veya gündüz diğer çocuklardan daha çok uyur.

(açıklayınız): _____

0 1 2 78. Dikkati kolayca dağılır.

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

0 1 2 80. Boş gözlerle bakar.

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

0 1 2 81. Evden bir şeyler çalar.

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

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

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

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

0 1 2 86. İnatçı ve huysuzdur.

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

0 1 2 88. Çok sık küser.

0 1 2 89. Şüphecidir, kuşku duyar.

0 1 2 90. Küfürlü ve açık saçık konuşur.

0 1 2 91. Kendini öldürmekten söz eder.

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

0 1 2 93. Çok konuşur.

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

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

0 1 2 96. Cinsel konuları fazlaca düşünür.

0 1 2 97. İnsanları tehdit eder.

0 1 2 98. Parmak emer.

0 1 2 99. Sigara içer, tütün çiğner.

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

0 1 2 101. Okuldan kaçar, dersini asar.

0 1 2 102. Hareketleri yavaştır, enerjik değildir.

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

0 1 2 104. Çok gürültücüdür.

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

(açıklayınız): _____

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

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

0 1 2 107. Gündüz altını ıslatır.

0 1 2 108. Gece yatağını ıslatır.

0 1 2 109. Mızırdanır, sızlanır.

0 1 2 110. Karşı cinsiyetten biri olmayı ister.

0 1 2 111. İçine kapanıktır, başkalarıyla kaynaşmaz.

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

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

0 1 2 _____

0 1 2 _____

0 1 2 _____

Appendix E. Adverse Childhood Experiences (ACE)

Aşağıdaki soruları çocuğunuzu düşünerek cevaplayınız.

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

1) Çocuğunuza küfretti, hakaret etti ya da aşağıladı?

Hiç Bir/İki kere Bazen Sıklıkla Çok Sık

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

Hiç Bir/İki kere Bazen Sıklıkla Çok Sık

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

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

Hiç Bir/İki kere Bazen Sıklıkla Çok Sık

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

Hiç Bir/İki kere Bazen Sıklıkla Çok Sık

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

5) Çocuğunuzun vücuduna cinsel şekilde dokundu mu?

Evet Hayır

6) Çocuğunuzu onların vücuduna cinsel şekilde dokundurttu mu?

Evet Hayır

7) Çocuğunuzla herhangi bir cinsel ilişkiye girdi mi?

Evet Hayır

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

8) Evet Hayır

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

9) Evet Hayır

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

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

Hiç Bir/İki kere Bazen Sıklıkla Çok Sık

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

Hiç Bir/İki kere Bazen Sıklıkla Çok Sık

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

Hiç Bir/İki kere Bazen Sıklıkla Çok Sık

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

Hiç Bir/İki kere Bazen Sıklıkla Çok Sık

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

14) Evet Hayır

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

15) Evet Hayır

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

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

16) Çocuğumun yeterince yiyeceği olmadı.

Hiç Bir/İki kere Bazen Sıklıkla Çok Sık

17) Çocuğumun kirli kıyafetler giymesi gerekti

Hiç Bir/İki kere Bazen Sıklıkla Çok Sık

18) Çocuğumun doktora götürecek kimsesi yoktu

Hiç Bir/İki kere Bazen Sıklıkla Çok Sık

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

Hiç Bir/İki kere Bazen Sıklıkla Çok Sık

J. ÇOCUĞUNUZ DOĞDUĞUNDAN BERİ aşağıdaki ifadeler ne sıklıkla doğrudur?

20) Ona bakacak ve onu koruyacak birisi oldu.

Hiç Bir/İki kere Bazen Sıklıkla Çok Sık

21) Çocuğumun özel ve önemli hissetmesine yardımcı olacak birisi oldu

Hiç Bir/İki kere Bazen Sıklıkla Çok Sık

22) Çocuğumun sevildiğine inanıyorum.

Hiç Bir/İki kere Bazen Sıklıkla Çok Sık

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

23) Evet Hayır

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

24) Hiç Bir/İki kere Bazen Sıklıkla Çok Sık

Appendix F. Emotion Regulation Checklist (ERC)

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

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

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

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

Appendix G. The Children's Play Therapy Instrument (CPTI)

Segmentation

The child's activity in the session is segmented into four categories. These four categories are: Pre-Play, Play Activity, Non-Play and Interruption. Segmentation of the child's activity in this manner permits an overall view of the ebb and flow of an entire session. It delineates a child who cannot play from a child who can; it highlights the experience of a child who undergoes play interruptions and contrasts it with the experience of a child capable of sustained play activity.

In order to start the segmentation:

1) View the tape/transcript in its entirety. Become familiar with the general progression of the session.

2) 2) Divide the tape into segments, categorizing each segment as Pre-Play, play, non-play, interruption as defined below (see category definitions).

3) Child's activity must be for more than 18-22 seconds to be considered

a Pre-Play activity segment,

a Play Activity segment,

a Non-Play segment or an Interruption.

Activity Type Definitions:

a. Pre-Play Activity – In Pre-Play Activity the child is "setting the stage" for play. He picks up a toy, begins to explore it, manipulate it, and may give it symbolic meaning. The predominant purpose is exploration and preparation for the Play Activity.

• In order to distinguish Pre-Play from Play Activity the vignette or session must be viewed in its entirety. Since defining the category of the child's activity is dependent upon context cues embedded within the entire sequence, it is often necessary for the rater to go back and forth, viewing the transition between activities several times before reaching a decision about classification.

• If the child is clearly preparing for a higher level of play, then, the preparation is classified as Pre-Play. If the child does not proceed to a more advanced level of play, but remains sorting, aligning, or constructing with toys (Not preparation for advanced play), this segment of the child's activity can be classified as Play Activity.

• There may be pre-play within a play segment. For example, the child pauses, chooses a new toy, and then, continues his Play Activity that has now become somehow altered. To be coded as pre-play, it needs to be more than 18-22 seconds.Thus, Pre-Play does not only occur at the beginning of playing however you need to make sure that this is preparation for a higher level of play. With inhibited children, they will often play much of the time organizing the toys which is itself part of the play structure (then this gets reflected in the inhibition code.)

b. Play Activity – The child becomes engrossed in playful activity often indicated by adult/child exhibiting one or more of the following behaviors:

1) An expression of intent (e.g. Let's play), followed by play activity.

2) Actions indicating initiative, such as, definition of roles, "This dolly will be the teacher;" verbally suggesting, "we can both climb the mountain."

3) An expression of specific positive or negative affects such as glee, delight, pleasure, surprise, anxiety or fear.

4) Focused concentration with toy or person, (may be in response to therapist's activities, reflecting child's engagement with therapist).

5) Purposeful use of toy objects, or physical surround.

The ending of a Play Activity is signaled by one, or several behaviors, including the following:

1) A clear termination of action, e.g. the child drops the object, or set of objects, he has been using;

2) A shift to Non-Play activity, e.g. the child stops jumping and starts talking to the therapist about an unrelated topic;

3) A change in the activity focus, e.g. the child moves from the doll house to listening to a story being read; or,

4) The impression the theme of the play has been "played out" (Play Satiation), as if the child is finishing a story.

In order to decide whether to open a new play segment, or a play segment please look for these indications:

-The child must even if briefly stop the other activity, shift his/her focus to a new activity and show a mental recognition that he has started a new activity. He also must state that he will now start something else. He will purposefully use the new set of toys he has discovered. His attention as well as affect tone must shift. He can say things like: “Let’s play with this now!”“Now, bring me that box to play with”“Let’s begin playing now” (after exploring for a while)“Let’s decide what to play next” If the child says the things above but continues the same activity, then do not start a new play segment. Sometimes the child does not show a clear shift of focus, however within the same play segment, he prepares to play a higher order game (symbolic play or board game). For example, he was playing symbolically with soldiers, and then suddenly he says look I found a ball and then uses the balls to prepare to play bowling. In that case, that part of the segment where he starts preparing becomes a new preplay segment and is counted as pre-play and when he begins higherorder play, that is counted as play. (Had he not prepared for a higher order play but only shifted from one activity to next without clear indications, then it would be the same play segment).

c. Non-Play Activity –This category includes all activities or behaviors of the child outside the realm of Play Activity. Examples of Non-Play activities are numerous for instance, reluctance, eating, reading, doing homework, conversing with the therapist, participating in putting away toys.All these activities, or behaviors, have in common the absence of involvement in a Play Activity. The child must have no contact with any toys. If a child has a toy in his hand that he manipulates (even hand in sand (coded as motor activity)) while doing any of the “nonplay” activities, this is NOT to be coded non-play.

IMPORTANT NOTE: A CHILD MAY PLAY MANY DIFFERENT THEMES OR DIFFERENT TYPES OF PLAY WITHOUT ANY BREAKS: IN THAT CASE, IF THE CHILD DOES NOT CLEARLY SIGNAL THE ENDING OF ONE PLAY ACTIVITY BUT KEEPS PLAYING EVEN IF USING DIFFERENT MEDIUMS, IT IS STILL CONSIDERED ONE PLAY SEGMENT.

d. Interruption –An interruption is marked by the absence of the child in the play session for more than 18-22 seconds. For example, the child goes to the bathroom, goes out to see parents, goes to get materials for playing.

Regulation and Modulation of Affect

Within the same category of affect how different intensities are expressed and how easily these oscillations occur within the child's control, i.e. from annoyance to irritability to anger to rage.When coding this category ask yourself these questions:

• How does the child show different intensities of the same affect? For example, one moment child is upset that he can't find a toy he wants and the next moment he starts to tantrum. This is clearly a child who can't regulate his sadness.

• After the child show intense affect, is the child able to modulate the affect to return to equilibrium? For example, a child gets so angry that he starts hitting the therapist and is unable to calm down unless he leaves the room. This is clearly a child who can't modulate his anger.

Please rate on a scale of 1-5 using the following anchors:

1. Very Rigid: Child's feelings rise suddenly and he can't calm down, ends up showing very extreme feelings or tantrums. He is stuck in that affect state and gets disorganized. Alternatively, child is unable to show any affect and is flat throughout the play.

2. Rigid: Feelings rise relatively suddenly and child has difficulty controlling the feeling. For example, the child starts out playing a theme, which evokes disruptive feelings (i.e. anxiety, shame, anger etc.) and child finds a way to stay away from the feelings.Examples:

• Child finds a doll with a broken arm, says his father broke his arm and afterwards only arranges the toys.

• While the child is drawing, he gets anxious that he can't draw well and has difficulty drawing again.

• Child is anxious to be alone with the therapist, asks "is this an experiment" and plays alone the rest of the session not interacting with the therapist.

3. Medium: Child has moderate control over feelings. Even though he does not completely dismiss the feeling, he can also at times show difficulty sustaining it. There may be disruptions in the play narrative, even though the child does not stop playing out that theme.

4. Examples:

• A feeling rises quickly and child starts looking for another toy. Then the same feeling is played out, it rises, child gets a new toy, again plays out that theme.

4. Flexible: Child has considerable control over feelings, does not get stuck in one intensity or stay away from a disruptive state. Even though there may be one or two occasional disruptions, the child is able to continue to express the feeling in an optimal range.

5. Very Flexible: Child has full control over different intensities of a feeling that gets expressed without disruptions in the narrative.

Functional Analysis

This level of observation assesses the child's play behaviors that manifest specific coping/defensive strategies. These strategies fall along a spectrum and are grouped into four clusters. Cluster One contains strategies within the adaptive domain; Cluster Two contains strategies within the conflicted domain; Cluster three contains strategies within the polarized / rigid domain; Cluster four contains strategies within the severe anxiety / isolated domain. At this level, even though you are assessing coping strategies, these are part of the various parameters that combine to produce play activity. The patterns, or profiles, of play activity reflect a specific child's experience of himself and others while playing, as well as his strategies for coping and adaptation. Therefore, please use your previous observations to assess the child's general play pattern which also includes coping strategies listed below.

All Functional Analysis ratings use the 5-point scale.

1 •••• None Observed

2 •••• Observed At Times

3 •••• Observed Some Times

4 •••• Observed Most Times

5 •••• Observed All of the Time

Adaptive Play Profile/Strategies

Please rate to what extent you observe some or all these characteristics. Ratings of play activity that suggest adaptive strategies to contribute to a child's style of playing include:

• The child uses materials available in the room to play. (Adaptation) Example: Child uses the Legos because "We don't have small dolls."

• The child anticipates what might happen next in the play activity. (Anticipation) Example: In preparation for an operation, the child plays at being the surgeon by putting all the stuffed animals in the hospital.

• The child transforms and enjoys playing at messing using available play materials. (Sublimation) Example: Child plays with glue on the table, smearing its surface and himself, then begins to use finger paints to make a picture of his house.

• Child solves a problem while playing. (problem solving)As the blocks tumble, the child places the larger blocks on the bottom.

• Child is pleased with the product of his play activity.

• Child uses humor to express himself while playing. (humor)

Example: (A 7-year-old child, while laughing) "Boo! I scared you!

Appendix H. The Difficulties in Emotion Regulation Scale-Brief Form (DERS-16)

1. Duygularıma bir anlam vermekte zorlanırım.

2. Ne hissettiğim konusunda karmaşa yaşarım.

3. Kendimi kötü hissettiğimde işlerimi bitirmekte zorlanırım.

4. Kendimi kötü hissettiğimde kontrolden çıkarım.

5. Kendimi kötü hissettiğimde uzun süre böyle kalacağına inanırım.

6.Kendimi kötü hissetmenin yoğun depresif duyguyla sonuçlanacağına inanırım...

7. Kendimi kötü hissederken başka şeylere odaklanmakta zorlanırım.

8. Kendimi kötü hissederken kontrolden çıktığım korkusu yaşarım.

9. Kendimi kötü hissettiğimde bu duygumdan dolayı kendimden utanırım.

10. Kendimi kötü hissettiğimde zayıf biri olduğum duygusuna kapılırım.

11. Kendimi kötü hissettiğimde davranışlarımı kontrol etmekte zorlanırım.

12.Kendimi kötü hissettiğimde daha iyi hissetmem için yapabileceğim hiçbir şey olmadığına inanırım.

13.Kendimi kötü hissettiğimde böyle hissettiğim için kendimden rahatsız olurum.

14.Kendimi kötü hissettiğimde kendimle ilgili olarak çok fazla endişelenmem.

15. Kendimi kötü hissettiğimde başka bir şey düşünmekte zorlanırım.

16. Kendimi kötü hissettiğimde duygularım dayanılmaz olur.

Appendix I. Parental Reflective Functioning Questionnaire (PRFQ)

Aşağıda siz ve çocuğunuz hakkında birtakım ifadeler yer almaktadır. Her maddeyi lütfen dikkatle okuyunuz ve her maddeye ne derecede katılıp katılmadığınızı belirtiniz. Cevaplarınızı maddelerin yanındaki sayıları seçerek gösteriniz. Belirtilen ifadeye tamamen katılıyorsanız 7; hiç katılmıyorsanız 1; ne katılıyor ne katılmıyorsanız ya da kararsızsanız 4 rakamını işaretleyiniz.

Kesinlikle Katılmıyorum	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**Kesinlikle Katılıyorum**

1) ___ Çocuğumun beni sevdiğinden yalnızca o bana gülümsediği zaman emin olurum.

2) ___ Çocuğumun ne istediğini her zaman bilirim.

3) ___ Çocuğumun duygu ve davranışlarının altındaki sebepleri anlamak isterim.

4) ___ Çocuğum yabancıların yanında beni mahcup etmek için ağlar.

5) ___ Çocuğumun aklından geçenleri tamamıyla okuyabilirim.

6) ___ Çocuğumun ne düşündüğünü ve hissettiğini çok merak ederim.

7) ___ Çocuğumun evcilik, doktorculuk ve benzeri oyunlarına aktif bir şekilde katılmakta zorlanırım.

8) ___ Çocuğumun ne yapacağını her zaman tahmin edebilirim.

9) ___ Çocuğumun nasıl hissettiğini genellikle merak ederim.

10) ___ Çocuğum bazen yapmak istediğim şeyden beni alıkoymak için hasta olur.

11) ___ Çocuğumun yaptıklarını bazen yanlış anlayabiliyorum.

12) ___ Olaylara çocuğumun gözünden bakmaya çalışırım.

13) ___ Çocuğum mızmızlandığı zaman bunu beni kızdırmak için yapar.

14) ___ Çocuğuma neyi neden yaptığımı her zaman bilirim.

15) ___ Çocuğumun neden yaramazlık yaptığını anlamaya çalışırım.

16) ___ Çoğu zaman, çocuğumun davranışları çaba göstersem de anlaşılamayacak kadar karmaşıktır.

17) ___ Çocuğumun davranışlarının sebebini her zaman bilirim.

18) ___ Çocuğumun ne hissettiğini tahmin etmeye çalışmanın bir işe yaramadığına inanıyorum.

19) ___ Çocuğum dikkat çekmek için ağlar.

20) ___ Çocuğumun kurduğu hayaller bana saçma gelir.

21) ___ Çocuğum başkalarına karşı beni kötü bir anne gibi göstermek için bazı davranışlarda bulunur.

22) ___ Çocuğumun üzüldüğünü sadece ağladığı zaman anlarım.

23) ___ Çocuğum başka işle ilgilenmemi engellemek için mızmızlanır.

24) ___ Çocuğumun bakış açısını anlamak benim için zordur.

Appendix J. Questions to be Asked to the Parents in the Interview

1. Terapi süreci sizin için nasıldı? Terapi sürecinden en çok neler aklınızda kaldı?

2. Terapiye başlamadan önce beklentileriniz nelerdi? Hangi alanlarda desteğe ihtiyacınız vardı?

3. Terapi sürecinden sonra bu beklentileriniz karşılandı mı?

4. Terapi sürecinde faydalı bulduğunuz ögeler nelerdi?

5. Terapi sürecinde faydasız bulduğunuz ögeler nelerdi?

6. Çocuğunuz terapi sürecindeyken zorluklarla karşılaştı mı? Uyum sağlamakta zorluklar yaşadı mı? Bu zorluklar zaman içinde kolaylaştı mı? Bunu sizce ne sağladı?

7. Çocuğunuzun terapisti ile kurduğunuz ilişki nasıldı? Sizce ilişkinizin terapi sürecinde bir etkisi olmuş muydu? Çocuğunuzun ilişkisi sizce nasıldı terapisti ile?

8. Terapinin sizin üzerindeki etkileri nelerdi? Terapiden sonra bu etkiler korunabildi mi?

9. Terapinin çocuğunuz üzerindeki etkileri nelerdi? Terapiden sonra bu etkiler korunabildi mi?

10. Terapi sürecinize dönüp baktığınızda değiştirmek istediğiniz bir şey var mı?

Appendix K. Questions To Be Asked To The Children In The Interview

1. Terapide olmak senin için nasıldı? En çok aklında kalan şeyler nelerdi?

2. Terapiden önce neler olmasını bekliyordun? Hangi konularda yardım almak istiyordun?

3. Terapiden sonra bu beklentilerin gerçekleşti mi?

4. Terapi sırasında en çok hoşuna giden şeyler nelerdi?

5. Terapide hiç hoşlanmadığın ya da faydasız bulduğun şeyler oldu mu?

6. Terapi sırasında senin için zor olan bir şey oldu mu? Uyum sağlamakta zorlandığın bir an var mıydı? Sonra bu zorluk kolaylaştı mı? Evet ise bunu ne sağlamış olabilir?

7. Terapistin ile ilişkiniz nasıldı? Bu ilişki sence terapideki deneyimini etkiledi mi?

8. Terapinin sana etkileri neler oldu? Kendini nasıl hissettin? Ebeveynlerinin üzerindeki etkisi sence nasıl oldu?

9. Terapiden sonra bu etkiler hala devam ediyor mu?

10. Terapi sürecine dönüp baktığında değiştirmek istediğin bir şey var mı?