İSTANBUL BİLGİ UNIVERSITY

INSTITUTE OF SOCIAL SCIENCES

CLINICAL PSYCHOLOGY MASTER'S DEGREE PROGRAM

ASSOCIATIONS BETWEEN PARENTAL MENTALIZATION, CHILDREN'S EMOTIONAL MENTAL STATE TALK, CHILDREN'S ADVERSE EXPERIENCES AND BEHAVIOR PROBLEMS

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İSTANBUL

2019

Associations between Parental Mentalization, Children's Emotional Mental State Talk, Children's Adverse Experiences and Behavior Problems

Ebeveyn Zihinselleştirmesi, Çocuğun Duygu Odaklı Zihin Durumu Konuşması, Çocuğun Olumsuz Deneyimleri ve Davranış Problemleri arasındaki İlişkiler

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Date of Thesis Approval: 31.05.2019

Total Number of Pages: 136

Keywords (Turkish)
1) Ebeveyn Zihinselleştirmesi
2) Çocukların Duygu Odaklı Zihin Durumu Konuşması
3) Davranış Problemleri
4) Olumsuz Deneyimler
5) Nicel Araştırma

Keywords (English)
1) Parental Mentalization
2) Children's Emotional Mental State Talk
3) Behavior Problems
4) Adverse Experiences
5) Quantitative Research

ACKNOWLEDGEMENTS

First of all, I would like to sincerely thank my thesis advisor, Sibel Halfon, for her guidance and encouragement which made this work possible, and for her endless support and containing attitude starting from the first year of the Master's program until the end of this process especially during the hardest times. I would also like to thank my second and third thesis advisors, Elif Göçek and Mehmet Harma, for their contributions during this process.

I would like to thank my friends from whom I have always felt support and encouragement. I am deeply thankful to Merve Özmeral for her invaluable presence in my life, for supporting me both emotionally and academically whenever it felt very difficult to continue. I am grateful for having her presence in my life during the last eight years from the good times to the hardest ones. I am profoundly thankful to Esra Hızır for her endless support, ideas, and contributions by always bringing a new perspective when I needed. Writing this study would have been more difficult without her companionship as a friend to have fun with, and as a colleague to discuss our confusions. I am also deeply thankful to Büşra Erdoğan, who motivated me to start to write this study and who has always been very understanding, thoughtful, and supportive when I need. I would also like to thank Emre Aksoy, Gözde Aybeniz, Ezgi Emiroğlu, Meltem Yılmaz, Şebnem Erinç, Seda Doğan, and Canan Tuğberk for their presence and for making the whole process of the graduate program meaningful and enjoyable for me. Last but not least, I would like to thank Tuğba Çetin and Buse Yeloğlu for their special presence in my life, for making the hardest times manageable and the good times enjoyable.

I am deeply grateful to my parents, Arif and Vildan, and to my sister and her husband, Gizem and Alper, for always supporting me and believing in me during this process. It would have been very difficult to complete this work and the graduate program without feeling their support during the hardest times.

This thesis was funded by Scientific and Technological Research Council of Turkey (TÜBİTAK) Project Number 215K180.

TABLE OF CONTENTS

Title Page i

Approval ii

Acknowledgements iii

Table of Contents v

List of Tables vii

Abstract viii

Özet x

CHAPTER 1: INTRODUCTION 1

1.1. Mentalization 2

1.1.1. Mentalization as a Multi-Dimensional Construct 4

1.2. The Development of Mentalization 5

1.2.1. Developmental Stages of Acquiring Mentalization 6
1.2.2. Subjectivity Before Mentalization 9
1.2.3. Social Bio-feedback Theory of Affect Regulation 10
1.2.4. Affective Mentalization 13
1.2.5. Mentalization and Attachment Trauma 15
1.2.5.1. Equation of Inner and Outer Reality 16
1.2.5.2. Separation of Inner from Outer Reality 16
1.2.5.3. "I Believe It when I See It" 17

1.3. Empirical Literature 17

1.3.1. Parental Mentalization, Attachment, and Mentalization in Children During Infancy Period 18
1.3.2. Parental Mentalization and Mentalization in Children of Older Ages 20
1.3.3. Mentalization in Children and Their Behavior Problems 24
1.3.4. Mentalization in Children and Their Adverse Experiences 32

1.4. Current Study 35

CHAPTER 2: METHOD 37

2.1. Data 37

2.2. Participants 37

2.3. Measures 39

2.3.1. The Child Behavior Checklist **39**
2.3.2. The Adverse Childhood Experiences Study Questionnaire **40**
2.3.3. The Parent Development Interview **41**
2.3.4. The Coding System for Mental State Talk in Narratives **44**
2.3.5. Turkish Expressive and Receptive Language Test **46**
2.4. Procedure **47**
2.5. Data Analysis Plan **48**
CHAPTER 3: RESULTS **50**
3.1. Descriptive Analysis **50**
3.2. Hypothesis Testing **53**
CHAPTER 4: DISCUSSION **56**
4.1. Hypothesis **57**
4.1.1. Exploring the Associations between Maternal Reflective Functioning and Children's Emotional Mental State Talk **57**
4.1.2. Exploring the Associations between Children's Emotional Mental State Talk and Their Behavior Problems **67**
4.1.3. Exploring the Associations between Children's Emotional Mental State Talk and Their Abuse and Neglect Histories **70**
4.2. Clinical Implications **72**
4.3. Limitations and Future Research **75**
4.4. Conclusion **77**
References **79**
Appendices **109**
Appendix A: Child Behavior Check List for Ages 1.5-5 (CBCL/1.5-5) **109**
Appendix B: Child Behavior Check List for Ages 6-18 (CBCL/6-18) **113**
Appendix C: Adverse Childhood Experiences Questionnaire (ACE) **120**
Appendix D: The Parent Development Interview (PDI) **123**

LIST OF TABLES

Table 2.1 Demographic Characteristics of the Sample (N = 108) 38

Table 3.1 Descriptive Statistics for Maternal Measure of Reflective Functioning (PDI), and Child Measures of Child Behavior Checklist (CBCL), Adverse Childhood Experiences (ACE), and Children's Emotional Mental State Talk (EMST) Variables 50

Table 3.2 Five Most Frequently Used Positive and Negative Emotional Mental State Words 51

Table 3.3 Five Most Frequently Used Emotional Mental State Words by Children with Abuse and Neglect Histories, Internalizing, Externalizing, and Total Behavior Problems 51

Table 3.4 Results of t-test and Descriptive Statistics for Emotional Mental State Talk (EMST), Maternal Reflective Functioning (PDI), Adverse Experiences of Abuse and Neglect, Internalizing, Externalizing, and Total Behavior Problems by Sex...52

Table 3.5 Bivariate Correlations of Children's Age and Expressive Language Ability with Emotional Mental State Talk (EMST), Maternal Reflective Functioning (PDI), Adverse Experiences of Abuse and Neglect, Internalizing, Externalizing, and Total Behavior Problems 53

Table 3.6 Partial Correlations between Children's Total Emotional Mental State Talk (EMST), Maternal Reflective Functioning (PDI), Children's Adverse Experiences of Abuse and Neglect, and Children's Internalizing, Externalizing, and Total Behavior Problems...55

Table 3.7 Partial Correlations between Children's Emotional Mental State Talk (EMST) Subscales, Maternal Reflective Functioning (PDI), Children's Adverse Experiences of Abuse and Neglect, and Children's Internalizing and Externalizing Behavior Problems Subscales 55

ABSTRACT

Mentalization is the capacity to understand mental states of the self and others and to interpret behaviors in terms of these mental states, namely, emotions, cognitions, desires, intentions, and the like. Among the contents of mentalization, mentalizing emotions has been found to be a protective factor against trauma and symptoms. While children's developed capacity of mentalizing emotions is related to parent's capacity to mentalize the child's mind, deficiencies in emotional mentalization are related to children's behavior problems and adverse experiences. Therefore, the aim of this study was to examine the association of children's emotional mental state talk with parental mentalization, children's behavior problems, and their adverse experiences of abuse and neglect. Participants were a clinical sample of 108 mother-child dyads who applied to the Istanbul Bilgi University Psychological Counseling Center. Children's emotional mental state talk was assessed with The Coding System for Mental State Talk in Narratives (CS-MST) by using the Attachment Doll-Story Completion Task (ASCT) and mothers' parental mentalization was assessed with the Reflective Functioning Scale by using the Parent Development Interview (PDI). Children's behavior problems and their adverse experiences of abuse and neglect were assessed by using mother reports of Child Behavior Checklist (CBCL) and Adverse Childhood Experiences Questionnaire (ACE). Results of this study revealed a positive association between children's use of frequent and diverse positive emotional mental state words and maternal reflective functioning; and a negative association between children's use of causal emotional mental state words and their aggressive and rule-breaking behaviors. Results also indicated a trend level negative association between children's use of total emotional mental state words and their abuse and neglect histories. Findings of this study suggest that assessing children's emotional mentalizing with its different aspects such as positive and negative valences and causal links regarding emotions are as important as assessing global emotional mentalization.

Keywords: parental mentalization, children's emotional mental state talk, behavior problems, adverse experiences, quantitative research

ÖZET

Zihinselleştirme, kişinin kendi ve başkalarının zihin durumlarını anlama ve davranışları bu zihin durumları açısından (duygular, bilişler, arzular, niyetler, v.b.) yorumlama kapasitesidir. Zihinselleştirmenin içerikleri arasından duygusal zihinselleştirmenin travmaya ve semptomlara karşın koruyucu bir faktör olduğu bulunmuştur. Çocukların duygusal zihinselleştirmelerini geliştirme kapasiteleri ebeveynin çocuğun zihnini zihinselleştirme kapasitesiyle ilgiliyken, duygusal zihinselleştirmede yaşadıkları zorluklar ise davranış problemleri ve olumsuz deneyimleri ile ilgili olabilmektedir. Bu çalışmanın amacı, çocukların duygusal zihin durum konuşmasının ebeveyn zihinselleştirmesi, çocukların davranış problemleri ve istismar ve ihmal deneyimleri ile ilişkisini incelemektir. Katılımcılar, İstanbul Bilgi Üniversitesi Psikolojik Danışma Merkezi'ne başvuran 108 anne-çocuk ikilisinden oluşan klinik bir örneklemi içermektedir. Çocukların duygusal zihin durumu konuşması, Çocuklarda Güvenli Yer Senaryolarının Değerlendirilmesi (ASCT) uygulaması üzerinden Anlatılardaki Zihin Durumlarını Kodlama Sistemi (CS-MST) kullanılarak ve annelerin zihinselleştirme kapasitesi Ebeveyn Gelişim Görüşmesi (PDI) üzerinden Yansıtıcı İşleyiş Ölçeği (RF Scale) kullanılarak değerlendirildi. Çocukların davranış sorunları ve istismar ve ihmal deneyimleri, Çocuk Davranış Değerlendirme Ölçeği (CBCL) ve Olumsuz Çocukluk Deneyimleri Anketi (ACE) kullanılarak değerlendirildi. Bu çalışmanın sonuçları, çocukların sık ve çeşitli olumlu duygusal zihin durum sözcükleri kullanması ile ebeveyn zihinselleştirme kapasitesi arasında pozitif bir ilişki olduğunu; ve çocukların neden-sonuç içeren duygusal zihin durum kelimeleri kullanması ile saldırgan ve kurallara karşı gelme davranışları arasında negatif bir ilişki olduğunu göstermiştir. Ayrıca, çalışmanın sonuçları çocukların toplam duygusal zihin durum kelimeleri ile istismar ve ihmal deneyimleri arasında olumsuz yönde bir eğilim olduğunu göstermiştir. Bu çalışmanın bulguları, çocukların duygusal zihinselleştirme kapasitesi değerlendirilirken bu kapasitenin çeşitli alt başlıklarının da (olumlu ve olumsuz duyguları ve duygulara ilişkin nedensel bağları zihinselleştirme), global duygusal zihinselleştirmeyi değerlendirmek kadar önemli olduğunu göstermektedir.

Anahtar Kelimeler: ebeveyn zihinselleştirmesi, çocukların duygu odaklı zihin durumu konuşması, davranış problemleri, olumsuz deneyimler, nicel araştırma

CHAPTER 1
INTRODUCTION

The concept of mentalization, which was initially used by Fonagy, Steele, Steele, Moran, and Higgitt (1991a) to explain the transmission gap (van Ijzendoorn, 1995) in the intergenerational transmission of attachment, is an important capacity of individuals for understanding and explaining behaviors in terms of underlying mental states of the self and others (Allen, Fonagy, & Bateman, 2008). The development of this capacity in children is suggested to have roots in the parents' capacity of having a mentalizing stance, i.e., recognizing and naming mental states such as feelings, thoughts, desires, and intentions of the self and of the child (Schmeets, 2008). This mentalizing stance of the caregiver also includes an affective mirroring function for the child which enables the child to find a representation of his/her mind in the mind of the caregiver, to understand his/her own mental states, to develop internal representations for the self and the caregiver, and to regulate himself/herself in cases of emotional arousal (Fonagy, Gergely, Jurist, & Target, 2002). In this regard, emotional mentalization is considered as crucial for children to regulate themselves during emotional arousal and to make sense of underlying emotions of other mental states or of behaviors (Allen et al., 2008). Mentalizing emotions is the ability of thinking about emotions while at the same time feeling these emotions (Fonagy et al., 2002) which enables the understanding of behavioral responses guided by specific emotions. Therefore, the capacity of emotional mentalization is regarded to be associated with affect regulation, empathic skills, and prosocial behaviors of children (Fonagy et al., 2002; Allen et al., 2008).

The aim of this study is to examine the relation of children's emotional mentalization with parental mentalization, children's behavior problems and their adverse experiences. Even though the literature provides significant findings on the associations between parental mentalization and mentalization in children, the findings were mostly based on studies with infancy aged children, or global capacities of mentalization (e.g. Fonagy, Steele, Steele, & Holder, 1997; Meins,

Fernyhough, Russel, & Clark-Carter, 1998). On the other hand, children's deficiencies in mentalization with respect to their behavior problems and adverse experiences were also studied by many researchers with a focus on these children's cognitive mentalization, affective mentalization, global mentalization, or biased mentalization (e.g. Ensink, Bégin, Normandin, Godbout, & Fonagy, 2016b; Sharp, Croudace, & Goodyer, 2007; Happe & Frith, 1996; Cook, Greenberg, & Kusche; 1994; Beeghly & Cichetti, 1994; Rogosch, Cicchetti, & Aber, 1995; Shipman, Zeman, Penza, & Champion, 2000). However, the literature lacks empirical studies that explored the relation of children's emotional mentalization with parental mentalization, behavior problems, and adverse experiences for emphasizing the developed and deficient capacity of emotional mentalizing with respect to specific categories of this ability in the same study. Therefore, this study aimed to contribute to the literature by providing a micro-level analysis of children's emotional mentalization capacity considering their mothers' mentalization capacities, their behavior problems, and abuse and neglect histories.

In the upcoming pages of this section, firstly the definitions of mentalization with its different dimensions, especially with a focus on emotional mentalization, are summarized. Along with these definitions, the development of mentalization in children is described in detail by addressing developmental stages of acquiring mentalization, the development of affect regulation in children, and non-mentalizing modes of children in case of attachment trauma. After the theoretical background, empirical findings in the literature are summarized for the association of children's mentalization capacity, especially with a focus on their emotional mentalization, with parental mentalization, children's behavior problems, and their adverse experiences.

1.1. MENTALIZATION

Mentalization is defined as the ability of understanding one's own and other people's mental states, namely, feelings, thoughts, desires, attitudes, and

intentions (Fonagy & Target, 1998). Since it is not possible to know exactly other people's feelings, cognitions, desires, and the like, the capacity of mentalization is regarded as "a form of mostly preconscious imaginative mental activity" (Fonagy, 2006, p.54,). By making sense of mental states, it is possible to interpret and predict people's behavior (Fonagy & Target, 1997). As a result of understanding others' behavior, a person learns to respond in an appropriate manner and to make meaningful relations with others (Fonagy & Target, 1998). Moreover, by making inferences about other people's behavior, a person can also understand his/her own experiences from a more meaningful perspective. These characteristics of mentalization, in turn, help a person to develop self-organization by enhancing the abilities of "affect regulation, impulse control, self monitoring, and the experience of self-agency" (Fonagy et al., 2002, p.25). When an individual's capacity of mentalization is limited, on the other hand, it is difficult for the individual to interpret the behavior of other people in terms of mental states. As a result, the individual responds to the behavior or to the situation not by being reflective, flexible, or adaptive but by being strict or stereotyped (Fonagy & Target, 2008).

In developmental psychology, one of the most similar concepts to mentalization was operationalized as "theory of mind" which means the capacity to attribute mental states to oneself and to other people (Premack&Woodruff, 1978). Though this definition seems very similar to the one of mentalization, the interest of theory of mind is mainly about cognitions whereas mentalization is also interesed in emotions (Allen, Fonagy, & Bateman, 2008). Another concept relating to mentalization is metacognition which is defined as "any knowledge or cognitive process that is involved in the appraisal, monitoring or control of cognition" (Wells, 2000, p.6). In line with the concept of theory of mind, the focus of metacognition is also cognition but it is mainly about a person's own cognitive processes (Allen et al., 2008). Furthermore, empathy is another term that is similar to mentalization yet it is only about understanding other people's emotions, cognitions, beliefs, desires, i.e. mental states of the other in general (Allen et al., 2008). In sum, compared to these concepts, mentalization is a

broader term with its emphasis on both the self and others, and with its interest on not just cognitions but also on emotions.

1.1.1. Mentalization as a Multi-Dimensional Construct

Although mentalization is a very broad concept in its definition, its evaluation as a skill should not be seen as broad or global but as dynamic, that is, varying with different contexts, situations, people, environment, culture, and the like (Fonagy & Target, 1997; Allen et al., 2008). In other words, mentalization cannot be evaluated as “a static and unitary skill or trait” (Fonagy et al., 2012, p.19) because it is “a dynamic capacity that is influenced by stress and arousal” (p.19). Accordingly, in recent years, mentalization has been conceptualized in terms of four different dimensions with two polarities for each of them. These dimensions are: implicit versus explicit mentalization; self-oriented versus other-oriented mentalization; internally focused versus externally focused mentalization; and cognitive versus affective mentalization (Fonagy et al., 2012). For each dimension, the imbalance between two polarities can be inferred as the cause of mentalization problems because “a dysfunction at one pole may manifest as the unwarranted dominance of the oppsite polarity” (Fonagy, Bateman, & Bateman, 2011, p.106). Therefore, these dimensions make it possible to understand an individual’s profile of mentalization by evaluating the level of balance between two polarities (Liljenfors & Lundh, 2015).

With respect to the first dimension of “explicit versus implicit mentalization”, explicit or controlled mentalization refers to a conscious and reflective process in which an individual is consciously aware of mentalizing by the use of language for its expression (Allen et al., 2008) whereas implicit or automatic mentalization is a more reflexive and intuitive process for which less or no effort is needed (Fonagy, Bateman, & Luyten, 2012). The second dimension of “self-oriented versus other-oriented mentalization” is about focusing only about mentalizing the self or the other, therefore, the relationship is considered as one-sided for these individuals (Allen et al., 2008; Bateman, Bolton, & Fonagy, 2013).

Regarding the third dimension of internal versus external mentalization, internally-focused mentalization is defined as “mental processes that focus on one’s own or another’s mental interior (e.g., thoughts, feelings, experiences)” (Fonagy et al., 2012, p.22) while externally-focused mentalization is about “the external, physical, and most often visual characteristics of other individuals, oneself, or the interaction of the two” (Lieberman, 2007, p. 279). Lastly, the dimension of cognitive versus affective mentalization is mainly about whether the focus of mentalization is on cognition, thought and belief or on affect, emotion and feeling (Luyten & Fonagy, 2012). In sum, though both poles of each dimension are important and functional in different contexts, it is important for an individual to be aware of the need of flexibly shifting to the other pole when necessary in any situation (Liljenfors & Lundh, 2015).

1.2. THE DEVELOPMENT OF MENTALIZATION

When infants are born, their understanding of the self and the external world is restricted to a physical stance where they experience everything as it is present physically. This aspect of the self is called “pre-reflective or physical self” (Fonagy, Moran, & Target, 1993). This physical self continues to develop in the first 6 months and the infant starts to understand that the mother is a different physical being (Stern, 1985). After the distinction of self and other in terms of physical beings, the infant’s understanding becomes more complex with the awareness of feelings, desires, beliefs, intentions and the like. This capacity to distinguish between feelings, desires, beliefs and intentions of the self and the other results in another aspect of the self which is called “reflective or psychological self” (Fonagy et al., 1993). The psychological self helps the infant to realize that there are different mental states behind any physical behavior (Stern, 1985). Yet, this capacity is not acquired genetically and it starts to develop from the infancy when an infant is in a relationship with an adult, possibly with the caregiver (Fonagy et al., 2002).

1.2.1. Developmental Stages of Acquiring Mentalization

Fonagy and his colleagues (2002) have divided the development of mentalization into five stages and have suggested that the process is completed during the first six years of life in normal development. These stages have been conceptualized as understanding the self and other as *physical, social, teleological, intentional* and *representational* agents. During the first months, infants understand their self and others as physical agents, meaning that they see their physical being as responsible of their actions and of the changes in the external world (Leslie, 1994). Then, infants start to understand the self and other as social agents in which they realize that social interactions can have an effect on the other (Neisser, 1988). Correspondingly, in the interactions with the caregiver, the infant assumes that facial expressions of the self and the caregiver can have impacts on each part (Beebe, Lachmann, & Jaffe, 1997). Afterwards, the infant starts to understand these facial expressions on the basis of expectations that he generates regarding his earlier information about these interactions. Therefore, the caregiver's behavior becomes more predictable for the infant as they are assumed rational and purposeful (Fonagy et al., 2002).

By acknowledging that intentions and behaviors are consequences of earlier observations, infants start to understand the self and other as teleological agents around 9 months of age (Csibra & Gergely, 1998). During the stage of teleological understanding, actions are interpreted by physical observations available to the infant. In other words, the infant understands actions in the context of specific goal states and situational constraints of physical reality without attributing any mental states (Gergely & Csibra, 1997). Therefore, the infant is still in a non-mentalizing stage where visual, audial or tactile information coming from the physical world is very crucial to interpret the intention and action of other people and to react accordingly (Schmeets, 2008). This interpretation of teleological stance is made with a focus on *"the principle of rational action"* which means that an action is the result of a rational goal state when the constraints specific to that situation are considered (Gergely & Csibra,

2003). Since actions are interpreted based on physical reality and rationality principle, there is no difference between the actions of living and non-living objects for the infant during the stage of teleological understanding (Fonagy & Target, 1997). Thus, the next stage in the development of mentalization, namely intentional understanding, is an important point as the infant starts to ascribe intentions to living objects as opposed to non-living ones (Schmeets, 2008). In the process of moving from teleological to intentional or mentalizing understanding, the interactions between the infant and the caregiver play a determinant role (Fonagy & Target, 1997).

When the infant is around 2 years old, he starts to understand the agency in terms of intentions and realizes that there are some mental states such as desires, emotions and perception behind any action (Wellman & Phillips, 2000). Moreover, the infant also understands that an action does not only lead to a change in the physical world or in the body, but also in the mind or in internal states (Fonagy, 2006). Thus, as opposed to teleological understanding, goal states are now considered as desires; and situational constraints in the physical world are seen as beliefs of the agent during the stage of intentional understanding (Fonagy & Target, 1997). As the result of interpreting the action of a person in terms of his intentions, the infant starts to realize that others have mental states, which is one of the prior conditions of mentalizing capacity (Fonagy et al., 2002). However, during this stage, the infant's understanding of mental states is still related to the physical reality which leads to an inability to differentiate between what is internal or external (Flavell & Miller, 1998). Therefore, confusions such as evaluating the reality based solely on internal experiences or separating these internal experiences completely from the physical reality may arise (Allen, 2006) and these confusions have been conceptualized as psychic equivalance and pretend modes respectively (Fonagy et al., 2002).

While the infant still understands the mental states as related to physical reality in intentional understanding, his understanding of agency starts to become representational around the ages of three to four (Fonagy, 2006). During the representational stage, the young child's mental states include epistemic ones such

as beliefs which enable the child to broaden his concrete, physical perception to an abstract, conceptual understanding (Schmeets, 2008). Therefore, in contrast to seeing mental states as the reason of an action, the child now realizes that his mental states are representational and that the mind does not have to be equal with the reality (Perner, 1991). The capacity of representational thinking then allows the child to make different assumptions regarding a specific situation or action. The child, for example, can understand that appearance may not be the reality when evaulating the emotional states of others about an event (Flavell & Miller, 1998). In order to develop a representational understanding, actual experiences in the physical reality should be transformed into specific concepts which define these experiences (Schmeets, 2008). Fonagy and his colleagues (2002) have referred to this process by using the terms *primary and secondary representations.* When the child experiences fear, for example, he may be unaware of what he is feeling or experiencing exactly and this is the primary representation. If this experience of the child is understood, processed and mirrored by the caregiver, then it becomes a secondary representation which helps the child to develop a concept about fear. This process was called as representational loop by Fonagy and his colleagues (2002).

Before the age of three and four, children do not have the capacity to construct specific personal memories about the events that they have experienced because they are unable to "encode personally experienced events as personally experienced" (Perner, 2000, p.306). During the age of six, after understanding the agency as representational, the child's capacity to construct these memories emerge as the result of conceptualizing their experiences in the *causal-temporal framework* and thus, the self starts to be seen as autobiographical (Povinelli & Eddy, 1995). With the development of an autobiographical self, personal experiences are remembered and turned into coherent narratives (Allen et al., 2008). In other words, as opposed to considering memories as separate experiences which are unrelated to each other and to the present self, they are now seen as "organized, coherent, and unified autobiographical self-representation" (Fonagy et al., 2002, p. 247). Therefore, the child comes to an understanding that

actions of self and other can be related to a variety of mental states of both sides and this understanding makes it easier to establish social relationships (Fonagy, 2006).

1.2.2. Subjectivity Before Mentalization

As stated above, children at age two or three cannot be able to understand experiences based on beliefs, wishes, emotions, desires, thoughts, etc. and they do not have the capacity to integrate internal and external reality or experience (Fonagy & Target, 1996). In other words, during this phase of their development, children are not aware of the fact that mental states of the self and others are only representations of the reality. Therefore, they have a “split mode of experience” (Fonagy & Target, 2006, p.561) in which they are either in the “psychic equivalence” or “pretend” mode which have to be turned into an integrated mode of mentalizing (Fonagy & Target, 1996).

In the psychic equivalence mode, there is an equation of the internal experience and external reality (Fonagy & Target, 1996). In other words, the young child believes that anything in his mind must be seen in the outside world and anything in the external reality must also be present in the internal world. In this mode of experiencing reality, the child thinks that any fantasy in the mind has the possibility of being real (Fonagy, 2006). Therefore, the child might develop serious anxieties and fears as a result of equating their imagination with the outside world (Allen et al., 2008).

Since experiencing the inner and outside reality as equivalent to each other is exhausting, an alternative way of thinking at age two or three is the pretend mode in which the internal world and external world are kept separate from each other (Fonagy & Target, 1996). Although this way of experiencing is needed for children especially during pretend play in order to be free from external reality (Dias & Harris, 1990), the result is a complete separateness of internal and external world (Allen et al., 2008). With this separateness of internal and external,

"the internal state is thought to have no implications for the outside world" (Fonagy & Target, 2006, p. 561).

For the reason that "psychic equivalence is too real while pretend is too unreal" (Bateman & Fonagy, 2004, p.70), these two modes do not allow the child to develop a full capacity of mentalization. Therefore, the integration of psychic equivalence and pretend modes is essential for the normal development in order to have a reflective mode (Fonagy & Target, 1996). During the age four and five, the child's mind takes the form of representations where mental states are regarded as not belonging to the real objects in the outside world but to the inner representations of these objects. With this form of representational mind, it becomes possible to link the inner and outer reality without full equation or a complete separation (Gopnik, 1993). In other words, representational mind allows the child to think about different alternatives about a specific situation (Allen et al., 2008). As a result, psychic equivalence and pretend modes are integrated at these ages and the capacity of mentalization is acquired (Fonagy & Target, 1996).

For the integration of psychic equivalence and pretend modes, and for the development of mentalization, the presence of a caregiver is crucial. While playing with a parent or an older child, the child's internal states are represented in the mind of the other and reflected back to the child (Fonagy & Target, 1996). In this process, the significant other creates a link between the child's mental states and external reality by presenting a different point of view from his own. Besides, the possibility of changing the external reality during pretend play is also shown to the child by the caregiver. Therefore "a pretend but real mental experience may be introduced" (p.57) and the psychic equivalence and pretend modes are integrated (Fonagy et al., 2002).

1.2.3. Social Bio-feedback Theory of Affect Regulation

Starting from the birth of the infant, communication between the caregiver and the infant, varying from nonverbal to verbal forms, is cruical for the development of mentalization (Fonagy & Target, 1997). It is possible in this

relationship that the infant moves beyond the first two stages of understanding the agency as physical and social to the understanding of teleological, intentional and representational agency (Fonagy et al., 2002). For the transition from physical and social understanding to a more reflective understanding, Watson (1994) suggested that there is an innate contingency detection mechanism which enables the infant to make connections between his responses and stimuli coming from the environment. This mechanism is very crucial for the development of an infant's self-awareness and self-control of emotions since it is assumed that the infant is not aware of his emotional states innately (Gergely & Watson, 1999).

In accordance with the understanding of agency as physical and social during the first months, the infant expects perfectly contingent responses (Bahrick & Watson, 1985). This expectation of perfect contingency makes it easier for the infant to understand his physical or bodily self in the world (Gergely & Watson, 1999). During three or four months, however, the infant starts to expect high but imperfect contingency and it helps the infant to realize the environment (Bahrick & Watson, 1985). Therefore, there is a transition from a focus on the self to a focus on the other and on the other's high but imperfect responsiveness which facilitates to the understanding of the mental self (Allen et al., 2008). In other words, it can be said that contingency detection mechanism plays an important role in the differentiation of self and other and in the understanding of the external environment (Gergely & Watson, 1999). For the development of the emotional awareness and the mental self as results of high but imperfect contingencies, the presence of an attuned caregiver and her empathic affect mirroring are crucial. The mirroring function of the mother was also seen as the core of emotional development by Winnicott (1967) and was described as "giving back to the baby the baby's own self" (p. 33). If the caregiver provides empathic affect mirroring repeatedly to the infant's affective states that are not familiar to the infant, the infant understands his own different affective experiences and different representations of these emotional internal states. This process of affect mirroring, thus, serves a teaching role for the infant and it is conceptualized by Gergely & Watsons (1996) as social biofeedback training.

The development of affect understanding and affect representation is therefore dependent on the capacity of the mother's affective mirroring and this capacity needs to meet specific criteria. Firstly, the caregiver's mirroring should be congruent with the infant's affective experience (Fonagy, 2006). If the criteria of congruent mirroring is not met, the infant's representation which is based on this incongruent mirroring will not resemble the actual internal state and this may cause to what Winnicott called "false-self" (1965) and a narcissistic structure in the personality (Fonagy, 2006). And secondly, the affective mirroring should not be confused with the mother's own emotional state since the focus of mirroring is on the experience of the infant (Fonagy et al., 2002). This characteristic of affective mirroring is referred to "markedness" (Gergely & Watson, 1996) which specifies the caregiver's ability to display that it is not the exact emotional state of herself but a differentiated or exaggerated version of it. If the affective mirroring coming from the mother is unmarked, then the infant might think that it is the experience of the mother, not of the self which may result in the absence of a secondary representation, and deficits in mentalization and affect regulation (Fonagy et al., 2002). Moreover, as a result of unmarked mirroring, the infant cannot adopt the negative affect as belonging to his own experience but as belonging to the outside world and this leads to an escalation rather than a regulation of the negative affect (Fonagy, 2006). Assuming that the negative affect belongs to the external world may in turn results in the borderline personality structure where the individual experience emotions depending on others (Fonagy et al., 2002). On the contrary, when the mirroring coming from the mother is both congruent and marked with the emotional experience of the infant, the infant first understands that this emotional experience belongs to his own feelings by internalizing the mother's mirroring. Then, his representations about these feelings and his emotional awareness can be developed which in turn increase the capacity to mentalize emotions and thus, affect regulation (Fonagy et al., 2002; Allen et al., 2008).

1.2.4. Affective Mentalization

As mentioned above, mentalization is recently regarded as a multidimensional concept in different domains. However, when contents specific to mentalizing ability is considered, there are basically two contents of emotions and cognitions. From these two contents, the main focus of clinicians is the capacity of mentalizing emotions as it is more difficult for individuals to mentalize emotions of the self and other in cases of emotional arousal (Allen, 2006; Allen et al., 2008). Besides, the capacity of understanding and then regulating emotions is one of the most important factors that protect people from developing psychopathology (Thompson, 1994; Thompson, 1991; Cicchetti, Ackerman, & Izard, 1995; Aldao, Nolen-Hoeksema, & Schweizer, 2010). In this regard, the concept of mentalized affectivity was suggested (Fonagy et al., 2002) in order to explain an individual's capacity for not just thinking about emotions in cognitive level, but also for feeling these emotions clearly in an affective level with a mentalizing stance. Besides, mentalizing emotions is also defined as the capacity to mentalize about internal states of cognitions, desires, physiological states, or physical actions as they all can be results or causes of specific emotions (Allen et al., 2008). Therefore, mentalizing emotions is regarded to recognizing these emotions, feeling these emotions in an affective level, and understanding other mental states or behaviors underlying these emotions with a mentalizing stance, which is therefore considered as an ability of "thinking and feeling about thinking and feeling" (Allen et al., 2008, p.63).

The concept of mentalized affectivity includes three aspects, namely, identification, modulation, and expression of emotions (Allen et al., 2008). The first aspect of identifying emotions is defined as labeling specific emotions such as happiness, sadness, anxiety, anger, etc. and then understanding the meanings of these labeled emotions in specific contexts (Fonagy et al., 2002; Allen et al., 2008). Secondly, the modulation of emotions is considered as making some changes in the tone of emotion that is expressed. This modulation of affects can be either in the form of downward or upward with respect to the intensity of

emotional expression (Allen et al., 2008). Lastly, expression of emotions is about expressing the affective state as either inwardly, which is feeling the emotion as an internal state without making others to notice, or outwardly, which is the expression of feelings towards the others more directly (Fonagy et al., 2002). These three aspects of mentalized affectivity are experienced as reciprocally in relationships rather than having a nature of developing step-by-step. Therefore, one aspect is not regarded as a prerequisite of the other as each may have impacts on the others reciprocally (Allen et al., 2008). In other words, mentalizing affectivity does not mean understanding and labeling an emotional state, explaining causes of that specific emotion, modulating the tone of emotion and then expressing the emotion in an accepted manner, but rather it means mentalizing about emotions with its different aspects while at the same time experiencing the emotional state, which is regarded as the adaptive capacity for understanding and feeling emotions (Fonagy et al., 2002; Allen et al., 2008).

The capacity of emotional mentalization starts to develop in children as early as 2 years of age. When children are two years old, their ability to label emotion states for themselves and for others starts to develop (Bretherton & Beeghly, 1982). During the third year of age, children start to understand the effect of past events on current emotional states (Pons, Harris, & Rosnay, 2004). Their capacity to understand external causes for emotional states and to recognize emotions with a false belief understanding are achieved when children are 4 and 5 years old (Pons et al., 2004; Pons, Lawson, Harris, & Rosnay, 2003). By the seventh year of age, children become able to understand the links between emotional states and other mental state categories. Their understanding of mixed emotional states and their ability to regulate emotions by using their cognitive skills are achieved when children reach 9-years of age (Pons et al., 2004). Although the capacity of emotional mentalization seems to have a gradual development during childhood, it was also suggested that several individual differences may cause delays or deficits in the development of emotional mentalizing (Pons et al., 2004; as cited in Bekar, 2014). On the other hand, the developed capacity of emotional mentalizing was also suggested to be a protective

factor for children in cases of psychopathological symptoms, and dysfunctional family contexts where abuse and neglect are likely to occur (Allen et al., 2008; Allen, 2013) by increasing children's empathic skills and prosocial behaviors, and therefore, socioemotional functioning (Denham, 1986).

1.2.5. Mentalization and Attachment Trauma

Attachment trauma (Adam, Keller, & West, 1995; Allen, 2001) can be defined as a subset of interpersonal trauma which occurs specifically in the attachment relationships in the forms of abuse and neglect. Based on the conceptualization of Bifulco, Brown, and Harris (1994), abuse can be in the form of sexual, physical or emotional. Neglect, on the other hand, was conceptualized as physical, emotional, cognitive, and social (Barnett, Manly, & Cicchetti, 1993). As stated in the above sections, the child feels secure and develops the capacity of mentalization in the attachment relationship with his caregivers. However, in the context of these types of maltreatment, the child has difficulty in finding his intentional agency in the abusive or neglectful caregiver's mind. Besides, it is very frightening for the child to understand the mental states behind the actions of the abusive or neglectful caregiver which are hostile, malevolent and cruel (Fonagy & Target, 1997). Therefore, these experiences of maltreatment result in a deficit of mentalization in the child and this deficit of mentalization is considered as "a form of decoupling, inhibition or even a phobic reaction to mentalizing" (Fonagy, Gergely, & Target, 2007, p. 306) since the child tries to protect himself from mentalizing the dangerous mind of the abusive caregiver (Fonagy, 1991). Examples of this deficit of mentalizing can be seen as an inability to involve in pretend play, a decreased capacity to perform on theory of mind tasks, or an absence of mental state language (Allen et al., 2008). Most importantly, since the child's mentalization capacity collapses in case of maltreatment, earlier modes of experiencing reality as psychic equivalence, pretend or teleological mode re-emerges (Fonagy & Target, 2000).

1.2.5.1. Equation of Inner and Outer Reality

Although the psychic equivalence mode is a form of pre-mentalization of children at around age three where they experience the outer reality as equal to the internal states, adverse experiences, occurring at any age, lead to the re-emergence of this equation of inner and outer (Fonagy & Target, 2000). Following a traumatic experience, the child assumes that there are physical or emotional threats in the outside world and in order to protect himself from these, he tries to focus on the external reality. However, focusing excessively on the external world makes the child to be unaware of an internal reality which is distinct from the external or to be suspicious of the internal world as it is too frightening or incomprehensible to think about the internal states of the abuser. Therefore, the child cannot trust to the internal world and equates it with the dangers of the physical world (Fonagy & Target, 2000). Post-traumatic flashback, for example, is one way of experiencing the psychic equivalence mode since the survivor assumes that remembering or thinking about the traumatic experience is in fact reliving that experience (Fonagy & Target, 2006).

1.2.5.2. Separation of Inner from Outer Reality

During the age of three, the complement of the psychic equivalence is regarded as the pretend mode in which the child keeps the inner experience apart from the outside reality. In cases of maltreatment, this way of experiencing reality can reemerge when the child cuts down the connection between internal reality and the dangerous or intolerable external world as a protection strategy (Fonagy & Target, 2000). In the pretend mode of experiencing, the child might also become hypersensitive to internal states for the reason that he needs to know feelings or thoughts of others to prevent further possibilities of traumatic events. This tendency is termed as hyperactive mentalizing and assumed as a type of pseudo mentalization since the child's understanding of the other's mind depends only on signals of threat. Therefore, there is not an accurate integration of inner and outer

reality (Fonagy & Target, 2000). Dissociation following trauma is also a reemergence of a pretend mode because the individual loses his contact with the external reality by entering into a fantasy world (Fonagy & Target, 2000). Examples of dissociative thinking such as blanking out, shutting down, or remembering trauma only in nightmares are ways of separating the internal completely from the external world following a traumatic experience (Fonagy & Target, 2006).

1.2.5.3. "I Believe It when I See It"

As mentioned above, infants at around nine months of age experience the reality in the teleological mode and they attribute specific goals to objects and people. However, these goals do not involve any mental states and they are based solely on observations. Following trauma, there may also be a reemergence of this teleological mode in which feelings or thoughts become meaningless and are replaced with actions (Fonagy & Target, 2006). This way of experiencing reality after a traumatic experience might be seen in ways of suicide attempts or self harm (Fonagy & Target, 1998).

To summarize, deficits in mentalizing in the context of maltreatment can affect the child in various aspects. First of all, the child's ability to think about the mental states of others is diminished because of the threats coming from the abuser's mind and the caregiver's inability to understand the intentional stance of the child (Fonagy, 2006). Moreover, as a consequence of mentalizing deficits in difficult situations, the child's further capacity for resilience to trauma is damaged (Fonagy, Steele, Steele, Higgitt, & Target, 1994). For this reason, maltreatment in childhood can make individuals to be vulnerable to trauma in adulthood and to result in developmental psychopathology or personality disorders (Fonagy, 2006).

1.3. EMPIRICAL LITERATURE

1.3.1. Parental Mentalization, Attachment, and Mentalization in Children During Infancy Period

Parental mentalization is defined as the parent's capacity to understand and represent the child's internal states in her mind. In other words, it is the ability of the parent to think about the behavior of the infant in terms of specific mental states (Zeegers, Colonnesi, Stams, & Meins 2017). Before the concept of parental mentalization, it was suggested that maternal sensitivity to the child's physical and emotional needs (Ainsworth, Bell, & Stayton, 1971, 1974) and representations of caregivers about their early attachment experiences (Main, Kaplan, & Cassidy, 1985; van Ijzendoorn, Kranenburg, Zwart-Woudstra, van Busschbach, & Lambermon, 1991; Fonagy, Steele, & Steele, 1991b; Levine, Tuber, Slade, & Ward, 1991) predicted intergenerational transfer of attachment security in infants. However, in his meta-analysis study about the links between attachment security, maternal sensitivity and the AAI classifications, van Ijzendoorn (1995) suggested that sensitivity and representations of caregivers about their early attachment relationships are not sufficient to explain attachment security in infants and that there is still a transmission gap. In this regard, the concept of parental mentalization and different ways of assessing this capacity, such as mind-mindedness (Meins, 1997) and reflective function (Fonagy, Target, Steele, & Steele, 1998), were suggested in order to explain the transmission gap regarding the intergenerational transmission of attachment (van Ijzendoorn, 1995). While the concept of maternal sensitivity is the physical and emotional responsiveness to the needs of the child, mentalization was suggested to be a broader concept that involves the capacity of mothers to be sensitive of the mental states of the child (Fonagy et al., 1994; Meins, 1991; Meins, Fernyhough, Fradley, & Tuckey, 2001). Parental mentalization, therefore, was believed to contribute to secure attachment, affect regulation, and mentalizing capacity in the child (Sharp, Fonagy, & Goodyer, 2006). While the study of Fonagy and his colleagues (1991a) showed that parental mentalization predicts the attachment security in the child; other studies have found that children with secure attachment are more likely to

develop the capacity of mentalization (Fonagy et al., 1997; Meins et al., 1998). In this regard, it was suggested that parental mentalization predicts secure attachment more than sensitivity does and that there is a reciprocal relationship between mentalization and attachment security (Fonagy & Bateman, 2006).

Initially, parental mentalization was studied by using samples of mothers with infancy aged children for understanding the associations between attachment and mentalization and they found significant associations between mothers' mentalization capacities and their infants' attachment styles. Besides, these studies also indicated significant findings suggesting the association between parental mentalization and mentalization in children. One of these studies was that of Meins, Fernyhough, Fradley, & Tuckey (2001) where they assessed parental mentalization by using the concept of maternal mind-mindedness (Meins, 1997). The concept was defined as the parent's ability to treat her child as not just having needs to be satisfied but also having a mind (Meins et al., 2001). In order to assess maternal mind-mindedness, Meins and colleagues (2001) examined mothers' and 6-month old infants' interactions during a 20 minutes of free play session and found that mothers' appropriate mind-related comments predicted attachment security of the infant at 12 months (Meins et al., 2001); and mentalizing capacity of the child at 45 to 55 months (Meins et al., 2002, 2003). Therefore, mind-related comments of mothers were considered as the core features of mind-mindedness (Zeegers et al., 2017). Similarly, in the study of Gocek, Cohen, & Greenbaum (2008), it was found that mothers' ability to talk about their own mental states is associated with relationship quality with their children. Besides, it was suggested that the ability of mothers to talk about their mental states make them more sensitive for their children's needs, which in turn may enhance their capacity for understanding their children's mental states (Gocek et al., 2008). Therefore, it was assumed that exposing to mental state language during infancy period may promote later understanding of mental states in children.

Another work was belong to Slade, Grienenberger, Bernbach, Levy, & Locker (2005a) in which the concept of reflective functioning was assessed by an adapted version of original RF scale (Fonagy et al., 1998) for using it with the

Parent Development Interview (PDI: Aber, Slade, Berger, Bresgi, & Kaplan, 1985; Slade, Aber, Bresgi, Berger, & Kaplan, 2004). Parental reflective functioning was defined as the mother's ability to think reflectively about her current experiences as a parent, her child's experiences and their dyadic relationship. Slade, Grienenberger, Bernbach, Levy, & Locker (2005a) investigated the associations between parental reflective functioning and intergenerational transmission of attachment with 40 mother-infant dyads by using AAI for measuring adult attachment representations during pregnancy; PDI for measuring maternal representations during 10th month; and Strange Situation for measuring infant attachment during 14th month. It was found in this study that high maternal RF scores were related to secure classification of mothers and secure attachment patterns of children whereas low maternal RF was linked to mothers who were classified as ambivalent-resistant and children who were found to have disorganized attachment patterns. Therefore, results of this study revealed that the role of parental reflective functioning is important for explaining the intergenerational transmission of attachment (Slade et al., 2005a). By considering the reciprocal relationship between mentalization and attachment, it can be suggested that secure attachment of parents' is associated with their higher mentalizing capacities, which in turn is related to children's secure attachment and the development of mentalization in children (Fonagy, 2006). Although this reciprocity and the relation between parents' and children's capacities of mentalizing were mostly studied during infancy period, there are also few studies suggesting a similar association for children of older ages.

1.3.2. Parental Mentalization and Mentalization in Children of Older Ages

There are several studies that assessed mothers' mentalization capacity and their school aged children's mentalization capacity in the domains of global, cognitive and emotional mentalization. First of all, there are few studies that examined global mentalization capacities of both mothers and their children with the assessment of reflective functioning. With the purpose of examining the

effects of maternal reflective functioning and attachment security on school aged children's mentalization capacities, Rosso and Airaldi (2016) found that children's reflective functioning, as assessed by using the Child Reflective Functioning Scale with Child Attachment Interview (Ensink, Target, & Oandasan, 2013), was related to both their attachment securities and their mothers' reflective functioning levels, as assessed by the Adult Attachment Interview (AAI). Studies that were conducted with mothers and their sexually abused school aged children revealed positive associations between maternal reflective functioning and children's reflective functioning levels, as assessed by using the Reflective Functioning Scale with Parent Development Interview and with Child Attachment Interview, respectively (Ensink et al., 2015; Ensink, Bégin, Normandin, & Fonagy, 2016a). There are also several studies that examined mentalization capacities of mothers and their children in the cognitive domain of mentalization. By focusing on mothers' mental state talk and their children's theory of mind understanding, Ruffman, Slade, and Crowe (2002) found that mothers' mental state talk predicted their 2 to 5-year old children's theory of mind understanding on three different time points over 1 year. Similarly, the study of Adrian, Clemente, and Villanueva (2007) also found that mothers' mental state talk, especially their use of cognitive terms, were related to their 3 to 5-year old children's theory of mind and mental state understandings.

While the findings of the above studies are significant for associations between maternal and child mentalization in the domains of global mentalization and cognitive mentalization capacities, it was suggested that emotional mentalization capacities of mothers and children are more predictive when socio-emotional skills of children are considered (Denham, 1986; Cutting & Dunn, 1999; as cited in Bekar, 2014). In this regard, there are also several studies that examined the relations between maternal and child emotional mentalization and children's empathic and prosocial behaviors. By assessing mothers' mentalization capacities with parental meta-emotion philosophy which is the capacity of mothers to mentalize emotions of the self and the child, Gottman, Katz, and Hooven (1996) conducted a longitudinal study. They assessed mothers'

mentalization capacity when their children were 5 years old and then assessed children's emotion regulation capacities when they were 8 years old. Results indicated that mothers' capacity to think about their own and their child's emotions were related to their children's emotion regulation skills. In another study, it was found that children used less negative emotional language during their play times with peers whose mothers' awareness of emotions for themselves and their children were higher (Katz & Windecker-Nelson, 2004). Besides, several studies found that mothers' emotional mental state talk with their children are positively associated with children's prosocial behavior such as empathy and helping others (e.g. Drummond, Paul, Waugh, Hammond, & Brownell; Denham, Cook, & Zoller, 1992; Laible & Thompson, 2000; Ruffman, Slade, Devitt, & Crowe, 2006; Garner, Dunsmore, & Southam-Gerrow, 2008; Ensor, Spencer, & Hughes, 2011). Results of these studies are suggestive for the importance of emotional mentalization on children's socio-emotional skills, yet they did not assessed children's emotional mentalization but only emotional mentalization capacities of mothers and explored its relation with child outcomes.

There are also several studies that assessed the relations between mothers' and their children's emotional mentalization capacities, mostly with mental state talk assessments. The study of Bekar (2014) aimed to understand associations between mothers' and pre-school aged children's mental state talk and children's social-emotional functioning by using the Coding System for Mental State Talk (CS-MST: Bekar, Steele, & Steele, 2014). Results of this study indicated that mothers' and children's emotional mental state talk were positively associated to each other but the association was found as trend-level. Moreover, a longitudinal study conducted by Dunn, Brown, Slomkowski, Tesla, and Youngblade (1991) and by Dunn (1995) four years after the initial study suggested a positive association between mothers' mental state talk and their children's emotional mentalization. The initial study assessed mother-child mental state talk during the age of 33-months, and children's emotion understanding with affective labeling and affective perspective taking tasks (Denham, 1986) when children were 40 months old. Children's emotion understanding, including mixed and conflicting

emotions, was again assessed when they were 6 years old (Dunn, 1995). Results of this longitudinal study revealed that mental state discourse between mothers and their children, including more causal and emotional mental state words, at 33 months was positively related with children's capacity of recognizing emotions during 40-months and their capacity to understand conflictual emotions when they were 6 years old (Dunn et al., 1991, Dunn, 1995). Studies that specifically examined the valence of emotional discourses also revealed important results. By examining the associations between emotional discourses of mother-child dyads, preschool aged children's attachment styles, temperaments, and prosocial behaviors, Laible (2004) found that the use of positive emotions during mother-child emotional discourse while talking about their past experiences was positively associated with children's emotion understanding and their prosocial behaviors. In another study, Garner and colleagues (2008) assessed preschool aged children's and mothers' emotional discourse, children's emotion knowledge, their prosocial behaviors and behavior problems. Results revealed that mothers' emotional discourse with their children was positively associated with children's emotional knowledge. Besides, a positive association between children's prosocial behavior and both children's and mothers' emotion explanations were also found in this study (Garner et al., 2008). Considering the reciprocal relationship between mentalization and attachment, the study of Mcquaid, Bigelow, McLaughlin, and MacLean (2007) revealed that mothers of securely attached children produced more mental state talk with their children, which in turn was found to be positively associated with their children's emotional expressions. Similarly, Raikes and Thompson (2006) also found that securely attached children and their mothers produced more emotional mental state discourse and that these children's emotion understanding capacities were higher than other children. Therefore, it can be inferred from the results of these studies that the use of emotions words during reflective interactions between mothers and children may promote children's emotion understanding capacities and their positive behaviors.

While the above studies investigated the links between maternal and child mental state talk with a focus on emotional terms, there are also few studies that

examined both reflective functioning capacities and mental state talk of mothers and their school-aged children. By using both measures of reflective functioning and mental state talk, the study of Scopesi, Rosso, Viterbori, & Panchieri (2014) measured reflective functioning of mothers with the AAI and mental state talk of mothers and children with the AAI and CAI, respectively. Results of the study indicated that mothers' reflective functioning capacities predicted their children's use of mental state words that included emotional, cognitive volitional, ability terms. However, mothers' mental state talk was not found to be associated with children's mental state talk and it was suggested that mentalization in children of older ages did not develop by imitating their mothers' mental state words but instead, through the global reflective functioning capacities of their mothers (Scopesi et al., 2014). In a similar study with the purpose of investigating the links between maternal mentalization and mentalization in preadolescent children, Rosso, Viterbori, & Scopesi (2015), aimed to understand associations between reflective functioning capacities and attachment patterns of mothers, both of which were measured by the AAI, and their preadolescent children's mentalization measured as reflective functioning and mental state talk by using the Child Attachment Interview (CAI: Shmueli-Goetz, Zeman, Penza, & Champion, 2000). Results indicated a positive correlation between maternal reflective functioning and children's mental state talk of cognitive, volitional, uncertainty words and overall use of mental state words. Furthermore, it was found that mixed-ambivalent mental state references of mothers, as opposed to positive or negative mental state references, were positively associated with children's use of emotional and overall mental state words. These studies are indicative for the importance of global maternal mentalization on school aged children's emotional mentalization capacity, yet these associations were only studied by very few studies.

1.3.3. Mentalization in Children and Their Behavior Problems

The role of mentalization is crucial for understanding children's behavior problems in social interactions since reflecting on mental states of the self and others is suggested to increase affect regulation and to enhance interpersonal relations (Sharp, 2006; Allen et al., 2008). Behavior problems of children are categorized as externalizing problems with symptoms of aggression, impulsivity, disruptive and antisocial behavior (Achenbach & Rescorla, 2001), and internalizing problems with symptoms of anxiety, depression, withdrawal and somatic complaints (Achenbach & McConaughy, 1992). The most common features of children with externalizing problems are their difficulties in following social norms and in engaging in interpersonal relations (Achenbach & McConaughy, 1997), especially with peers (Vitaro, Tremblay, & Bykowski, 2001) and with parents (Greenberg, Speltz, DeKlyen, & Endriga, 1991). On the other hand, internalizing behavior problems occur as a result of "overcontrolled" behaviors of children (Cicchetti & Toth, 1991). Therefore, one of the main characteristics of children with internalizing problems is that these children have an inner distress which makes them more difficult to be assessed by others (Wilmshurst, 2015). Even though the characteristics of externalizing and internalizing problems seem different than each other, there are several research studies suggesting the co-occurrence of these problems in children and adolescents, especially the comorbidity of depression or anxiety disorders with oppositional defiant disorder (e.g. Boylan, Vaillancourt, Boyle, & Szatmari, 2007; Martin, Granero, & Ezpeleta, 2014; McElroy, Shevlin, Murphy, & McBride, 2018). Therefore, examining the associations between mentalization and behavior problems, in general, is important.

By using a global assessment for children's mentalization capacities, namely, the Child Reflective Functioning Rating Scale (CRFS: Target, Oandasan, & Ensink, 2001), few studies found significant associations between children's mentalization and behavior problems. The CRFS is a broad measure to assess mentalization in children aged 8-11 with its focus on mental state terms of the self and significant others with the use of the Child Attachment Interview (CAI: Target, Fonagy, Shmueli-Goetz, Schneider, & Datta 2000; Ensink, 2003). While

lower scores of CRFS indicate absence or limited use of mentalization skills, higher scores represent complex and elaborated use of mentalization (Vrouva, Target, & Ensink, 2012). By using the CRFS, it was found that 7 to 12-year old children's reflective functioning scores were negatively correlated with their depressive symptoms and externalizing difficulties (Ensink et al., 2016a; Ensink et al., 2016b) . Even though the CRFS is an important assessment for understanding global mentalization capacities of children, it has been criticized for not assessing different dimensions of mentalization and for generating a single global score (Choi-Kain & Gunderson, 2008; Katznelson, 2014). Besides, CRFS is also restricted in a specific age group of children and does not allow assessing mentalization capacities of children of younger ages. Therefore, there are several other studies that assessed mentalization capacities of children with behavior problems by focusing on different domains of mentalization and different age groups.

In order to understand and explain the association between cognitive mentalization capacities and behavior problems of children, social-cognitive research provides a framework of social-information processing theory. According to this theory, any kind of behavior is a result of different steps of processing information or social interactions. With regard to aggressive children, studies in this field have found that these children relied on less social cues while making a behavioral decision (Dodge & Newman, 1981); they had a tendency to attend especially to hostile cues (Gouze, 1987); their aggressive responses were the results of attending on and attributing hostile cues to others especially in ambiguous situations (Dodge, 1980; Dodge & Frame, 1982); and thus, they display a "hostile attributional bias" while interpreting the intentions of others (Nasby, Hayden, & DePaulo, 1980). Considering children with depressive symptoms, on the other hand, studies found that these children had a tendency to use more negative words and less positive ones while describing their memories (Hammen & Zuppan, 1984; Zuppan, Hammen, & Jaenicke, 1987); they evaluate new social situations with negative characteristics and seek internal causes for these events (Dodge, 1993). There are also studies that focused on mentalizing

deficits of children with social anxiety. According to Banarjee (2008), children with anxiety problems were hypervigilant to possible negative evaluations and threats coming from others in social situations; and they had problems in understanding and linking different types of mental states to each other (Banarjee & Henderson, 2001). On the grounds of these findings, the capacity of cognitive mentalization in children with externalizing problems can be interpreted as a deficit of assuming that others have hostile mental states in ambiguous situations (Sharp & Venta, 2012). With respect to the capacity of cognitive mentalization in children with internalizing problems, it can be suggested that they tend to have negative mental states for self and others in social situations and have problems in understanding multiple mental states (Banarjee, 2008).

In line with the findings of social information processing theory regarding cognitive biases of children with behavior problems, Sharp and colleagues (2007) developed a mentalizing task to assess children's response styles with three categories: rational, overly negative, and overly positive. Among these three response styles, Sharp and colleagues (2007) suggested that overly negative and overly positive responses might be associated with attributional biases and poor mentalization capacities whereas rational response style may be related to an adaptive way of coping with problems and thus, a developed capacity of mentalization. Studies using this assessment of mentalization found that children with externalizing behavior problems whose ages range between 7 and 11 had a tendency to make overly positive and biased attributions about their competencies and to attribute unrealistic mental states to their peers and to themselves in distressing situations (Sharp et al., 2006; Sharp et al., 2007). This kind of a biased and inaccurate mentalizing ability of children with externalizing problems was therefore referred to as distorted mentalizing by Sharp and colleagues (2006, 2007). The associations between distorted mentalizing in children and conduct problems were also studied by Ha, Sharp, and Goodyer (2011) and it was found that distorted mentalizing in children predict future conduct problems.

There are also several studies that assessed cognitive mentalization capacities of children with behavior problems by using theory of mind tasks.

Similar to the definition of mentalization, theory of mind refers to the capacity of the child to predict the behavior of the self and others in terms of specific internal states such as beliefs, thoughts or desires (Premack & Woodruff, 1978). However, the main focus of theory of mind tasks is about beliefs, and more specifically, "false belief" which is defined as the child's understanding that the content of internal states and the outside reality may contradict, i.e. mind and world, or appearance and reality, are not equal to each other (Wellman, Cross, & Watson, 2001; Astington, Harris & Olson, 1988). In this regard, the study of Happé and Frith (1996) focused on investigating a relation between theory of mind capacities and interpersonal difficulties of children with conduct problems. However, it was found that all participants, including normal control group and children with conduct problems, passed these false belief tasks. Similarly, Sutton, Reeves, and Keogh (2000) examined associations between disruptive behavior and theory of mind capacities of 11-13 year-old children by using a theory of mind task but results indicated no significant correlation between theory of mind and disruptive behavior. Even if it was found that children with behavior problems did not have any problems in cognitive domain of mentalization, these studies also found that children with conduct problems display more antisocial behavior than other children; they had a tendency to deny responsibility and to lack remorse in social situations; they used their mentalizing capacity for antisocial behavior (e.g. lying, cheating, teasing, bullying) by not recognizing or denying emotions; and therefore they had "a theory of nasty minds" and pseudo-mentalizing (Happe & Frith, 1996; Sutton et al., 2000; Allen et al., 2008).

While the above research studies have found deficits of mentalizing, such as distorted and pseudo mentalizing, in children with externalizing problems, they have also showed that these children can have an advanced capacity of mentalizing in the cognitive domain by reading the minds of others. Since it was suggested that these children use their cognitive mentalization capacity to manipulate others (Happe & Frith, 1996; Sutton et al., 2000; Allen et al., 2008), deficits in affective mentalization and empathy were thought to be associated with antisocial behavior of children with behavior problems (Sharp, 2006). Although

empathy is not a synonym for the concept of mentalizing, Blair (1995) described the overlap of these concepts by suggesting that empathy requires role taking which in turn requires understanding internal states of the other and thus, mentalizing. Based on this overlap, several studies have indicated that children with antisocial tendencies have impairments in empathizing and affective mentalizing. In the study of Blair and Coles (2001) it was found that adolescents aged 11 to 14 with antisocial problems had difficulty recognizing sad and fearful facial expressions. Similarly, Stevens, Charman, and Blair (2001) have found that children of ages 9 to 15 year-old with psychopathic tendencies had impairments in recognizing sad and fearful expressions. Besides, using a theory of mind task which expected children to name emotions of people from the eye regions of their faces (Child's Eye Task: Baron-Cohen, Wheelwright, Scahill, Lawson, & Spong, 2001b), Sharp (2008) have found that children of ages 7 to 11 with conduct problems have difficulties in emotion understanding.

There are also several studies that examined children's mental state understanding, especially with an emphasis on emotional understanding, and their prosocial behaviors and behavior problems. Initial studies in this domain focused on children's mental state understanding and emotion recognition by assessing these capacities with theory of mind tasks or emotion understanding tasks such as affective labeling and affective perspective taking tasks developed by Denham (1986). These tasks assess children's emotion understanding by asking them to verbalize and show the correct emotion for facial expressions and to guess the correct emotion that the puppet might have felt in different stories. By developing these tasks and assessing preschool aged children's emotional understanding, Denham (1986) found a positive association between prosocial behavior and emotion labeling. More specifically, results suggested that prosocial behavior was positively associated with the use of "happy" word, and a negative association with the uses of "sad" and "angry" words. Using these assessments, Dunn (1995) found a positive association between children's early understanding of emotions when they were 3 years old and their later social competencies at school when they were 6 years old. Similarly, Ensor and Hughes (2005) also found a positive

association between children's emotional understanding, as measured by Denham's (1986) affective labeling tasks, and their positive behavior. However, these studies were mostly conducted with preschool aged children who were normally developing and did not consider their behavior problems.

Considering behavior problems of children, on the other hand, there are also several studies that suggested negative relations with emotional understanding. Hughes, Dunn, and White (1998), in this regard, examined preschool aged children's behavior problems and emotional understandings by using the affective perspective taking task of Denham (1986). Results of this study suggested that emotion understanding capacity was poorer among preschoolers with behavior problems compared to the control group. In another study, children's emotional understanding was assessed with affective labeling and affective perspective taking tasks, and their understanding of mind was assessed with theory of mind tasks. Results indicated that both emotion and mind understanding were significantly positively related to children's prosocial behavior whereas they were negatively related to behavior problems (Cassidy, Werner, Rourke, Zubernis, & Balaraman, 2003). Focusing on the associations between 6 to 10-year old children's behavior problems and emotion understanding, the study of Cook and colleagues (1994) found that higher levels of behavior problems were negatively associated with emotional understanding and emotion recognition which were measured with the Kusche Affective Interview-Revised (KAI-R; Kusche, Beilke, & Greenberg, 1988).

Regarding the links between depression, anxiety and mental state understanding, on the other hand, there are few studies with conflicting results that examined mentalization deficits by focusing on children's and adolescents' ability of recognizing emotions. In the study of van Beek and Dubas (2008), perceiving intensity of anger and joy for facial expressions with low intensity was found to be related with depressive symptoms among children and adolescents aged 9 to 15 years. In another study (Walker, 1981), it was found that 9 to 13-year-old anxious-depressed children's ability to recognize emotions, especially positive or neutral ones, from facial expressions was poorer than the control

group. On the contrary, another study (Lenti, Giaccobbe, & Pegna, 2000) indicated that emotion recognition abilities of depressive adolescents aged 11 to 17 years were poorer than the comparison group only for negative emotions such as anger and fear. By criticizing the small sample sizes of these studies and their narrow focus on basic emotions, Mellick & Sharp (2016) conducted a study to investigate the links between mental state understanding and depressive symptoms of adolescent boys. Results of this study revealed that recognizing negatively valenced items, as measured with Child Eye Test (CET: Baron-Cohen et al., 2001), was higher among adolescent boys with major depressive disorder compared to the healthy controls while there was no significant group differences for positive or neutral items. Therefore, it can be said that there are no consistent results among studies that focused on affective mental state understandings of children with depression and anxiety regarding positive, neutral, or negative valences, yet they all found that these children had difficulties in understanding some of the emotional mental states.

There are also few studies that directly examined associations between children's behavioral problems and their mental state talk. . The use of mental state words is defined as the capacity of children to understand and attribute psychological states to themselves and others in different domains such as emotions (e.g. happy), cognitions (e.g. think), desires (e.g. want), physiology (e.g. sleep), perception (e.g. see), action-based mental states that imply emotions or cognitions (e.g. kiss, find), etc. (Bretherton & Beeghly, 1982; Symons, 2004). Although, mental state talk is not a direct synonym of mentalization, assessing the ability to use mental state words in narratives is crucial for understanding the capacity of mentalization since it helps children to understand that internal states of people can be different than each other and therefore enables them to recognize different motives underlying behaviors (Fonagy et al., 1998; Symons, 2004). Besides, assessing mentalization capacity by focusing on children's mental state talk was thought as more appropriate when specific dimensions such as different contents (e.g. emotions, cognitions, desires, etc) and different age groups of children are considered. Recently, Pinto, Primi, Tarchi, and Bigozzi (2017)

suggested that there are two components of narrative-based mental state talk. The first component was defined as superficial mental state talk regarding simple motives underlying behaviors such as perceptions, physiology or action-based words. The second component, on the other hand, was described as complex mental state talk since it is about deeper motives underlying behaviors such as emotion words (Pinto et al., 2017). In line with this recent categorization, several studies suggested that children with behavior problems use less mental state words and they mostly prefer to use perceptual or action-based mental state words, i.e. “rudimentary” or “superficial” mental state words rather than using “more complex” emotional mental state words. In this regard, children with behavioral problems were found to have difficulties in understanding emotions and talking about their emotional experiences appropriately (Cook et al., 1994). In line with the findings of Cook and colleagues (1994), the study of Bekar (2014) found that the capacity of preschool aged children to understand and talk about emotions, as measured with the CS-MST, was negatively correlated with their behavior problems. In another study, it was found that children with attention deficit and hyperactivity disorder used significantly less mental state words especially regarding cognition, physiology and judgment than healthy controls. Besides, these children also used less emotion words even though the difference was not found as significant compared to healthy controls (Rumpf, Kamp-Becker, Becker, & Kauschke, 2012). Furthermore, similar results were also found in the study of Halfon, Bekar, Ababay, and Dorlach (2017b) where they revealed that the use of perception and action-based mental state words were higher than the use of emotional mental state words, as measured with the CS-MST, among both parents and children with behavior problems.

1.3.4. Mentalization in Children and Their Adverse Experiences

As it was stated in the above sections, adverse experiences, such as abuse and neglect, occurring in the attachment relationships may result in mentalization deficits. In this regard, relations between adverse experiences and mentalization

deficits of children were mainly studied by measuring child mentalization as reflective functioning using the Child Reflective Functioning Scale. With the purpose of examining associations between parental mentalization, child mentalization and sexual abuse, Ensink and colleagues (2015) found that RF scores of children were significantly lower among children with a history of sexual abuse than the control group. Besides, sexual abuse was also examined in this study as occurring in or outside the family context, and results revealed that child RF scores were lower for children with intrafamilial sexual abuse history compared to extrafamilial sexual abuse. To put differently, it was found that abuse histories in the context of attachment relationships were related to lower mentalization capacities in children as opposed to abuse histories outside the attachment contexts. Mentalization capacities of children with sexual abuse were also examined in the study of Tessier, Normandin, Ensink, and Fonagy (2016) and significant differences in other-oriented child RF among sexually abused and nonabused children of ages 3 to 8 were found. Similarly, the study of Ensink and colleagues (2016b) examined the associations between mentalization, dissociation, sexual abuse, and behavior problems of 7 to 12-year-old children and found that child RF scores of sexually abused children were lower than the control group. These findings are in line with the suggestion that children may relapse into non-mentalizing modes in cases of abuse occurring in attachment relationship as a defense for not understanding malevolent internal states of attachment figures (Allen, 2013; Fonagy, 2004).

There are also few studies that examined the internal state language of maltreated children but their samples mainly included children of younger ages. In the study of Cicchetti and Beeghly (1987), where they investigated the associations between child maltreatment and internal state language, it was suggested that maltreated toddlers used fewer internal state words, they showed less differentiation for attributing internal state words to agents, and their use of internal state words were more context bound than nonmaltreated children. In another study of Beeghly and Cicchetti (1994), it was found that maltreated toddlers' use of internal state words were fewer than the nonmaltreated group.

Besides, it was also found that maltreated toddlers use less physiological and affective internal state words than nonmaltreated ones (Beeghly & Cichetti, 1994).

Regarding the affective domain of mentalizing in the context of maltreatment, several studies showed that maltreated children have difficulties in emotion recognition, emotional knowledge, and emotional understanding. Studies that focused on emotion recognition abilities on facial expressions found that abused children were less successful in recognizing emotions compared to nonabused ones (Camras, Grow, & Ribordy, 1983; Camras et al., 1988; During & McMahon, 1991). In the study of Pollak, Cicchetti, Hornung, and Reed (2000), emotion recognition of physically abused and physically neglected preschoolers was investigated. Results showed that the ability to recognize different emotions was poorer in physically neglected children compared to physically abused and control groups (Pollak, Cicchetti, Hornung, & Reed, 2000). Besides, with regard to emotion knowledge of 4-year-old children, which was assessed with emotion labeling, emotion recognition and emotion expression tasks, it was found that neglected children's emotion knowledge was poorer than the control group (Sullivan, Bennett, Carpenter, & Lewis, 2008; Sullivan, Carmody, & Lewis, 2010).

There are also several studies suggesting that emotional understanding capacities of children with adverse experiences are lower than their peers. In this regard, Pears & Fisher (2005) found that maltreated foster children's capacity for understanding emotions is lower than that of nonmaltreated ones as measured by both expressing and pointing emotions on facial expressions, and choosing the emotion that the puppet might have felt on each story that were told to children. Similarly, Rogosch and colleagues (1995) measured physically maltreated children's understanding of emotions by reading them stories regarding interpersonal situations and then asking them to choose the correct emotions for characters in stories. Results of the study illustrated that the capacity to understand negative affects was limited in maltreated children and that the association between maltreatment and behavioral dysregulation among children was mediated by negative affect understanding. There are also several studies that

assessed children's emotional understanding with the Emotional Understanding Interview (EUI: Cassidy, Parke, Butkovsky, & Braungart, 1992) which allows understanding children's ability to label and to talk about emotions of characters and of themselves with a series of questions. By using this assessment, 6 to 12-year old children's lower levels of emotional understanding were found to be significantly associated with physical maltreatment (Shipman & Zeman, 1999); sexual maltreatment (Shipman, Zeman, Penza, & Champion, 2000); and neglect (Shipman, Edwards, Brown, Swisher, & Jennings, 2005; Edwards, Shipman, & Brown, 2005). In line with the above findings, a recent meta-analysis research of 19 studies was conducted regarding emotional understanding and emotion knowledge capacities of abused or neglected children, and a negative association between emotion skills of children and maltreatment histories was suggested based on the results of these studies (Luke & Banarjee, 2013). Therefore, findings of these studies might be interpreted as a deficit for mentalizing emotions in maltreated children (Fonagy et al., 2007).

1.4. THE CURRENT STUDY

As stated in the above sections, research studies regarding mentalization have revealed many important findings especially on the associations between parental mentalization and mentalization in children; mentalization in children and their behavior problems; and mentalization in children and their adverse experiences. While the above studies focused on assessing children's mentalization capacities with theory of mind tasks, affective tasks, global mentalization assessments, or mental state talk, many of these studies have found significant associations for emotional skills of children when their behavioral problems and adverse experiences were considered. Besides, mental state talk was found to be highly associated with the concept of mentalization and it was suggested that mental state talk assessments can be used with a variety of different age groups. Therefore, mentalization in children was operationalized as mental state talk in this study for specifically assessing 3 to 10-year-old children's

emotional mental state talk. Emotional mental state talk was examined in this study by analyzing children's use of total emotion words, positive and negative valences of these words, variety and causality among these words. With regard to parental mentalization, on the other hand, the operationalization of maternal reflective functioning was used in this study. Besides, studies investigating the associations between adverse experiences and mentalization capacities of children were mainly focused on children's abuse and neglect histories. Therefore, abuse and neglect histories of children were operationalized in this study from mother reports of adverse experiences. Lastly, children's behavior problems were studied by focusing on internalizing, externalizing, or comorbid problems and also by specifically focusing on depression, anxiety, or aggressive behaviors. For this reason, mother reports of behavior problems were examined for all these behavior problems in this study. By using these operationalizations, the relation of children's emotional mental state talk with variables of parental mentalization, children's behavior problems and adverse experiences were investigated with a sample of mothers and their 3 to 10-year-old children.

In sum, the aims of this study are to find: (1) a positive association between maternal reflective functioning and children's emotional mental state talk; (2) a negative association between children's emotional mental state talk and their behavior problems; (3) a negative association between children's emotional mental state talk and their adverse experiences.

CHAPTER 2
METHOD

2.1. DATA

The data of this study was collected from the İstanbul Bilgi University Psychotherapy Research Laboratory. The main focus of the laboratory is to conduct research studies on psychodynamic psychotherapy processes and to develop and adapt measurement tools. Research studies of this laboratory are conducted within the İstanbul Bilgi University Psychological Counseling Center where budget friendly outpatient psychotherapy with a psychodynamic orientation is provided by graduate students enrolled in Master's Degree Clinical Psychology Program. Referrals of parents or mental health, medical, and child welfare professionals are evaluated for the inclusion criteria: 3-11 years old, no significant developmental delays, no psychotic symptoms, no drug abuse, and no significant risk of suicide attempts. A licensed clinical psychologist makes interviews with parents and children to understand their reason of referral, to evaluate the inclusion criteria, to inform parents about the research which was approved by the İstanbul Bilgi University Ethics committee and to collect informed consent forms from those who accept to participate in the study. Parents are informed that it is a volunteer based research project so that they are free to participate or to leave the process. Besides, their permission for either audio or video recording based on their preferences is also asked if they accept to participate in the study.

2.2. PARITICIPANTS

Participants were 108 mother-child dyads who were referred to the İstanbul Bilgi University Psychological Counseling Center and who accepted to participate in the study. Demographic characteristics of participants were displayed in Table 1. With respect to children, there were 44 female (40.7 %) and

64 male (59.3 %) among a total of 108 children. Ages of children ranged between 3 and 10 years with a mean age of 7,06. While most of the children were going to the elementary school (79.6%), the remaining children were going to preschool (20.4%). Considering the application reasons for therapy, the most common reasons were children's rule-breaking and aggressive acts (41.7%) and anxiety (32.4%). Other referral reasons were school/learning problems (19.4%) and social problems (5.5%). Considering mothers, on the other hand, their age range was in between 24 and 53 years with a mean of 36,32. The levels of socioeconomic status (SES) of participants ranged mostly from low to middle SES.

Table 2.1. Demographic Characteristics of the Sample (N = 108).

Children's Age (years): ***N*** **(%)**	
3-5 years old	23 (21.3)
6-8 years old	56 (51.8)
9-10 years old	29 (26.9)
Mean (*SD*)	7.06 (1.98)
Sex: ***N*** **(%)**	
Female	44 (40.7)
Male	64 (59.3)
Referral Reason: ***N*** **(%)**	
Rule-breaking and aggressive acts	45 (41.7)
Anxiety and depressive complaints	36 (32.4)
School problems	21 (19.4)
Social problems	6 (5.5)
Mothers' Age (years):	
Min	24
Max	53
Mean (SD)	36.32 (4.98)
Monthly Gross Income[a]: ***N*** **(%)**	
Less than 100 USD	23 (21.3)
100-300 USD	82 (75.9)
More than 300 USD	3 (2.8)
Mean (*SD*)	154 USD

Notes. [a]Converted to USD. (1 USD = 6,24 TL)

2.3. MEASURES

2.3.1. The Child Behavior Checklist (CBCL)

Children's behavior problems were assessed by using the Child Behavior Checklist which was developed by Achenbach (1991) with the purpose of assessing both adaptive and maladaptive functioning of children. The CBCL is completed by parents and has two versions for children between the ages of 1,5 and 5 years old; and for children between the ages of 6 and 18-year old. Parents are wanted to rate 112 problem items that describe the child's symptoms in the last 6 months by choosing either "not true" (0); "somewhat or sometimes true" (1); or "very often or often true" (2) on a 3-point Likert scale.

Items of the CBCL are categorized into eight syndrome scale scores: Anxious/Depressed, Withdrawn/Depressed, Somatic Complaints, Social Problems, Thought Problems, Attention Problems; Rule-Breaking Behavior, and Aggressive Behavior. These categories generate three domains of behavior problems: Internalizing, Externalizing, and Total problems. The domain of internalizing problems consists of anxious/depressed, withdrawn/depressed, and somatic complaints. The domain of externalizing problems, on the other hand, includes rule-breaking behavior and aggressive behavior. Lastly, total problems involve all of the eight categories. Furthermore, CBCL also assesses Competence scores of children with three different domains: Activities, Social, and School. The scores of the CBCL are calculated by using the ASEBA Software program. Symptom severities of internalizing, externalizing, and total problems are specified with cut-off scores of above 63 points for clinical level; 60 to 63 points for borderline level; and below 60 points for non-clinical level where points range between 0 and 100.

CBCL has high levels of reliability for which test-retest reliability was found to be .90, .94, and .97 for internalizing, externalizing, and total problem scales respectively (Achenbach & Rescorla, 2001). The Turkish form of CBCL was adapted and standardized by Erol, Arslan, and Akçakın (1995). Test-retest

reliability level of the Turkish form was found to be .84 and the internal consistency was found to be .82, .81, and .88 for internalizing, externalizing, and total problem scales respectively (Erol et al., 1995). In this study, internalizing, ezternalizing, and total problem scales showed good internal consistency for both versions of CBCL. Internal consistency reliabilities were found as .87, .92, .94 for internalizing, externalizing, and total problem scales respectively on the CBCL for children between the ages of 1,5 and 5 years old. . Internal consistency reliabilities were found as .89, .89, .95 for internalizing, externalizing, and total problem scales respectively on the CBCL for children between the ages of 6 and 18-year old.

2.3.2. The Adverse Childhood Experiences Study Questionnaire (ACEs)

Children's adverse experiences of abuse and neglect were assessed by using the Adverse Childhood Experiences Study Questionnaire which was developed by Felitti and colleagues (1998) to assess exposure to maltreatment and household dysfunction during the first 18 years of life. In this study, the Child ACE (Murphy, Dube, Steele, & Steele 2007) was used which is completed by the child's primary caregivers regarding the child's exposure to adverse experiences starting from the birth. The questionnaire includes 24 items in total and 10 subcategories: physical abuse, sexual abuse, emotional abuse, parental/household substance abuse, parental/household mental illness, domestic violence, incarcerated parental/household member, parental divorce or separation, physical neglect, emotional neglect. While 16 items of the questionnaire are answered on a 4-point Likert scale: Never (0); Once, twice (1); Sometimes (2); Often (3); Very often (4); the other 9 items are rated with answers of Yes or No.

Since the current study focused on children's histories of abuse and neglect, only the subcategories of emotional abuse, physical abuse, sexual abuse, physical neglect, and emotional neglect were used. Emotional abuse was assessed with two questions: "Since your child was born, did any parent, stepparent, or an adult in your home (1) swear at or insult your child?; (2) insult in a way that your

child was afraid of being physically hurt?". Physical abuse was assessed with two questions: "Since your child was born, did any parent, stepparent, or an adult in your home (1) push, grab, slap, or throw something to your child?; (2) hit your child so hard that your child was physically injured?" (Straus, 1979; Murphy et al., 2014). Sexual abuse was assessed with three questions: "Since your child was born, did any adult, relatives, or acquaintances who were at least 5 years older than your child (1) touch your child's body sexually?; (2) make your child to touch their body sexually?; (3) have any type of sexual intercourse with your child?" (Wyatt, 1985; Murphy et al., 2014). Physical neglect was assessed with four questions: "Since your child was born, (1) there was not enough food for your child; (2) your child had to wear dirty clothes; (3) there was no one to take your child to the doctor; (4) any parents or adults living in the home were too drunk or high to take care of your child." (Bernstein et al., 1994; Murphy et al., 2014). Lastly, emotional neglect was assessed with three questions: "Since your child was born, (1) there was no one to take care of or to protect your child; (2) there was no one to make your child feel special and important; (3) you don't believe that your child is loved (Murphy et al., 2014). ACE questionnaire was found to have a high internal consistency level with Cronbach's alpha of .88 (Murphy et al., 2014). The ACE was translated into Turkish by research assistants of the İstanbul Bilgi University Psychotherapy Research Laboratory using the translation-back translation method. In this study, abuse and neglect subscales of ACE questionnaire was found to have good internal consistency (Cronbach's alpha = .74).

2.3.3. The Parent Development Interview (PDI)

Maternal reflective functioning was measured in this study by using the Parent Development Interview which was developed by Aber and colleagues (1985). The PDI is a semi-structured interview and used with parents of children from infancy to adolescence. It includes 45 questions regarding mothers' representations about their child, themselves as a parent, the child-parent

relationship, and relationships with their own parents. In the first part of the interview, the parent is asked questions about descriptions of the child (e.g. three adjectives that describe the child). Then, questions regarding the parent-child relationship, such as describing a moment when they were getting along well with their child, are asked. Following these parts, parents are asked for their experiences as being a parent such as describing themselves as a parent with pleasurable and challenging memories, talking about moments that they felt angry, guilty or needy as a parent in the last two weeks, etc. Afterwards, questions regarding past experiences of parents with their own parents are asked to understand the impacts of being raised by their parents on their own parenthood, their similarities and dissimilarities with their own parents, and the like. In the end, questions regarding memories of separation and loss are also asked to the parents.

The interview is completed in approximately 1 hour and transcribed for the coding procedures. For the coding procedures, the Addendum to the Reflective Functioning Scoring Manual (Slade et al., 2004) which was developed for the PDI is used. There are four categories of assessing reflective functioning on the PDI, namely "(1) awareness of the nature of the mental states; (2) the explicit effort to tease out mental states underlying behavior; (3) recognizing developmental aspects of mental states; and (4) mental states in relation to the interviewer" (Slade, Bernbach, Grienenberger, Levy, & Locker, 2005b, p.288). The first category indicates the ability of being aware of the nature of mental states such as opaqueness, susceptibility to disguise, limitations for understanding other's mind. The second category is about recognizing and attributing possible mental states of the self and others that underlie specific behaviors. The third category implies the parents' capacity to understand and reflect on developmental changes that their children are going through. The last category, on the other hand, focuses on parents' ability to attribute mental states to the interviewer which is an indication of their reflective functioning capacities in other relationships (Slade et al., 2005a). Based on assessments of these four categories and parents' understanding and description of mental states such as feelings, desires, thoughts, intentions,

etc., parents' capacities of reflective functioning are categorized as limited, moderate or high. RF scores on the PDI range from -1 to 9 on an 11-point continuous scale, where -1 stands for "negative RF" and 9 for "full or exceptional RF".

Low levels of parental reflective functioning can take many forms such as becoming defensive, lacking or denying the capacity to reflect on mental states of the child or of themselves; focusing on physical behavior or personality traits instead of understanding internal experiences; making bizarre or inappropriate attributions to the child's experience; using superficial or cliché sentences while answering questions (Slade, 2005). An average level of parental RF can be seen when a parent understands her child as having mental states and when she is able to reflect on these mental states of the child. However, it is not very common to understand the links between different mental states or between mental states and behaviors on this level of RF (Fonagy et al., 1998). High levels of parental RF, therefore, indicate the capacities of reflecting on mental states of the self and the child, and creating links between different types of mental states or between mental states and behaviors (Slade, 2005). Besides, an important indication of high RF is being aware of the opaqueness of mental states, i.e., understanding that it is not always possible to be sure of intentions of others. Similarly, understanding the nature of mental states as being susceptible to disguise is another indication of high RF. Other indications for high RF are recognizing the limitations for understanding mental states of self and other; attributing mental states to behaviors; acknowledging that mental states may vary according to developmental aspects; etc. (Slade, 2005; Fonagy et al., 1998). In other words, the ability to understand "the complex interactions between mental states and behavior that occur within the context of the continually developing parent-infant relationship" (Slade et al., 2005a, p. 289) is evaluated as a high level of parental reflective functioning.

After scoring each single question on the PDI separately, an overall score that best represents the overall RF is determined by the coders. Using the RF coding manual developed for the PDI, a good inter-rater reliability for the PDI

was found where ICC was .87 for overall RF scores and ranged from .78 to .95 for single RF scores on each question (Slade et al., 2005a). For this study, the PDI scores were coded by three independent coders who were trained by Anna Freud Center and received the accreditation after completing the reliability test. Thirty nine percent of protocols from a total of 108 PDI interviews were rated by a pair of two coders in order to calculate inter-rater reliability. These ratings showed good inter-rater reliability (ICC (2,1) = .80).

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

Children's emotional mental state talk capacities were assessed by using the Coding System for Mental State Talk in Narratives which was developed by Bekar and colleagues (2014). The CS-MST assesses children's and parents' ability of mentalizing by coding various dimensions of their mental state talk from narratives. The coding system was initially designed to be used with the picture book "Frog, Where are You?" (Mayer, 1969) that includes pictures without words. For the coding procedures of the CS-MST, children and parents are asked to look at the pictures in the book and tell stories about these pictures. Their narratives are then recorded and transcribed in order to code their use of mental state words in different categories.

The coding system measures mental state talk in 11 different categories. The first five categories of CS-MST were designed to assess the content of mental state words as emotion words that are coded as positive and negative (e.g. happy, angry); cognitive words (e.g. believe, think); perception words (e.g. hear, see); physiological words (e.g. hurt, sleep); and action-based words (e.g. escape, hug). These first five categories are coded for unique mental state words in order to understand the number of unique words that are told among a total number of mental state words. For example, when the narrator uses the word "happy" three times and the word "excited" four times, the number of unique emotion words is counted as two. Moreover, these categories are also coded for mental state words that imply a cause and effect relationship between two mental state words or

between a mental state word and a behavior. Sixth and seventh categories of the coding system are about the direction of mental states as focusing on the self and the listener. The next category is about the ability of the story teller to make a resolution for the story. There are also three more categories of the coding system which are still in progress. One of these categories was designed to elicit the opacity of mental states with words such as guess, maybe, etc. Another category assesses inappropriate/pseudo mental state words which are about attributions that are not accurate for the characters or for the listener (e.g. “Are you crazy?”). The last category of the coding system is about situational mental state words that are not used for characters but for specific situations (e.g. this is an upsetting story).

For the coding procedures, the sum of mental state words for each category and for each subcategory are counted and then proportioned to the sum of total words used by the narrator in order to understand the proportion of mental state words in a story. The inter-rater reliability of all categories in the CS-MST was found as .90. The adaptation study of the CS-MST to the Turkish language was initially conducted by Bekar and Çorapçı (2016) by using a sample of Turkish speaking mothers and their preschool aged children. Besides, other adaptations of the CS-MST were also conducted for Turkish speaking parents and children in the studies of Halfon, Bekar, and Gürleyen (2017a) and Halfon and colleagues (2017b) where they used the coding system for play therapy sessions of parent-child dyads and they operationalized it as “play-oriented mental state talk”. Moreover, Cantaş (2018) and Coşkun (2018) also adapted the CS-MST into Turkish samples for their thesis studies and used the coding system with the Attachment Doll Story Completion Task (ASCT: Bretherton, Ridgeway, & Cassidy, 1990). During the assessment of the ASCT, children are told the beginning of specific stories regarding attachment related conflictual situations and then they are expected to show and tell what happens next in the story by using dolls. After telling a warm-up story, children are asked to complete five stories, namely, the spilled juice, hurt knee, monster in the bedroom, separation, and reunion. During the first story-stem of “spilled juice”, the child is told that the family is eating their dinner and the child spills his/her glass of juice. In the

second story, “monster in the bedroom”, the child goes to sleep but then screams that there is a monster in his/her room. In the third story, “hurt knee”, after going to a park with his/her parents, the child tries to climb a high rock but then falls down and hurts his/her knee. In the forth story, “separation”, while the parents go to a vacation for one week, the child stays with his/her grandmother. In the last story-stem, “reunion”, the parents come back from their vacation. The task was adapted into Turkish by Uluç in 2005 (Uluç&Öktem, 2009).

Since the current study focused on children’s emotional mental state talk, only the category of emotional mental state words was used. Similar to the adaptations of Cantaş (2018) and Coşkun (2018), emotional mental state words of children were assessed in this study from their narratives of the Attachment Doll Story Completion Task. First of all, children’s emotion words on these narratives were identified. These emotion words were then counted and categorized as “total emotion words”. Besides, the valences of emotion words were also identified and categorized as “positive” and “negative” emotion words. Among these positive and negative emotion words, each unique emotion word was also identified and counted as “unique emotion words”. Furthermore, emotion words were also categorized as “causal emotion words” if any cause and effect relationship was told by children. For the coding procedures, the assessments of ASCT were recorded and transcribed verbatim. Then, six masters-level students, after receiving 5 hours of training from Özlem Bekar, Ph.D. and an excellent inter-rater reliability (ICC=.87 to .93) for CS-MST, coded narratives of children for mental state words. Twenty five percent of the data were coded by pairs of coders in order to identify inter-rater reliability of each pair. Among these codings, ICCs were found as ranging from .83 to .99. Differences more than three mental state words among each pair were resolved by coming to an agreement after revising the codings. The remaining data was coded by these six raters individually.

2.3.5. Turkish Expressive and Receptive Language Test (TİFALDİ)

Children’s expressive verbal abilities were measured by using Turkish Expressive and Receptive Language Test which was developed by Berument and Güven (2010) with the purpose of assessing both expressive and receptive language abilities of Turkish speaking children aged 2 to 12. Items of both expressive and receptive subscales are asked to the children starting from the easiest age-appropriate items which were determined by the chronological ages of children and items to be asked become harder towards the end of the test. For the expressive language subscale, children are shown age appropriate black and white picture cards one by one among a total number of 80 cards and are asked to name what they see on the picture. For the receptive language subscale, on the other hand, children are told age appropriate words among a total number of 104 words one by one and are wanted to show the picture of that word among 4 options of pictures that are shown on a quartered card at a time. Both subscales of TİFALDİ were found to have very high reliability levels. Internal consistency across different age groups ranged between .86 and .96 for expressive language subscale, and between .88 and .96 for receptive language subscale. Regarding validity of TİFALDİ, it was found that both expressive language subscale and receptive language subscale scores were significantly related with verbal scale scores of WISC-R ($r=.521$, $p<.001$; $r=.447$, $p<.001$ respectively). Children were given standardized scores ($M=100$, $SD=15$) based on their chronological ages and raw scores for both subscales. In this study, children’s standardized scores for expressive language subscale were controlled.

2.4. PROCEDURE

Parents and their children, who volunteered for the study, were invited for a one-hour intake assessment meeting by masters-level research assistants of the Psychotherapy Process Research Laboratory for research procedures. These procedures involve various scales that are filled by mothers and fathers, and cognitive and emotional assessments with children. During this meeting, children were given the Attachment Doll Story Completion Task for the purpose of coding

their emotional mental state talk with the CS-MST and TİFALDİ for assessing their language abilities. At the same meeting, mothers were given the CBCL in order to assess children's total problem behavior scores and the ACE-child questionnaire in order to assess children's adverse experiences. After these assessment procedures, the first sessions of the therapy processes were arranged to understand the presenting problems and the developmental history of children. The second sessions were arranged with mothers for the Parent Development Interview (PDI) in order to understand parental reflective functioning levels and these sessions took approximately 50 minutes.

For the coding procedures, the Attachment Doll Story Completion Task and the Parent Development Interview were videotaped and then transcribed verbatim by undergraduate psychology students. Using the transcriptions, one clinical psychologist with 10 years of experience and a total number of eight master's level students who were also research assistants of the Psychotherapy Research Laboratory coded these assessments. All these raters were trained for coding procedures and they were blind to histories of children as each participant in the study was assigned an ID number. While six of these assistants coded the ASCTs with the CS-MST for emotional mental state talk, the other two research assistants and the clinical psychologist coded the PDIs for parental reflective functioning levels. Therefore, coders of children's emotional mental state talk were blind to mothers' RF scores and vice versa. The data of this study consisted psychotherapy patients of the counseling center from 2016 Fall-2017 Spring term to 2018 Fall-2019 Spring term.

2.5. DATA ANALYSIS PLAN

In order to understand which variables among children's age, gender, and expressive language ability needed to be controlled for in further analysis, their relations with children's emotional mental state talk, behavior problems, adverse experiences and maternal reflective functioning will be explored by using bivariate correlation on SPSS. After that, partial correlation analysis will be used

to analyze the associations between maternal reflective functioning, children's emotional mental state talk, children's behavioral problems, and children's adverse experiences.

CHAPTER 3
RESULTS

3.1. DESCRIPTIVE ANALYSIS

Since the number of total words used in narratives can affect the number of mental state words used by children, number of all words in each narrative was counted and found to be ranged between 23 and 3018 (M=466, SD=392). Then, the number of emotional mental state words was divided by the total word count with the purpose of controlling the variations in children's verbosity. This process was conducted for all the emotional mental state talk variables, including total emotion words, positive emotion words, negative emotion words, unique positive emotion words, unique negative emotion words and causal emotion words, which were included in the further analysis.

Descriptive statistics for maternal measure of reflective functioning (PDI), and child measures of Child Behavior Checklist (CBCL), Adverse Childhood Experiences for abuse and neglect (ACE child), and children's emotional mental state talk were displayed in the Table 3.1 with minimum and maximum levels, means, and standard deviations.

Table 3.1 Descriptive Statistics for Maternal Measure of Reflective Functioning (PDI), and Child Measures of Child Behavior Checklist (CBCL), Adverse Childhood Experiences (ACE), and Children's Emotional Mental State Talk (EMST) Variables

	Minium	Maximum	Mean	SD
PDI	1,00	6,00	3,24	1,23
ACE (Abuse & Neglect)	0,00	9,00	1,69	2,02
CBCL Internalizing Problems	43,00	84,00	63,39	9,56
CBCL Externalizing Problems	33,00	86,00	62,60	9,96
CBCL Total Problems	43,00	86,00	64,38	8,84
Total EMST	0,00	,07	,02	,01
Positive EMST	0,00	,03	,00	,01
Negative EMST	0,00	,05	,01	,01
Positive Unique EMST	0,00	,02	,00	,00
Negative Unique EMST	0,00	,03	,01	,01
Causal EMST	0,00	,02	,00	,00

Five most frequent positive and negative emotional mental state words among all children were demonstrated in Table 3.2 with their percentages. Besides, five most frequent emotional mental state words used by children with abuse&neglect histories, internalizing, externalizing, and total behavior problems were illustrated in Table 3.3 with their percentages.

Table 3.2 Five Most Frequently Used Positive and Negative Emotional Mental State Words

Positive	Happy	Love	Pleased	Excited	Like
%	49.61%	21.54%	8.02%	4.20%	3.82%
Negative	Sad	Scared	Angry	Miss	Mad
%	33.40%	28.34%	17.81%	8.30%	2.43%

Table 3.3 Five Most Frequently Used Emotional Mental State Words by Children with Abuse and Neglect Histories, Internalizing, Externalizing, and Total Behavior Problems

Abuse & Neglect	Sad	Fear	Angry	Happy	Love
%	20.56%	17.22%	10.56%	10.56%	6.67%
Internalizing	Sad	Happy	Scared	Angry	Miss
%	23.85%	20%	16.92%	16.92%	6.15%
Externalizing	Scared	Miss	Sad	Angry	Happy
%	26.67%	17.78%	15.56%	8.89%	8.89%
Total	Scared	Sad	Happy	Angry	Love
%	20.14%	18.74%	16.86%	14.29%	6.56%

In order to understand whether gender needed to be controlled for in further analysis, an independent sample t-test was conducted. Results of the t-test, as presented in Table 3.4, indicated that there was no significant difference for mean scores of variables between females and males. Furthermore, bivariate correlational analysis was conducted for all variables in order to examine whether children's age, and children's verbal ability (measured with TİFALDİ Expressive Language Scale) needed to be controlled for in further analysis. According to the results, children's age was found to be significantly correlated with their emotional mental state talk. Children's expressive language abilities were found to be correlated with both emotional mental state talk and behavioral problems. Pearson Correlation coefficients were demonstrated in Table 3.5.

Table 3.4 Results of t-test and Descriptive Statistics for Emotional Mental State Talk (EMST), Maternal Reflective Functioning (PDI), Adverse Experiences of Abuse and Neglect, Internalizing, Externalizing, and Total Behavior Problems by Sex

	Group	Mean	SD	t	p
EMST	Female	.019	.015	.632	.529
	Male	.018	.011		
PDI	Female	3.17	1.31	-.460	.647
	Male	3.28	1.18		
ACE (Abuse & Neglcet)	Female	1.83	2.31	.611	.543
	Male	1.59	1.81		
CBCL Internalizing	Female	64.00	9.97	.549	.584
	Male	62.97	9.33		
CBCL Externalizing	Female	61.59	8.91	-.873	.384
	Male	63.30	10.64		
CBCL Total	Female	64.66	8.36	.271	.787
	Male	64.19	9.21		

Table 3.5 Bivariate Correlations of Children's Age and Expressive Language Ability with Emotional Mental State Talk (EMST), Maternal Reflective Functioning (PDI), Adverse Experiences of Abuse and Neglect, Internalizing, Externalizing, and Total Behavior Problems

	Children's Age	Tifaldi Expressive Language
EMST	.239**	.260**
PDI	,019	.109
ACE (Abuse & Neglect)	.042	.042
CBCL Internalizing	.013	-.091
CBCL Externalizing	-.136	-.202*
CBCL Total	-.094	-.208*

Note. * p<.05
**p<.01

Based on the results of the independent sample t-test and bivariate correlation analyses, children's age, and children's TİFALDİ Expressive Language scores were used as control variables for hypothesis testing. Considering the variable of children's emotional mental state talk, children's use of total emotional mental state words was used in partial correlation analyses. For further analyses, on the other hand, children's use of positive, negative, unique positive, unique negative, and causal emotional mental state words were also examined for associations with other variables.

3.3. HYPOTHESIS TESTING

Hypothesis 1: *There will be a positive association between children's emotional mental state talk and maternal reflective functioning.*

The association between children's emotional mental state talk and maternal reflective functioning was not found to be significant even though there was a positive direction. (See Table 3.6). As follow up analysis, the associations between maternal reflective functioning and children's emotional mental state talk subcategories (positive and negative valences of emotion words, unique uses of

positive and negative emotion words, and emotion words that imply causality) were also examined. Results indicated that children's use of positive emotion words and their use of unique positive emotion words were significantly and positively correlated with maternal reflective functioning levels (See Table 3.7).

Hypothesis 2: *There will be a negative association between children's emotional mental state talk and children's adverse experiences of abuse and neglect.*

A trend level association between children's emotional mental state talk and their adverse experiences of abuse and neglect was found (See Table 3.6). Results of follow up analysis that included subcategories of emotional mental state talk indicated no significant relationship between these subcategories and children's abuse and neglect histories (See Table 3.7).

Hypothesis 3: *There will be a negative association between children's emotional mental state talk and their behavior problems.*

The association between children's total emotional mental state talk and their internalizing, externalizing, and total behavior problems were not found as significant (See Table 3.6). As follow up analysis, the associations between children's emotional mental state talk subcategories and internalizing and externalizing behavior problems subcategories (anxious/depressed, withdrawn/depressed, somatic complaints, aggressive behavior, rule breaking behavior) were also examined. Results indicated that children's use of emotion words that imply a causal relationship was significantly and negatively correlated with their aggressive behavior and rule breaking behavior problems (See Table 3.7).

Table 3.6 Partial Correlations between Children's Total Emotional Mental State Talk (EMST), Maternal Reflective Functioning (PDI), Children's Adverse Experiences of Abuse and Neglect, and Children's Internalizing, Externalizing, and Total Behavior Problems

	PDI	ACE Abuse & Neglect	CBCL Internalizing Score	CBCL Externalizing Score	CBCL Total Score
Total EMST	.024	-.186*	-.114	-.109	-.120

Note. * p<.06

Table 3.7 Partial Correlations between Children's Emotional Mental State Talk (EMST) Subscales, Maternal Reflective Functioning (PDI), Children's Adverse Experiences of Abuse and Neglect, and Children's Internalizing and Externalizing Behavior Problems Subscales

	PDI	ACE Abuse & Neglect	CBCL Anxious Score	CBCL Depressed Score	CBCL Somatic Score	CBCL Aggressive Score	CBCL Rule Breaking Score
Positive EMST	.244*	-.105	.031	.043	-.025	-.048	-.009
Negative EMST	-.104	-.123	-.017	-.039	-.113	-.169	-.018
Positive Unique EMST	.224*	-.083	-.029	-.046	-.095	-.025	-.006
Negative Unique EMST	-.022	-.048	-.051	.011	-.149	-.129	.138
Causal EMST	-.034	-.103	.013	-.119	.065	-.247*	-.215*

Note. *p<.05

CHAPTER 4
DISCUSSION

The aim of this study was to explore the associations between parental mentalization, children's emotional mentalization, children's adverse experiences and their behavior problems. The initial step was to examine the relation of children's total emotional mental state talk with maternal reflective functioning, children's adverse experiences of abuse and neglect, and lastly children's behavior problems which was operationalized as internalizing, externalizing, and total behavior problems. The second step was to examine the associations of children's emotional mental state talk subcategories, namely, positive and negative emotional mental state words, diverse positive and negative emotional mental state words, and causal emotional mental state words with other variables.

Considering the association between maternal reflective functioning and children's total emotional mental state talk, no significant relationship was found. However, results of further analysis for emotional mental state talk subcategories revealed significant positive associations between maternal reflective functioning and children's use of positive emotional mental state words and diverse positive emotional mental state words. It means that when maternal reflective functioning scores increase, children's use of positive emotional mental state words, with frequency and diversity, also increase. Regarding the association of children's total emotional mental state talk with adverse experiences of abuse and neglect, a trend level negative association was found. In other words, as children's abuse and neglect histories increase, their use of emotional mental state words decreases. Results of further analysis for emotional mental state talk subcategories indicated no significant association between emotional mental state talk and children's abuse and neglect histories. Lastly, the relations between children's total emotional mental state talk and their internalizing, externalizing, and total behavior problems were examined. No significant association between children's total emotional mental state talk and behavior problems was found as opposed to what was expected. However, results of further analysis indicated significant

negative associations between children's causal emotional mental state words and their aggressive and rule breaking behaviors, both of which are subscales of externalizing problems. It means that children's capacity to understand and attribute cause and effect relationships between mental state words or between a mental state word and a behavior decreases when their aggressive and rule breaking behavior increase.

In sum, findings of this study revealed that children's use of emotional mental state talk may show differences with regard to their abuse and neglect histories, their different types of behavior problems, and their mother's reflective functioning capacities. While abuse and neglect histories of children were found to be related to children's use of less emotional mental state words, their aggressive and rule breaking behaviors were found to be associated with less causal emotional mental state talk. Furthermore, higher levels of maternal reflective functioning were found to be related with frequent and diverse use of positive emotional mental state talk in children. As there are different findings for total emotional mental state talk and for subcategories of emotional mental state talk, these findings were discussed below for maternal reflective functioning, children's behavior problems, and children's abuse and neglect histories respectively.

4.1. Hypothesis

4.1.1. Exploring the Associations between Maternal Reflective Functioning and Children's Emotional Mental State Talk

With respect to maternal reflective functioning, it was found that mothers with higher levels of reflective functioning had children who use more frequent and diverse positive emotional mental state words. Since higher maternal reflective functioning capacity is an important predictor for the development of affect regulation and mentalization capacity in children (Sharp et al., 2006), producing more positive emotional mental state talk may be interpreted as a

protective factor for children. This association for positive emotional mental state talk is especially important when the assessment of Attachment Doll Story Completion Task (Bretherton et al., 1990) is considered. Since this assessment includes stories that elicit especially anxiety provoking situations in attachment relationships, the capacity of using positive emotional mental state words might be interpreted as these children's positive representations, or internal working models (Bowlby, 1969, 1973, 1980), regarding their attachment relationships with their mothers. Even though initial associations for emotions are mainly anxiety, fear, or hurt in stories of spilled juice, monster in the bedroom, and hurt knee, it can be said that children whose mothers' reflective functioning levels are higher may resolve these stories more securely and thus, attribute more positive feelings in return. Following examples for children's answers to these stories were presented as examples of a comparison between mothers with high or low levels of reflective functioning capacities. Besides, children's positive (+) and negative (-) emotional mental state words were underlined:

Spilled Juice:

Therapist: The child, her mom and dad are eating the dinner. The child stands up to reach out her juice. While she is taking the juice, she drops the glass on the floor. Her mom says: "Hey, you've spilled your juice." Then what happened?

A child's story whose mother has an RF score of 5:

Child 1: Then she told her mom that it happened accidentally and asked her mom "Can you give me another juice?". And her mother said "Sure honey, if it was an accident, I'll give you another". Then her mom gave another juice to her and put it on the table. And she drank her juice. (How did she feel in this story?) She felt very happy (+)!

A child's story whose mother has an RF score of 1:

Child 2: His mom cleaned out the floor. He cleaned out too. Then they ate their dinner. (How did he feel?) He felt that his mom doesn't love (-) him and that she won't take care of him again.

Monster in the Bedroom:

Therapist: Now, the child's mom says "It's time to sleep." and dad says "That's right. Go to your bed and sleep." And the child says "Ok mom, ok dad, good night" Then, the child goes to his room and starts to scream "Mom, dad, there is a monster in my room, there is a monster!" Then what happened?

A child's story whose mother has an RF score of 6:

Child 3: His mom and dad ran to his room and said "What happened?". Then he said that there is a monster. Her mom said to him "No, honey, it is the shade of a tree. Let me turn on your lamp. Now you can sleep. Don't worry (-), we will be in the next room okay? Then he slept. (How did he feel?) He felt very good (+) and relaxed (+) because he believed to his mom and happily (+) slept.

A child's story whose mother has an RF score of 2:

Child 4: His mom said that there is not a monster. Then he said that the monster is in his bed. Then his dad looked at the bed and said the child "See there's not a monster". Then he said, okay I'm going to bed but after that, the lightning flashed and the child felt so scared (-) again.

Hurt Knee:

Therapist: This is a park. And this is a big rock at the middle of the park. The child, mom and dad came to this park. The child ran and started to climb to the rock and said "Mom, dad look how I am climbing to this rock." While the child was climbing, he/she fell down and said "Oh, my knee hurts!" Then what happened?

A child's story whose mother has an RF score of 6:

Child 5: Then her mom and dad ran and came to look at her. They said "don't climb to that rock again" and then went to their home to apply a plaster to her knee. Then they went to the park again and she climbed to the rock but she was very careful at this time. She managed to stand on the

rock and her mom and dad said "Well done honey!" (How did she feel?) She felt very happy (+), surprised (+) and lucky (+)! And she felt that she had a very good mom and dad.

A child's story whose mother has an RF score of 1:

Child 6: Then he died. (How did he feel?) You cannot feel anything when you die. My mom and dad told me that. (Okay, then what happened?) Then the child went to the cemetery.

As it can be seen from these examples, children whose mothers have higher levels of RF scores told stories that are longer, more coherent and they made a positive resolution in the end. Besides, as a result of resolving these anxiety provoking events with positive representations of their caregivers, they used more positive emotion words when probed for. On the other hand, children whose mothers' RF scores are lower told stories that are shorter, incoherent and they were unable to resolve story themes with positive representations. Instead, they used inappropriate attributions regarding the minds of their caregiver by stating that she will never take care of the child, or they gave bizarre responses such as dying. Besides, it was also seen in their stories that even though they tried to resolve the story by using the help of caregivers, it was not enough for the child to feel good as he was still feeling scared. These differences of narratives of children are indicative for the importance of higher levels of maternal reflective functioning for children's ability to tell coherent stories, to use their caregivers in distressful situations, to make resolutions for these events and thus to feel positive emotions in the end. This is in line with the suggestion that children, whose mothers are sensitive to their needs, are more likely to develop supportive and responsive representations of their mothers, which in turn enable them to resolve anxiety provoking situations and negative emotions in the attachment system by using their supportive caregivers (Splaun, Steele, Steele, Reiner, & Murphy, 2010). However, children, whose mothers are less sensitive, have representations for their mothers as unsupportive or rejecting, and thus, they are unable to solve

negative emotions or anxiety provoking events successfully with the assistance of their caregivers (Splaun et al., 2010).

On the other hand, the last two stories of the ASCT, separation and reunion, can be regarded as more anxiety provoking than the former three stories as these two stories elicit themes of being separated from caregivers and then reunited again. Therefore, these stories might be more informative for children's internal working models since attachment representations were suggested to be understood better when the parent is absent and then comes back (Main et al., 1985). Besides, their response styles in the reunion story may be indicative about their representations of caregivers as either positive/supportive or negative/rejecting. The reason for positive representations might be about children's expectation that their caregiver will return and continue to be supportive in the attachment relationship. This expectation of children may lead to attributing more positive emotions in the end. On the other hand, dismissive or preoccupied children may respond the reunion stories with very limited answers, without noticing the presence of their caregiver or by exaggerating their anxiety in the end (Ainsworth et al. 1971, 1974). Examples for separation and reunion stories were presented below for children whose mothers had high or low scores on RF. Besides, examples of mothers on the separation question on the PDI for these children were also presented for comparison:

Responses of a child to the themes of separation and reunion and her mother to the separation question who has an RF score of 6:

Child's response for separation and reunion stories

Therapist: This is the garden of the family's house and this is their car. The child's mom says "We are going to a vacation for a week with your dad. Grandma will stay with you for a week. " and her dad says "That's right, we will not be there for a week." And they are going to their car. Then what happened?

Child 1: They went to vacation and her grandma said to her "Don't be <u>upset</u> (-), they will be back in one week." And she said that one week is

too long but her grandma explained her that one week is not that long actually. Then her grandma gave her 7 beads in order to count each day. She waited for her parents by counting these beads.

Therapist: Okay, do you know what happened next? One week has past. Grandma was looking out of the window. She said “Hey, look, your mom and dad came back from their vacation.” Then what happened?

Child 1: She said to her mom and dad that she missed (-) them so much and they became very happy (+) after coming together again. She felt very happy (+) and very excited (+) to see her mom and dad.

Her mother’s response for separation question on the PDI

Therapist: Can you think of a moment that you and your child were not together, that you were separated. Can you tell me about that memory? How did it affect you and your child?

Mother 1: When I first left her, her sister was one year old and she was 3 years old. We left her to his grandmother for fifteen days during the summer because we didn’t have a babysitter at that time. I was working at that time. Her sister stayed with us because she was younger than her. Honestly, I felt very relaxed because it was very difficult for me and my husband to take care of two children without any support and without a babysitter. I remember I was thinking that having only one child was easier. But I also missed her too much. I mean, I really missed her. I also thought about going and taking her back earlier than we’ve planned but I knew that it would have been very difficult for us. She was very happy during the first week at her grandmothers’. But during the second week, my mom called and said “Don’t call her in the morning because it became very difficult for her during the rest of the day. Call her before sleeping.” So the last 5 days were very difficult for my child. She was saying “Why don’t you come back?” all the time. I know that she missed me a lot. I also remember talking to my husband “Do you think she felt like we preferred her sister and left her alone?” But we cannot find an answer to this

question even today. But we know that it was never a preference for us to leave her. My mother wasn't able to take care of my other child, who was 1-year-old. It was easier for her to take care of a three-year-old. But I remember thinking about the possibility that she might have felt being left alone.

Responses of a child to the themes of separation and reunion and her mother to the separation question on the PDI who has an RF score of 1:

Child's response for separation and reunion stories

Therapist: This is the garden of the family's house and this is their car. Her mom says "We are going to a vacation for a week with your dad. Grandma will stay with you for a week." and her dad says "That's right, we will not be there for a week." And they are going to their car. Then what happened?

Child 2: Then they went to the park and played with her grandma. And it's the end.

Therapist: Okay, do you know what happened next? One week has past. Grandma was looking out of the window. She said "Hey, look, your mom and dad came back from their vacation." Then what happened?

Child 2: They came back from vacation and they said "We came back". Her dad said her to take the toy that side. The end.

Mother's response for separation question on the PDI

Therapist: Can you think of a moment that you and your child were not together, that you were separated. Can you tell me about that memory? How did it affect you and your child?

Mother 2: We rarely remained separate in the last year. But when she went to her grandmother, it felt like a weight off my mind. I felt very relaxed; I rested as long as I want. So I felt very happy. But like I said before, it is difficult with or without her. We miss each other and so on. But I just worry about things like Did she upset my mom?, Did my mom get upset?,

> Did she make my mom angry? Did she make anything that will disgrace me? I mean did she make something to put me to shame? Did my mom said things like ‘what a spoiled, shameless child she is’? Did my mom become annoyed or tired? I always keep thinking about these things. (How do you think it affects your child?) She gets very happy. Staying with her grandmother always makes her very happy so it is not important for her to go with or without me.

These examples from narratives of children and their mothers are indicative for understanding their mentalization levels, their representations, and their attachment relationships with each other. While the child whose mother’s RF level is higher acknowledged the feeling of sadness after separation but then thought of a resolution while waiting for her parents by taking the help of grandmother; the other child whose mother’s RF level is lower denied the negative feelings of being separated from parents and instead, made the child to play with the grandmother. During the reunion story, while the first child expressed her positive feelings of happiness and excitement for seeing her parents, the second child did not show any closeness or positive affect after seeing the parents. When their mothers’ responses to the separation question are examined, it can be seen that the first mother, whose RF level is higher, answered the question by making both positive and negative attributions for her own feelings about separation. She also gave explanations about how her child might have been affected from the separation by talking about both positive and negative feelings of her child. Besides, she was also able to think reflectively about how her child might have felt or thought about being left without being sure of the answer which was an indication of the opacity of mental states. On the other hand, the second mother’s, whose RF level is lower, answer to the separation question can be evaluated as more unreflective as she usually made negative mental state attributions for her child’s behavior. Besides, she only talked about positive effects of being separated without acknowledging any negative feelings that might have been elicited on herself or on her child. These two examples of mother-child

dyads can be interpreted in the context of children's representational system and their attachment relationships for understanding the positive emotional mental state talk of children. As maternal reflective functioning levels increase, mothers become more open to think reflectively about their parenting experience, about their children's mental states behind their behaviors and this allow children to develop their own mentalization capacity and a secure attachment relationship with their caregivers where their representations are more positive (Koren-Karie, Oppenheim, & Getzler-Yosef, 2004; Steele & Steele, 2008; Bekar, 2014). These secure children's internal representations allow them to expect that even if their mothers leave for a while, they will be back again as the same reflective parents who treat them as psychological beings with their own minds (Bowlby, 1969, 1973, 1980; Main, 1991; Fonagy et al., 1991a). This capacity may allow children to resolve distressful events with more positive attributions and to feel safe in the relationship with their mothers which in turn increase their capacity to make resolutions for distressing events and thus, to produce more positive emotion words (Fonagy, Target, Gergely, Allen, & Bateman, 2003; Steele, Steele, & Johansson, 2002; Slade, 1999; Bekar, 2014). This is in line with the suggestion that children are able to expect more positive responses and solving strategies for their crisis when they have representations of caregivers as helping, attuning, and being sensitive to their needs (Steele, Steele, Croft, & Fonagy, 2008; Fonagy & Target, 2007). These explanations are also in line with the concept of "mind-mindedness" suggested by (Meins, 1997) which was defined as the mother's ability to treat her child as a separate mind with his/her own needs and mental states, and to be sensitive of the child by using appropriate mental state comments for their child's mind. This capacity of maternal mind-mindedness has been found to result in a secure attachment style and developed mentalization capacity in children (Meins et al., 2001), which in turn may enhance children's capacity to use positive representations for their caregiver in distressing situations. The importance of attachment security and positive representations for caregivers for children's ability to identify and regulate emotions was also emphasized by Fonagy and colleagues (2007).

Unlike this association between maternal reflective functioning and children's use of positive emotion words, similar associations were not found for causal emotion words or total emotion words. One explanation for causal emotional mental state words may be that making causal links are regarded as a more complex and developed capacity for mentalization because giving causal explanations for mental states or for behaviors are more similar to the definition of mentalization (Fonagy et al, 1998). Therefore, making complex causal associations may be more difficult for children in a clinical sample as opposed to a non-clinical sample since this study used only children with psychopathological symptoms. In addition, difficulty in making causal attributions was founded in this study for children with symptoms of aggression which supports the explanation for clinical sample and it was discussed in the below heading for associations between behavior problems and emotional mental state talk. Another explanation for no association between causal and global emotional mental state talk and maternal reflective functioning may be that the capacity of making causal explanations and to develop mentalization skills were found to increase with chronological age in children in several studies (Caroll & Steward, 1984; Donaldson & Westerman, 1986; Harris, 1983; Nannis & Cowan, 1987; Selman, 1981; Wintre & Vallance, 1994; Bohnert, Crnic, & Lim, 2003). In line with this finding, this study also found a positive association between children's ages and their emotional mental state talk, but age was controlled rather than to be used as an independent variable. Besides, literature regarding the association between parental mentalization and the development of mentalization in children mostly used samples for infancy aged children (Fonagy, Redfern, & Charman, 1997; Meins, 1997; Oppenheim & Koren-Karie, 2002). Therefore, for school aged children, it might be interpreted that their own capacity for mentalization can be more predictive for their global emotional mental state talk or for their causal explanations.

4.1.2. Exploring the Associations between Children's Emotional Mental State Talk and Their Behavior Problems

Another aim of the study was to explore the association between children's emotional mental state talk and behavior problems. Results revealed that children's causal emotional mental state talk was significantly and negatively associated with their aggressive and rule-breaking behaviors. It means that when children's symptoms of aggression and rule-breaking behaviors increase, their ability to make causal explanations for emotional mental state talk decreases. These results were supported by several studies that suggested that children with aggressive behaviors did not have difficulty in labeling emotion words but in understanding and describing causes of emotions (Casey, 1996; Casey & Schlosser, 1994; Bohnert et al., 2003; O'Kearney & Dadds, 2005). In this regard, the similarity between the definition of mentalization and causal mental state talk might be seen as an explanation for this finding. Since mentalization is the ability to understand mental states of the self and others, and then to attribute these mental states for predicting behaviors of the self and others, (Fonagy & Target, 1997), making causal explanations between two mental states or between a mental state and a behavior is regarded as an important aspect of mentalization capacity. In this regard, even though understanding and labeling mental states is also very important, understanding causes for mental states or behaviors is said to be a more developed capacity for mentalization. With respect to children with externalizing difficulties, especially with aggressive and rule-breaking behaviors, their ability to label emotional words was not found to be poor. However, their ability to attribute causes for these emotion words was found to be poor in case of aggressive and rule-breaking behaviors. It means that these children have a difficulty in explaining the causes of behaviors and the relations between different mental states. Therefore, this inability may make them become more aggressive and show symptoms of rule-breaking behaviors since they cannot mentalize and find reasons for distressing emotions of the self or the other in relationships. Besides, several studies have found that children with aggressive symptoms have distorted

or pseudo mentalization (Sharp et al., 2006, 2007; Happe & Frith, 1996; Sutton et al., 2000; Allen et al., 2008) which result in their unrealistic or inappropriate mental state attributions to themselves and others for explaining behaviors. In line with this, it was found in the study of Coşkun (2018) that children with externalizing behavior problems used more inappropriate/pseudo mental state comments. Therefore, even though these children may have been used causal interpretations for their emotional mental state talk, these interpretations may be restricted to inappropriate and flawed causal attributions (e.g. *not feeling anything as a result of dying)* which were not taking into consideration in this study as causal mental state talk.

In line with the above explanations, these children's poor ability to understand causes of emotions might be suggestive for their aggressive behavior. Since they cannot understand causes of emotions, they may resort to acting out aggressively. This explanation is in line with the concept of "hostile attribution bias" (Nasby et al., 1980) of these children when interpreting behaviors of others. As they have difficulty in interpreting behaviors with causal explanations, they have a tendency to make hostile attributions and to act aggressively in accordance. Even though a similar association was not found in this study for children with depressive or anxiety symptoms, this finding was also supported by studies that suggested that children with internalizing difficulties described more causes for emotions as compared to children with externalizing difficulties (O'Kearney & Dadds, 2005). This may be the result of internalizing children's tendency for over thinking, seeking internal causes for events, and their hypervigilance in social situations (Dodge, 1993; Banarjee, 2008).

Contrary to what was expected, no significant association was found between behavior problems and total emotional mental state talk, including positive and negative emotional mental state words. This finding of the study does not support the prior findings of studies which suggested that children with behavioral problems, especially with externalizing difficulties, had problems in understanding and expressing their emotions appropriately (Cook et al., 1994; Hughes et al., 1998; Cassidy et al., 2003) and used less emotional mental state

words compared to other types of mental state talk categories (Bekar, 2014; Rumpf et al., 2012; Halfon et al., 2017b). An explanation may be that this study did not compare different types of mental state talk categories, and thus failed to reveal low variances for emotional mental state talk of children with behavioral problems as opposed to other categories such as cognitive, physiological, perceptual, or action-based mental state talk as has been found in several studies (Bekar, 2014; Rumpf et al., 2012; Halfon et al., 2017b). Moreover, the associations between children's emotional mental state talk and their behavior problems were based on correlational findings in this study. Therefore, no comparison between clinical and non-clinical groups, or between children with internalizing problems and externalizing problems were reported by dividing the sample due to the small size. Therefore, findings of the study may failed to support significant results of the prior studies which used comparison groups such as clinical and nonclinical or internalizing and externalizing problems. By comparing children with internalizing and externalizing behavior problems, for instance, O'Kearney and Dadds (2005) suggested that adolescents with internalizing and externalizing difficulties showed different types of emotion language inabilities for different types of emotion eliciting events. While internalizing children used more inner-directed emotion words such as sadness for events that elicit sadness and anger, externalizing children used more outer-directed emotion words such as anger for same events. Therefore, since internalizing and externalizing children's behavior strategies are very different than each other, their inabilities for using emotional mental state words might also be in different domains of emotion language. In other words, there might not be a global deficit of emotion language for children with internalizing and externalizing problems but these children may have difficulties in different domains of emotional mental state talk specific to different ways of processing emotions (O'Kearney & Dadds, 2004, 2005; Burger & Miller, 1999; Wellman, 1995; Ferguson & Stegge, 1995; Lenti et al., 2000). Besides, several studies have also found that children's understanding of simple or complex emotions varied with respect to different ages and verbal abilities (Hoffner & Badzinski, 1989;

Lightfoot & Bullock, 1990; Zabel, 1979) and that especially for children with externalizing problems, the ability to decode emotions increase with age and verbal ability (Tramontana & Hooper, 1989; Egan, Brown, Goonan, Goonan, and Celano, 1998).Therefore, instead of assessing global capacities of emotional mental state talk, it might be more meaningful to examine different aspects of emotional mental state talk with different age groups and with different types of behavioral problems.

4.1.3. Exploring the Associations between Children's Emotional Mental State Talk and Their Abuse and Neglect Histories

Another aim of the study was to explore the association between children's emotional mental state talk and their adverse experiences of abuse and neglect. Results revealed that children with more adverse experiences of abuse and neglect used less emotional mental state words even though the association was at trend level. This finding was supported by several studies that suggested negative associations between children's emotion labeling and their abuse and neglect histories (Beeghly & Cichetti, 1994; Sullivan et al., 2008; Sullivan et al., 2010; Pears & Fisher, 2005; Rogosch et al., 1995; Shipman & Zeman, 1999; Shipman et al., 2000; Shipman et al., 2005; Edwards et al, 2005). This finding might be interpreted as children's inability to use their mentalization capacity in cases of abuse and neglect experiences. One explanation for this might be that in case of maltreatment such as abuse or neglect coming from attachment figures, these attachment figures might be unable to mentalize about their child reflectively. In other words, these caregivers might abuse or neglect their children without understanding their mental states such as feelings, thoughts, desires, etc. This inability to be a reflective parent may make it easier for them to abuse or neglect their children (Allen, Fonagy, & Bateman, 2010). In return, since their parental mentalization capacities were lower, their abused or neglected children might not be able to develop their own mentalization capacities as they cannot find a caregiver who treats the child as a psychological agent with his/her own mind.

Therefore, it may be difficult for these children to understand mental states behind any behavior as they lack the capacity of mentalizing (Allen et al., 2008). In addition, even though the child might be able to develop the capacity of mentalization, this capacity might be affected from these adverse experiences negatively. In cases of abuse and neglect experiences, children may find it difficult to trust caregivers or be curious about minds of others (Allen et al., 2010). Therefore, they may have a tendency of preventing themselves from understanding mental states behind abusive and neglectful behavior (Fonagy & Target, 1997; Fonagy et al., 2007). The reason for this kind of inhibition for mentalizing capacity is that it is too frightening for these children to think about the destructive and abusive minds of their caregivers as they fear from finding just fearful intentions. Moreover, children may use this inhibition as a protection mechanism for themselves as they cannot escape from the abusive or neglectful home environment (Fonagy & Target, 2000). Preventing themselves from mentalizing may allow them to tolerate these abusive behaviors of their caregivers in the expense of a deficit in their mentalization skill which may cause other psychopathologies in the future (Allen et al., 2008). This is in line with the literature that suggest that in case of attachment trauma, children may relapse into nonmentalizing modes where they have a tendency to experience the mind and the reality as equal to each other (psychic equivalence mode); to completely separate mind from the outside reality (pretend mode); or to evaluate physical actions as they are without thinking about the mind (teleological mode). In line with these explanations, it is meaningful for these children to have a difficulty in using emotional mental state words. As it was found in this study that these children's most frequently used emotion words include both positive and negative feelings of sadness, fear, anger, happiness and love, it might be said that these children do not have an inability for recognizing and labeling specific emotions. The main difficulty that they experience can be interpreted as their inhibition for using frequent emotional mental state terms. Another explanation that is specific to these children's poor ability for using emotional mental state words might be related to the nature of emotions. As opposed to other types of mental state talk

categories, emotional mental state terms are regarded as more complex and deeper (Pinto et al., 2017). Since the experiences of abuse and neglect are associated with several painful emotional states, poor capacity for labeling these intense emotions is thought to be more meaningful in the context of abuse and neglect. Children with these experiences may have a tendency to prevent themselves from experiencing painful emotions by inhibiting their emotional language and emotional mentalizing (Allen, 2005; Allen et al., 2010; Solomon, 2007). Even though the association between children's emotional mental state talk and their experiences of abuse and neglect is important for understanding these children's difficulties, this association was found at trend level in this study. An explanation for a trend level association might be related to these children's tendency for recognizing especially negative emotions as a result of angry and fearful figures who abuse or neglect them (Harris, 1999; Allen et al., 2008). This tendency to recognize negative feelings might also be seen in this study as these children's most frequently used emotion words were found as sadness, fear, and anger. Another reason might be that in case of abuse and neglect, these children may actually become resilient to traumatic experiences thanks to their mentalization capacity. This is usually seen when they experience abuse from the outside of their home environment and when they are able to find attachment figures to whom they can trust and depend on securely (Fonagy et al., 1991a; Sroufe, Egeland, Carlson, & Collins, 2005; Bifulco & Thomas, 2012).

4.2. Clinical Implications

The findings of this study indicate that children's emotional mentalization capacity may show differences when difficulties in different domains are considered. Children's emotional mentalization portrays a more complex picture regarding their strengths and difficulties in this capacity. Therefore, other than evaluating the global capacity for emotional mental state talk, it is more informative to understand children's use of positively and negatively valenced emotions, frequencies of these emotions, and also causal attributions of these

emotions. In this regard, assessing specific domains of emotional mentalization by focusing on children's production of positive and negative emotion language, their ability to explain causes of emotional mental states, and complexities of these emotions provides a more comprehensive picture for understanding these children's mentalization capacity.

With respect to strengths of children's emotional mentalization, children produced more positive emotional mental state talk when their mothers' reflective functioning levels increase. Therefore, it might be informative for clinicians to initially understand mothers' reflective functioning capacities during the psychotherapy process of children. This understanding may enable clinicians for evaluating emotional mentalization capacities of children and for focusing on increasing the balance for negative and positive emotions during the psychotherapy process for those children whose mothers' reflective functioning levels are lower. Besides, when the narratives of a mother and her child with low level of reflective functioning was examined, it was seen that the mother made inappropriate attributions to the mind of her child, was unable to make connections between different mental states and to see positive and negative sides of the relationship. Her child, on the other hand, told a very limited story without making any attributions to mental states or specifically to emotions. This example might be useful for clinicians to understand the effect of low maternal reflective functioning levels on children's narratives, play themes, representational styles and relations with therapists during the psychotherapy process. By understanding these effects, clinicians may use a more reflective and mentalizing stance while working with these children to treat them as psychological beings, to attribute mental states to their minds, and to make them recognize emotions underlying their play structure. On the other hand, focusing on mentalization-based strategies during parent sessions might increase mothers' reflective functioning levels which in turn have positive effects on children's emotional mental state talk.

With respect to difficulties of children on emotional mentalization in the context of aggressive and rule-breaking behaviors, it was revealed that children made less causal explanations when their aggressive and rule breaking behaviors

were high. Assessing emotional mentalizing skills before starting to psychotherapy process and understanding their deficit for making causal links can be informative for working with children who have especially externalizing behavior problems. With this understanding, clinicians may focus on increasing these children's ability to make causal explanations for their emotions during the sessions by enabling them to see alternative explanations for any kind of behaviors. It would also be beneficial to make these children understand negative impacts of behaviors, or results of these behaviors on others and to make them recognize emotional mental states underlying their aggressive behaviors. Since this difficulty is in line with externalizing children's difficulties in empathy, another target of clinicians while working with these children may be to increase their empathic skills with perspective taking interventions.

Lastly, even though the negative association between children's emotional mental state talk and their adverse experiences of abuse and neglect was found at trend level, this association might also be indicative for clinicians while working with children who have trauma histories. Traumatic experiences of abuse and neglect may lead to deficits in mentalization such as inhibition of mentalization and preventing themselves to think about mental states of others. These deficits of mentalization is in line with these children's limited uses of emotional mental state talk as talking about emotions might be more difficult and frightening for these children. Therefore, clinicians might benefit from assessing these children's mentalization capacities before starting to psychotherapy process. Their first target during the process might be to establish a trust relationship with these children because children who expose to adverse experiences especially in their attachment contexts may find it difficult to trust others and thus, to attribute mental states in these relationships (Allen, 2013). Therefore, the aims of clinicians might be establishing a trusting environment in which it is safe to understand and reflect on mental states of the self and the other, and then to promote mentalizing about emotions while working with children who have abuse and neglect histories.

4.3. Limitations and Future Research

This study has several limitations. First of all, even if the sample size of the study can be regarded as substantial, it is also relatively small. Further studies with larger sample sizes might be better for understanding the association of children's emotional mental state talk with maternal reflective functioning, children's behavior problems and their abuse and neglect histories. Specifically, larger sample sizes would be better for generalizability of results for the relations between emotional mental state talk, maternal reflective functioning and externalizing problems. Besides, it would also be better for understanding the association between emotional mental state talk, children's abuse and neglect histories, and internalizing problems as this study revealed less or no significant results between these variables.

The aim of this study was to examine the relation of children's emotional mental state talk with other variables in a clinical population. In this regard, future studies may also examine these associations in non-clinical populations. Making comparisons between clinical and nonclinical groups for their capacities of mentalizing, children's behavioral problems and their adverse experiences would be more comprehensive for interpreting the associations between these variables among clinical and nonclinical samples.

Considering the assessment of mentalization capacities of mothers and children, there are also some limitations. Although the Reflective Functioning assessment with the Parent Development Interview was suggested to be very informative for understanding maternal reflective functioning levels, this assessment reveals a global score for each participant. As this study focused on children's emotional mentalization capacity, assessing mothers' emotional mentalization with a content-specific task would be more indicative to interpret the relations between mothers' and childrens' mentalization capacities. It would also be better to focus on specific questions of the PDI that focus on understanding positive and negative emotional states of both mothers and their children as described by mothers. Besides, narratives of mothers on the PDI can

also be assessed qualitatively in order to understand their distorted representations which in turn may lead to problem behaviors in their children (Schechter et al., 2008). Furthermore, while the language capacities of children were controlled in the present study, mothers' language capacities were not controlled. Since language is important for understanding the minds of others (Astington & Baird, 2005; Gocek et al., 2008), future studies may also consider assessing mothers' mentalization levels by controlling their language capacities. Regarding the mentalization assessment of children, on the other hand, this study focused on assessing children's emotional mentalization capacity with a mental state talk assessment. It would be better for future studies to assess children's emotional mental state talk more specifically by focusing on simple and complex emotions, self-oriented and other-oriented, and positive and negative emotions. Besides, there are several emotional expression words such as laugh, hug, cry that might be informative to examine for understanding children's emotional language (Bretherton & Beeghly, 1982). Since this study relied on the frame of the CS-MST, emotional expression words were not taken into consideration as these words are coded under the action-based mental state words in the CS-MST (Bekar, 2014). Future studies might also benefit from examining children's emotional expression words along with emotional mental state words as these words might especially be suggestive for younger children whose emotional language capacity is not as developed as older ones.

Moreover, this study focused on assessing children's explicit emotional mental state talk by using the Attachment Doll Story Completion Task. Even though this task is very suggestive for understanding children's explicit mentalization capacities especially in their attachment relationships, some emotional mental state words of children were actually elicited by the theme of these stories. Besides, it would have been difficult for some children, especially for children with dismissive attachment style, to produce emotional mental state talk during these attachment specific stories or for others, with preoccupied attachment style, who have a tendency to exaggerate the use of emotional mental state talk. Since attachment security was not controlled or examined in this study,

examining its effect on children's mentalization capacity, as these two concepts are strongly related to each other (Fonagy et al., 1991a), would be beneficial for future studies. On the other hand, future studies might also assess children's emotional mental state talk implicitly with natural observations, mother-child play sessions, or nonverbal behavior observations and might compare children's explicit and implicit capacities of emotional mentalization. Lastly, mentalization capacities of both mothers and their children were assessed in this study with questions or stories which may be considered as stressful contexts. Since it can be more difficult to use the capacity of mentalizing in stressful contexts, future studies may consider using contexts where mothers and children may feel more relaxed (Gocek et al., 2008).

With respect to the assessments of children's behavior problems and their adverse experiences, this study relied on mother reports. Since understanding and assessing internalizing behavior problems are not as easy as externalizing behavior problems, using several measures for the assessment of these behavior problems such as child reports, teacher reports, or clinical evaluations of therapists might be more informative for future studies. Besides, sharing the traumatic experiences of their children openly on a parent report before starting to a psychotherapy process might have been difficult for mothers for several reasons. Therefore, assessing children's adverse experiences of abuse and neglect during the psychotherapy process with clinical interviews or with clinical evaluations of therapists might be more suggestive to interpret the results for abuse and neglect since parents or children would feel more secure to open themselves.

4.4. Conclusion

The aim of this study was to investigate the relation of children's emotional mental state talk to maternal reflective functioning, children's behavior problems, and children's abuse and neglect histories. Firstly, the relations between children's total emotional mental state words and maternal reflective functioning, children's internalizing, externalizing, and total behavior problems, and children's

abuse and neglect histories were examined. Secondly, children's emotional mental state talk subcategories of positive and negative emotional mental state words, unique uses of positive and negative emotional mental state words, and causal emotional mental state words were used for further analysis with the purpose of exploring their associations with maternal reflective functioning; children's behavior symptoms of anxiety, depression, somatic complaints, aggression, and rule-breaking behaviors; and children's abuse and neglect histories.

In sum, findings of this study revealed a significant positive association between children's use of positive emotional mental state words, with frequency and diversity, and maternal reflective functioning levels; and a significant negative association between children's use of causal emotional mental state words and aggressive and rule-breaking behaviors. Besides, a trend-level negative association between children's total emotional mental state talk and their abuse and neglect histories was found. On the other hand, children's total emotional mental state talk was not found to be significantly associated with maternal reflective functioning levels, and with children's behavior problems.

These findings of the study suggested that rather than examining the global capacity of children's emotional mentalization, a microlevel analysis for different categories of emotional mentalization might reveal more informative results for children's different types of difficulties and strategies. Therefore, these findings contributed to the literature as being a preliminary study for understanding different capacities of emotional mentalization among children with different strategies based on levels of maternal reflective functioning, aggressive and rule-breaking behavior and abuse and neglect histories.

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APPENDIX A: Child Behavior Check List for Ages 1.5-5 (CBCL/1.5/5)

ÇOCUĞUN;
Cinsiyeti: ___ ERKEK ___ KIZ
Yaşı: ____
Doğum Tarihi: GÜN___AY___YIL_____
Kreşe, anaokuluna gidiyor mu? ___ HAYIR ___EVET
(Okulun adı: ___________)

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

FORMU DOLDURAN:
___ Anne
___ Baba
___ Diğer (Çocukla olan ilişkisi: _____________________________________)

Çocuğunuzun davranışlarıyla ilgili bu formu lütfen görüşlerinizi yansıtacak biçimde yanıtlayınız. Her bir madde ile ilgili bilgi verebilir ve 2. sayfadaki boşluklara yazabilirsiniz. Lütfen bütün maddeleri işaretlemeye çalışınız.

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.

APPENDIX B: Child Behavior Check List for Ages 6-18 (CBCL/6-18)

ÇOCUĞUN;
Cinsiyeti: ___ ERKEK ___ KIZ
Yaşı:
Doğum Tarihi: GÜN___AY___YIL_______
Sınıfı: ______ Okula devam etmiyor ____

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

FORMU DOLDURAN:
___ Anne
___ Baba
___ Diğer (Çocukla olan ilişkisi: ____________________________________)

Çocuğunuzun davranışlarıyla ilgili bu formu lütfen görüşlerinizi yansıtacak biçimde yanıtlayınız. Her bir madde ile ilgili bilgi verebilir ve 2. sayfadaki boşluklara yazabilirsiniz. Lütfen bütün maddeleri işaretlemeye çalışınız. Teşekkür ederiz.

I. Çocuğunuzun yapmaktan hoşlandığı sporları a, b, c şıklarına yazınız. Örneğin: Yüzme, futbol, basketbol, voleybol, atletizm, tekvando, jimnastik, bisiklete binme, güreş, balık tutma gibi.
___ Hiç yok.

Çocuğunuz her birine ne kadar zaman ayırır?

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

Çocuğunuz her birinde ne kadar başarılıdır?

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

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

___ **Hiç yok.**

Çocuğunuz her birine ne kadar zaman ayırır?

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

Çocuğunuz her birinde ne kadar başarılıdır?

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

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

___ **Hiç yok.**

Çocuğunuz her birinde ne kadar başarılıdır?

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

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

___ **Hiç yok.**

Çocuğunuz her birinde ne kadar başarılıdır?

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

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

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

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

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

VI. Yaşıtlarıyla karşılaştırıldığında çocuğunuzun:

a. Kardeşleriyle arası nasıldır?

Kötü	Normal Sayılır	Oldukça İyidir	Kardeşi Yoktur
O	O	O	O

b. Diğer çocuklarla arası nasıldır?

Kötü	Normal Sayılır	Oldukça İyidir	Kardeşi Yoktur
O	O	O	O

c. Size karşı davranışları nasıldır?

Kötü	Normal Sayılır	Oldukça İyidir	Kardeşi Yoktur
O	O	O	O

d. Kendi başına oyun oynaması ve iş yapması nasıldır?

Kötü	Normal Sayılır	Oldukça İyidir	Kardeşi Yoktur
O	O	O	O

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

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

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

e. _________________________	O	O	O	O
f. _________________________	O	O	O	O
g. _________________________	O	O	O	O

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

O Hayır O Evet – Ne tür bir sınıf ya da okul? _________________

3. Çocuğunuz hiç sınıfta kaldı mı?

O Hayır O Evet – Kaçıncı sınıfta ve nedeni ____________________

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

O Hayır O Evet – açıklayınız ____ ___________________________

Bu sorunlar ne zaman başladı? _ ___________________________________

Sorunlar bitti mi?

O Hayır O Evet – Ne zaman?

Çocuğunuzun herhangi bir bedensel hastalığı ya da zihinsel engeli var mıdır?
O Hayır O Evet – açıklayınız _____________________________________

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

Çocuğunuzun en beğendiğiniz özellikleri nelerdir?

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

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

0 1 2 1. Yaşından çok çocuksu davranır.
0 1 2 2. Anne babanın izni olmadan içki içer.
0 1 2 3. Çok tartışan bir çocuktur.
0 1 2 4. Başladığı etkinlikleri (oyunu, dersleri, işleri) bitiremez.
0 1 2 5. Hoşlandığı ya da zevk aldığı çok az şey vardır.
0 1 2 6. Kakasını tuvaletten başka yerlere yapar.
0 1 2 7. Bir şeylerle övünür, başkalarına hava atar.
0 1 2 8. Bir konuya odaklanamaz, dikkatini uzun süre toplayamaz.
0 1 2 9. Kafasından atamadığı, onu rahatsız eden bazı düşünceleri vardır (mikrop bulaşma, simetri takıntısı, okul sorunları, bilgisayar gibi) (açıklayınız):
____
0 1 2 10. Yerinde sakince oturamaz, çok hareketli ve huzursuzdur.
0 1 2 11. Gereken gayreti göstermeden, sırtını tamamen büyüklere dayayıp her şeyi onlardan bekler.
0 1 2 12. Yalnızlıktan şikayet eder.
0 1 2 13. Kafası karışık, zihni bulanıktır.
0 1 2 14. Çok ağlar.
0 1 2 15. Hayvanlara eziyet eder.
0 1 2 16. Başkalarına eziyet eder, kötü davranır, kabadayılık eder.

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

0 1 2 a. Ağrı ve sızılardan yakınır (baş ve karın ağrısı dışında)
0 1 2 b. Baş ağrılarından yakınır (şikayet eder)
0 1 2 c. Bulantı, kusma duygusu olur
0 1 2 d. Gözle ilgili şikayetleri olur (Gözlük, lens kullanma dışında) (açıklayınız):____
0 1 2 e. Döküntü, pullanma ya da başka cilt hastalığı olur
0 1 2 f. Mide-karın ağrısından şikayet eder
0 1 2 g. Kusmaları olur
0 1 2 h. Diğer (açıklayınız): ___________________________________
0 1 2 57. İnsanlara vurur, fiziksel saldırıda bulunur.
0 1 2 58. Burnunu karıştırır, derisini ya da vücudunu yolar, saç ve kirpiğini koparır.(açıklayınız): ____
0 1 2 59. Herkesin içinde cinsel organıyla oynar.
0 1 2 60. Cinsel organıyla çok fazla oynar.
0 1 2 61. Okul ödevlerini tam ve iyi yapamaz.
0 1 2 62. El, kol, bacak hareketlerini ayarlamada güçlük çeker, sakardır.
0 1 2 63. Kendinden büyük çocuklarla vakit geçirmeyi tercih eder.
0 1 2 64. Kendinden küçüklerle vakit geçirmeyi tercih eder.
0 1 2 65. Konuşmayı reddeder.
0 1 2 66. İstemeyerek de olsa, belli bazı davranışları tekrar tekrar yapar (elini defalarca yıkama, kapı kilidini tekrar tekrar kontrol etme gibi) (açıklayınız): ____
0 1 2 67. Evden kaçar.
0 1 2 68. Çok bağırır.
0 1 2 69. Sırlarını kendine saklar, hiç kimseyle paylaşmaz.
0 1 2 70. Olmayan şeyleri görür. (açıklayınız):______________________
0 1 2 71. Topluluk içinde rahat değildir, başkalarının kendisi hakkında ne düşünecekleri ve ne söyleyecekleriyle ilgili kaygı duyar.
0 1 2 72. Yangın çıkartır.
0 1 2 73. Cinsel sorunları vardır. (açıklayınız): _____________________
0 1 2 74. Gösteriş meraklısıdır, maskaralık yapar.
0 1 2 75. Çok utangaç ve çekingendir.
0 1 2 76. Diğer çocuklardan daha az uyur.
0 1 2 77. Gece ve/veya gündüz diğer çocuklardan daha çok uyur. (açıklayınız): ____
0 1 2 78. Dikkati kolayca dağılır.
0 1 2 79. Konuşma problemi vardır. (açıklayınız):___________________
0 1 2 80. Boş gözlerle bakar.
0 1 2 81. Evden bir şeyler çalar.
0 1 2 82. Ev dışındaki başka yerlerden bir şeyler çalar.
0 1 2 83. İhtiyacı olmadığı halde birçok şey biriktirir. (açıklayınız): _______________
0 1 2 84. Tuhaf, alışılmadık davranışları vardır (eşyaların belli bir düzende ve sırada olmasını isteme gibi). (açıklayınız): _____________________
0 1 2 85. Tuhaf, alışılmadık düşünceleri vardır (bazı sayıları, sözcükleri tekrarlama ve bunları zihninden atamama gibi). (açıklayınız):_________________

0 1 2 86. İnatçı ve huysuzdur.
0 1 2 87. Ruhsal durumu ya da duyguları çabuk değişir.
0 1 2 88. Çok sık küser.
0 1 2 89. Şüphecidir, kuşku duyar.
0 1 2 90. Küfürlü ve açık saçık konuşur.
0 1 2 91. Kendini öldürmekten söz eder.
0 1 2 92. Uykuda yürür ve konuşur. (açıklayınız):____________________
0 1 2 93. Çok konuşur.
0 1 2 94. Başkalarına rahat vermez, onlara sataşır, onlarla çok dalga geçer.
0 1 2 95. Öfke nöbetleri vardır, çabuk öfkelenir.
0 1 2 96. Cinsel konuları fazlaca düşünür.
0 1 2 97. İnsanları tehdit eder.
0 1 2 98. Parmak emer.
0 1 2 99. Sigara içer, tütün çiğner.
0 1 2 100. Uyumakta zorlanır. (açıklayınız): ________________________________
0 1 2 101. Okuldan kaçar, dersini asar.
0 1 2 102. Hareketleri yavaştır, enerjik değildir.
0 1 2 103. Mutsuz, üzgün ve çökkündür (depresyondadır).
0 1 2 104. Çok gürültücüdür.
0 1 2 105. Sağlık sorunu olmadığı halde madde kullanır (içki ve sigarayı katmayınız) (açıklayınız): ____
0 1 2 106. Çevresindeki kişi ve eşyalara kasıtlı olarak zarar verir, zorbalık eder.
0 1 2 107. Gündüz altını ıslatır.
0 1 2 108. Gece yatağını ıslatır.
0 1 2 109. Mızırdanır, sızlanır.
0 1 2 110. Karşı cinsiyetten biri olmayı ister.
0 1 2 111. İçine kapanıktır, başkalarıyla kaynaşmaz.
0 1 2 112. Evhamlıdır, her şeyi dert eder.
113. Çocuğun yukarıdaki listede belirtilmeyen başka sorunu varsa lütfen yazınız:
0 1 2 ____
0 1 2 ____
0 1 2 ____

APPENDIX C: Adverse Childhood Experiences Questionnaire (ACE)

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 D: The Parent Development Interview (PDI)

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

A. Çocuk Hakkındaki Görüşler

1. Öncelikle, çocuğunuzun nasıl biri olduğuna dair biraz fikir sahibi olmak istiyorum. Çocuğunuzu tarif eden 3 sıfat/tanım/kelime seçerek başlayabilir miyiz? (Ebeveyn sıfatları sıralarken bekleyin.) Şimdi her sıfatın üzerinden geçelim. ____________ ile ilgili aklınıza gelen herhangi bir olay ya da anı var mı? (Her sıfatı inceleyip, o sıfat hakkında belirli bir anı öğrenin.)
2. Peki, şimdi çocuğunuza dönelim... Tipik bir haftada, onun yapmaktan hoşlandığı, vaktini ayırdığı şeyler nelerdir?
3. Ve en fazla problem yaşadığı şeyler nelerdir?
4. Çocuğunuzda en çok ne hoşunuza gidiyor?
5. Çocuğunuzda en az hoşlandığınız şey nedir?

B. Çocuk ile İlişkisi Hakkındaki Görüşler

1. Çocuğunuzla olan ilişkinizi yansıttığını düşündüğünüz 3 sıfat/tanım/kelime seçmenizi rica ediyorum. (Sıfatları sıralarken bekleyin.) Şimdi de bu sıfatların üzerinden geçelim. ___________ ile ilgili aklınıza gelen herhangi bir olay ya da anı var mı? (Her sıfatı inceleyip, o sıfat hakkında belirli bir anı öğrenin.)
2. Son bir hafta içinde, çocuğunuzla gerçekten iyi anlaştığınız bir anı anlatabilir misiniz? (Gerekirse şu sorular eklenebilir: Bana bu anıdan biraz daha bahsedebilir misiniz? Siz nasıl hissettiniz? Sizce çocuğunuz nasıl hissetti?)
3. Şimdi de, son bir hafta içerisinde çocuğunuzla iyi anlaşmadığınız bir anı anlatır mısınız? (Gerekirse şu sorular eklenebilir: Bana bu anıdan biraz daha bahsedebilir misiniz? Siz nasıl hissettiniz? Sizce çocuğunuz nasıl hissetti?)
4. Çocuğunuzla olan ilişkiniz, onun gelişimini ya da kişiliğini nasıl etkiliyor sizce?

C. Ebeveynlikte Duygusal Deneyim

1. Bir anne/baba olarak kendinizi tanımlayabilir misiniz?

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

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

4. Çocuğunuzla ilgili endişelendiğinizde en çok nelerden endişe duyuyorsunuz?

5. Çocuğunuzun olması sizi nasıl değiştirdi?

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

6a. Bu duygular, çocuğunuzu nasıl etkiliyor?

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

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

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

8a. Bu duygular, çocuğunuzu nasıl etkiliyor?

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

10. Çocuğunuzun, kendini hiç reddedilmiş hissettiği olur mu?

D. Ebeveynin Aile Öyküsü

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

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

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

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

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

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

E. Ayrılık/Kayıp

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

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

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

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

F. Geriye ve İleriye Bakış

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