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INTERACTION STRUCTURES IN PSYCHODYNAMIC PARENT  
TELE THERAPY SESSIONS DURING THE COVID-19 PANDEMIC:  
RELATIONS WITH PARENTAL REFLECTIVE FUNCTION AND  
EMOTIONAL DIALOGUES

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Interaction Structures in Psychodynamic Parent Teletherapy Sessions During the  
COVID-19 Pandemic: Relations with Parental Reflective Function and Emotional  
Dialogues

COVID-19 Küresel Salgın Sürecinde Psikodinamik Ebeveyn Çevrimiçi  
Seanslarındaki Etkileşim Yapıları: Ebeveyn Yansıtıcı İşleyiş Kapasitesi ve  
Duygusal Diyaloglar ile İlişkiler

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## ABSTRACT

COVID-19 pandemic had adverse impacts on mental health of adults, parents, and children. However, the course of psychotherapy sessions during the pandemic is not known yet. The first aim of the present study was to examine collateral parent sessions in psychodynamic child and adolescent teletherapy during the COVID-19 pandemic. Parent sessions are examined by the exploration of interaction structures which refer to repetitive relational patterns between the therapist and client. Interaction structures are identified by using Psychotherapy Process Q-Set (PQS) which is used to reveal specific characteristics of the adult psychotherapy processes. Secondly, the current study investigated whether interaction structure scores vary according to differences in mother's parental reflective functioning capacity which is defined as a parent's ability to contain her own and her child's mind and feelings. Lastly, the current study examined whether interaction structure scores vary according to differences in mother's capacity to form and guide emotional dialogues which is referred as one of the most important factors that enable mothers and children to cope with stressful or traumatic events. 20 mothers and children who were applied to Istanbul Bilgi University Psychological Center participated in the study and session data included 38 sessions of 20 parent-therapist dyads. The data was collected via Psychotherapy Research Laboratory at Istanbul Bilgi University between April – September, 2020. Mothers' reflective functioning capacity is assessed by Parental Reflective Functioning Questionnaire (PRF-Q) and capacity to form emotional dialogues is assessed by The Autobiographical Emotional Events Dialogue (AEED). Principal component analyses revealed four interaction structures in the psychotherapy processes of the mothers 1) Misattuned, distant, self-focused therapist with disconnected and misunderstood patient, 2) Sensitive and confident therapist with psychodynamic stance with expressive, independent, and confident patient, 3) Nondirective therapist with involved and introspective patient with positive expectations, 4) Supportive and accepting therapist with explorative patient. Results of the Mann Whitney-U and Kruskal-Wallis tests showed that

there is not a significant difference in averaged scores of four interaction structures according to mother's parental reflective functioning capacity and capacity to form and guide emotional dialogues. Interaction structures reveal psychodynamic features of parent sessions. Results of this study may help opening a newer page in understanding parent sessions. Also, this research could be a first step that help the understand the nature of teletherapy processes in COVID-19 pandemic.

*Keywords:* covid-19 pandemic, teletherapy, interaction structure, emotional dialogues, parental reflective function

## ÖZET

Birçok çalışma COVID-19 küresel salgınının yetişkinlerin, ebeveynlerin ve çocukların ruh sağlığı üzerinde olumsuz etkileri olduğunu ortaya çıkardı. Bununla birlikte, küresel salgın sırasında psikoterapi seanslarının nasıl şekillendiği henüz bilinmemektedir. Bu çalışmanın ilk amacı, COVID-19 küresel salgını esnasında yapılan psikodinamik çocuk ve ergen terapi süreçlerindeki çevrimiçi ebeveyn seanslarını incelemektir. Çevrimiçi ebeveyn seansları terapist ve danışan arasındaki tekrarlayan ilişkiel örüntüleri niteleyen etkileşim yapılarının araştırılmasıyla incelenmiştir. Seanslar esnasında tekrarlayan ilişkiel örüntüler yetişkin psikoterapi süreçlerini araştırmak için kullanılan Psikoterapi Süreci Q-set (PQS) kullanılarak belirlenmiştir. İkinci olarak, bu çalışma, bir ebeveynin kendisinin ve çocuğunun zihnini ve duygularını fark etme ve anlama becerisi olarak tanımlanan, ebeveyn yansıtıcı işleyiş kapasitesindeki farklılıklara göre etkileşim yapıları arasında bir fark olup olmadığını araştırmıştır. Son olarak, bu çalışma, annelerin ve çocukların stresli veya travmatik olaylarla başa çıkma ve başa çıkma becerilerini sağlayan en önemli faktörlerden biri olarak adlandırılan duygusal diyalogları oluşturma ve yönlendirme kapasitesindeki farklılıklara göre etkileşim yapıları arasında bir fark olup olmadığını incelemiştir. Katılımcıları 20 anne ve çocuk ikilisi oluşturmaktadır. 20 anne-terapist ikilisinin gerçekleştirdiği 38 seans incelenmiştir. Annelerin yansıtıcı işleyiş kapasitesi Ebeveyn Yansıtıcı İşleyiş Ölçeği (PRF-Q) ve duygusal diyaloglar oluşturma kapasitesi Otobiyografik Duygusal Olaylar Diyalogu (AEED) ile değerlendirilmiştir. Temel bileşenler analizi yoluyla dört anlamlı etkileşim yapısı ortaya çıkmıştır: 1) Uzak, kopuk, kendine odaklanan terapist ve anlaşılmasız danışan, 2) Psikodinamik bir duruş sergileyen, hassas ve kendine güvenen terapist ve dışavurumcu, bağımsız ve kendine güvenen danışan, 3) Yönlendirici olmayan terapist ve olumlu beklentileri olan iç gözlemsel danışan, 4) Destekleyici ve kabul eden terapist ve kendini keşfedebilen danışan, tespit edilmiştir. Mann Whitney-U ve Kruskal-Wallis testlerinin sonuçları annenin ebeveyn yansıtıcı işleyiş kapasitesine ve duygusal diyaloglar oluşturma ve rehberlik etme kapasitesine göre dört etkileşim yapısının

ortalama puanlarında anlamlı bir fark olmadığını göstermiştir. Bu çalışmanın sonuçları, ebeveyn seanslarını anlamak açısından literatürde yeni bir sayfa açmıştır. Ayrıca, bu araştırma COVID-19 küresel salgını esnasında yapılan çevrimiçi psikoterapi seans süreçlerinin doğasını anlamak için atılan ilk adım olmuştur.

*Anahtar kelimeler:* covid-19 küresel salgını, çevrimiçi terapi, etkileşim yapıları, duygusal diyaloglar, ebeveyn yansıtıcı işleyiş kapasitesi

## **CHAPTER 1**

### **INTRODUCTION**

New coronavirus disease (COVID-19) is declared as a global pandemic by World Health Organization (World Health Organization, 2020). This disease is caused by a severe acute respiratory syndrome coronavirus 2. Fever, cough, myalgia (muscle pain), fatigue and dyspnea (difficulty in breathing) are common symptoms of COVID-19 (Chan et al., 2020). At the present time there are more than 62.5 million approved cases across the world and 638 thousand in Turkey. Besides its physical effects, there are many psychological effects of the pandemic. The present study is the first to examine baseline mentalization level, and the quality of parent–child emotion dialogues among families during the pandemic. In the first phase of the present study, the baseline maternal reflective function capacity was assessed via the Parental Reflective Functioning Questionnaire (PRF-Q; Luyten et al., 2012) and the quality of emotional dialogues was assessed with Autobiographical Emotional Events Dialogue (AEED; Koren-Karie et al., 2003). Effect of COVID-19 pandemic on mothers will also be evaluated by The Impact of Events Scale-Revised (IES-R; Weiss and Marmar, 1997). In the second phase, using Psychotherapy Process Q-Set (PQS), collateral parent sessions of mothers in child and adolescent psychotherapy process were analyzed to determine specific interaction structures between therapists and mothers over the course of treatment. These structures reflect the unique relationship between these two parties. The relation between specific interaction structures, maternal reflective functioning capacity and quality of emotional dialogues was examined.

In the following section, literature on effects of COVID-19 pandemic on adults, children and parents will be reviewed. Next, two important capacities in stressful and traumatic situations; reflective functioning and ability to form coherent emotional dialogues will be discussed. The nature of psychotherapy process research will be described. Finally, the importance and effects of parental reflective functioning capacity and parental emotional dialogue capacity in psychotherapy process will be examined.

## **1.1.COVID-19 PANDEMIC**

### **1.1.1. COVID-19 Pandemic and Mental Health**

Gruber et al. (2020) described three characteristics of COVID-19 pandemic that have adverse impacts on mental health. First, they stated that it is an uncertain process and there is not a due date. It disrupts individuals' daily routines, and people are having difficulty supplying their immediate and future-oriented needs. Second, they mentioned the multidimensional feature of the process. It influences the person individually and it influences the household, educational, industrial and health systems. Third, it attacks the protective factors that lower the stress such as social relationships and behavioral activation due to precautions to control the spread of the virus such as lockdown and social distance (Gruber et al., 2020). Verdery et al. (2020) discussed the effects of COVID-19 on mental health from a different perspective. They focused on the sudden COVID-19 deaths and their impact on the population. They developed an indicator (COVID-19 bereavement multiplier) to reveal the estimated number of the individuals who will lose their relatives (grandmother or grandfather, parent, sibling, spouse, or child) because of COVID-19. Their results were striking. The indicator showed that nearly nine living Americans will lose a relative for every COVID-19 death. Created models imply that 190.000 Americans will die from COVID-19, which means that 1.7 million Americans will experience loss of a loved one without death ceremonies or rituals because of the COVID-19 restrictions (Verdery et al., 2020).

Qiu et al. (2020) found that COVID-19 pandemic triggered panic attacks, depression, and anxiety for many people. Mandatory quarantine status (MQS) was correlated with mental challenges (Brooks et al., 2020). It removes face to face social interactions. Lee et al. (2020) found that levels of loneliness increase between January and April/May. They also showed that there is an increase in depression symptoms. Luo et al. (2020) compared quarantined people with not

quarantined ones in their study. Self-harm or suicidal ideation, and emotional stress were considerably higher in quarantined people. Qiu et al. (2020) conducted a large-scale study in China. They collected data from 52730 participants and %35 of the participants stated that they experienced psychological distress during COVID-19 pandemic. Their research demonstrated that age, gender, occupation, and region are important factors in experienced distress. In accordance with previous research results, women participants reported more psychological stress than men in their research.

Prout et. al (2020) examined the predictors of psychological distress during COVID-19. They found gender, socioeconomic class, trauma history, somatization level and defense mechanisms to be important predictors. They showed that women give higher stress responses. Furthermore, people with higher numbers of ACE (Adverse Childhood Experiences) scores had higher self-reported anxiety, depression, and PTSD symptoms. They also found that high somatization and less reliance on adaptive defenses predicted higher anxiety, depression, and PTSD symptoms (Prout et. al., 2020). Alonzi et al. (2020) showed that women, nonbinary people, and people with previous physical and mental health conditions have higher levels of depression and anxiety during this process.

Simon et al. (2020) drew attention to the impact of this process on children and adolescents. They emphasized the importance of social support, national, cultural, and religious traditions in mourning processes. Social distance and isolation prevent these kind of rituals, and children and adolescents who lost a grandparent or relative cannot find a chance to say goodbye. They stated that this process and these sudden deaths of the loved ones harm the children's sense of a safe world, and restrictions make it difficult for them to cope with these losses (Simon et al., 2020). Golberstein et al. (2020) mentioned the importance of school closures in their study. They stated that 55 million US students are affected by school closures in this process. There are 18 million students in Turkey. These students did not go to school physically after the first closure in March 2020. There are no studies that investigate the effects of school closures on mental health in Turkey. However, it is shown that schools are important mental health

care systems for many children and adolescents in USA. 13% of adolescents benefited from a school mental health system in 2014 (Burns et al., 1995; Lipari et al., 2016).

Spinelli et al. (2020) examined the effects of COVID-19 pandemic on children and parent's well-being within a dyadic perspective. Their participants were parents whose children were 2-14 years old. Their measures were COVID-Contact Risk Index, Home Environment Risk Index, Quarantine Parent Risk Index, Parent's Dyadic Parenting Stress, Parent's Individual Stress and Children's Psychological Problems. Quarantine Parent Risk Index is a newly developed tool to assess how parents perceive the difficulties in the quarantine process. It includes 13-items with 7-point Likert scale. Parent's dyadic parenting stress was assessed with a subscale (Parent-Child Dysfunctional Interaction) of PSI (Abidin, 1995). Moreover, they measured children's psychological problems with Goodman's Strengths and Difficulties Questionnaire (SDQ) (Goodman, 2001). They found that parents' perception about COVID-19 played an important role in their own stress levels and their children's psychological problems. Their study revealed that parents who reported the changes that the pandemic has brought (constant stay at home, decreasing in special time for oneself and partner, homeschooling etc.) as more difficult experienced this period to be more stressful. They found that there was a significant correlation between the parent's stress level and the child's state of psychological well-being, and that child-parent mental health should not be considered separate from each other (Spinelli et al., 2020).

Lassri and Desatnik (2020) emphasized that mentalization-oriented work will be beneficial for children and families in this time, but there is no research that examines how this process shaped the mentalization based or psychodynamic work with children or parents.

Steele (2020) interpreted the COVID-19 pandemic from the perspective of attachment in his article. He mentioned two dominant theories about fundamental fears in human life. One is the theory of terror management (Greenberg et al., 1997) and the other is the theory of attachment (Bowlby, 1969). In addition, he

emphasized the importance of mentalizing what has been happening in this pandemic, noting that this will help emotion regulation and understanding possible pandemics or crises that will occur in the future (Steele, 2020).

### **1.1.2. Domestic Violence during COVID-19 Pandemic**

It is known that many restrictions are applied to control the spread of the Coronavirus, and that many adults, parents and children have been spending much longer hours together at home in a socially isolated manner. What has been happening inside the houses in this period is also an important matter. Mohler et al. (2020) examined the effects of social distancing policies on crime in Los Angeles, CA, and Indianapolis. It was shown that there has been a significant increase in the domestic violence calls between January and April (Mohler et al., 2020). A significant increase in domestic violence calls was also found in Australia (Kagi, 2020). Studies that indicate an increase in domestic violence cases have been published in many countries around the world. China, France, USA, UK, Italy, and Australia were some of these countries (Kagi, 2020; Allen-Ebrahimian, 2020; Davies & Batha 2020; France Reuters News Agency 2020; Wagers 2020; Kelly & Morgan 2020, as cited in Usher et al.,2020). Findings in Turkey are also similar with other countries. According to the statement of the Presidency of the Federation of Women's Associations of Turkey, physical violence increased by 80%, psychological violence by 93%, and application to women's shelter increased by 78% compared to the previous year in March 2020 (Ankara Metropolitan Municipality Women and Children Newsletter, May 2020, as cited in Ergönen et al., 2020). Another study was conducted with the participation of 1873 women living in 28 different cities by the Center for Socio-Political Field Research Center (Sosyopolitik Saha Araştırmaları Merkezi) between April 3-8, 2020. The results of this study showed that violence against women increased by 27.8% during the pandemic (Socio-Political Field Research Center Report, 2020, as cited in Ergönen et al., 2020). In addition, it was revealed that the number of female domestic violence patients in March 2020 who applied

to Dokuz Eylül University Medical School Emergency Department was 3 times higher than the same period in 2019 (Ergöner et al., 2020)

### **1.1.3. COVID-19 Research in Turkey**

In Turkey, the government response to the COVID-19 pandemic after March was to order a curfew, and intermittently announce general lockdowns in varying locations and periods of time. Schools were replaced by virtual classes, and there has been recurring closure of entertainment venues, e.g., shopping malls, bars, cafes, restaurants, theaters.

Doğan and Düzel (2020) investigated the effects of COVID-19 pandemic in Turkey. They collected data between March 20 and April 10, 2020. 95% of the respondents stated that they were afraid that their families would be infected. 92% of the respondents reported that they were afraid of being exposed to the virus in a crowded place. 60% of the respondents noted that the pandemic had poorly affected their mental health. These rates show that the epidemic caused fear and anxiety for many people in Turkey, too. In addition to the fact that people were afraid of being infected, they were also worried about their loved ones. This, in turn, seemed to increase the level of anxiety and fear and psychological difficulties. They examined the variation in fear and anxiety according to demographics. Men reported higher fear and anxiety than women and blue-collar workers reported higher fear and anxiety than white-collar ones. The significant difference in gender was contradictory with the previous literature. Unlike other studies, Erdoğan et al. (2020) included different variables in their study: hopelessness and perception about preventions. They investigated the anxiety and hopelessness levels in people during COVID-19 pandemic in Turkey. About one in 4 participants showed symptoms of anxiety and about one in 3 participants showed symptoms of hopelessness at moderate to severe levels. It was found that women's anxiety levels were significantly higher compared to men. Anxiety and hopelessness levels of participants who reported that health, economic and safety preventions at the regional level were not sufficient were higher compared to

participants who reported that they were sufficient (Erdođdu, Koçođlu & Sevim, 2020).

In addition, studies were conducted in Turkey showing how this period affected the home environment, parents, and children. Göl-Güven et. al. (2020) conducted a study with the participation of 323 parents with children between the ages of 4 and 12 from 39 different towns. In their research, 1 in 3 parents stated that they experienced negative emotions during COVID-19 restrictions. In addition, 41% of the parents who participated in the study stated that they were responsible for all needs of their children.

Mothers were found to be more responsible for the child's care during this process. 80% of parents stated that they were happy with their relationship with their child, meanwhile 12% were unhappy, and 8% were neither happy nor unhappy. Half of the parents involved in the study indicated that they were worried about the closure of schools and felt very inefficient in supporting their children in online education. Parents expressed that they had difficulty creating time for themselves and that they felt unhappy about it. Lastly, 41% of parents involved in the study stated that they felt helpless regarding their children's challenging behavior (Göl-Güven et al., 2020).

Başaran and Aksoy (2020), Yalçın et al. (2020) and Usta and Gökcan (2020) focused on the family environment in their studies. Başaran and Aksoy (2020) examined what changes appeared in children, parents, and the home environment during this period. They used a qualitative method and interviewed 26 parents. Their research revealed that parents had positive and negative experiences together during COVID-19 pandemic. It seems important to note that they conducted this experiment at the beginning of the limited lockdown period in Turkey (March 2020). The parents reported increasing communication among family members as a positive experience. They reported mental health difficulties, physical and educational problems as negative experiences. Mental health difficulties included increased parental stress, technology addiction and conduct problems in children (Başaran & Aksoy, 2020). Yalçın et al. (2020) also found that COVID-19 pandemic caused negative affectivity on children and parents.

They showed that parent's negative affectivity was positively correlated with children's stress levels. As parents' negative affective status increased, children's anxiety levels also increased (Yalçın et al., 2020). Moreover, Usta and Gökcan (2020) aimed to understand pre-school children's and their mothers' views about the Coronavirus. They also investigated the mothers' views about their children's opinions. They explored children's views and feelings about this pandemic with questions and children's paintings. Children stated that their information sources were their families, media, and teachers/school. All mothers stated that they experienced negative emotions such as anxiety, uneasiness, and distress. Children expressed negative feelings, such as bad and unhappy in response to the changes due to the pandemic. At the same time, some children stated that the process was strange and that they had ambivalent feelings. Although there were mothers who stated that their children were negatively affected by these changes, there have been those who expressed that their children were not negatively affected by this process and were happy to be together with their parent who was working outside of the house before the pandemic. In addition to the mothers who stated that their children did not experience behavioral changes, there were also those who noted that their children experienced technology addiction and restlessness or eating and sleeping problems (Usta & Gökcan, 2020).

## **1.2.IMPORTANT CAPACITIES IN THE CONTEXT OF STRESS AND TRAUMA**

### **1.2.1. Reflective Functioning Capacity**

As the studies described above show, the COVID-19 pandemic affected children, adults, and parents in various ways. Many studies demonstrate that this period has impaired individuals' mental health (e.g., Luo et al., 2020; Qiu et al., 2020; Prout et. al., 2020; Simon et al., 2020).

Since it is a unique and stressful process that harms mental health, it is very important to examine and structure psychotherapy processes to determine

what is beneficial for whom. Hence, it is necessary to address the important capacities that help people handle stressful situations.

There is research that examined psychotherapy sessions with child and adult patients with different levels of reflective functioning. It was shown that the needs and processes varied depending on the mentalization level (eg; Müller et al., 2006; Taubner et al., 2011; Katznelson, 2014; Halfon et al., 2017; Ramires et al., 2020). Hence, initially, I will define reflective function and parental reflective function, describe its development, and explain why it is important to assess the reflective functioning capacity during the COVID-19 process. Afterwards, the relationship of reflective functioning capacity and psychotherapy process will be discussed.

High reflective functioning capacity is generally linked with high resilience in studies (Fonagy et al., 1994; Berthelot et al., 2019; Ensink et al., 2014). Fonagy and Target (1997) consider reflective function as a tool that help people to organize their own and others' behaviors according to mental states. They mention that this function is the core of the self-organization because they stated that it is the central part of the emotion regulation, impulse-control, and one's ability to monitor oneself (Fonagy & Target, 1997).

#### **1.2.1.1. Development of Reflective Function**

Fonagy (1991) emphasizes that the development of reflective function depends on the relationship between the caregiver and the infant in the early period. If the infant's physical and emotional needs are met by his caregiver in accordance with his/her demands during this period, his reflective function capacity starts to develop. Fonagy (1991) emphasizes that the child's capacity for reflective function will develop if the caregiver reflects the child's mental experience back to the child in a way that the child can understand (Fonagy, 1991).

Fonagy, Steele, Steele et al. (1991) also examined the relationship between reflective function and attachment in their work. They emphasized that a warm

and caring understanding of the states of mind beneath needs and behaviors improves the capacity for reflective function. In fact, this warm and caring understanding is also considered to be the basis of secure attachment. Four different attachment styles in Bowlby's theory were measured by infants' responses to stress and absence of the caregiver. How the infant regulates this stress is the building stone in the attachment theory (Bowlby, 1969). Fonagy et al. (1991) also noted that only in such cases where children who are understood and whose mental state is reflected to them could have a secure attachment style. In other cases, children apply to different strategies to cope with stress, they noted, which are also examples of insecure attachment. Moreover, they expanded their work and investigated the transgenerational processes in resilience in the context of the attachment theory and mentalization (Fonagy, Steele, et al., 1991).

A large body of research show that deprivation, abuse, and neglect history of a parent is a risk factor for future problems in family life, mental health, and close relationships. Also, children of these parents are likely to have educational and psychiatric problems (Kaufman & Zigler, 1989; Egeland et al., 1988). Fonagy, Steele and Steele (1991) asked whether the mother's own attachment style predicted the form of attachment that would occur between her and her child before her child's birth. They analyzed the attachment style of the mother with the Adult Attachment Interview (George, Kaplan & Main, 1985). They also used strange situation paradigm to assess the attachment between the infant and mother in 12 months (Ainsworth & Witting, 1969; Ainsworth et al., 1978). One of their findings was that insecure attachment was transmitted intergenerationally. Further, they found that mothers who scored high on neglect and rejection were more likely to have insecure attachment with their child. Moreover, they found that there was a strong correlation between mother's reflective function and parent-infant attachment. (Fonagy, Steele & Steele, 1991)

They expanded this and investigated if reflective function was a protective factor for mothers with a history of abuse. They found that mothers who were good at mentalizing their child were able to establish secure bonds with their children despite their history of trauma (Fonagy et al. 1994). The overall goal of

these works was to present the relationship between attachment and reflective function. Their work suggests that there is strong relationship between reflective function and attachment style. It is also shown that reflective functioning is a core protective factor in the context of trauma.

### **1.2.1.2. Parental Reflective Function**

Meins et. al (1998) investigated the ability of mothers to acknowledge that their babies have a separate mind, and that babies also have an intention beneath their behavior. He named this skill as “mind-mindedness”. Mothers who had a secure attachment style were found to more accurately understand the intentions underlying their babies' behavior compared to mothers who had an insecure attachment style. Mothers ' mind-minded comments were found to be an important indicator of attachment style (Meins et al., 1998; Meins et al., 2001). Further, Meins et al. (2001) claimed that it was best to measure how much mental state words mothers used explicitly when making references to the child's mind. They emphasized the importance of using explicit mental state words while referencing to child's mind for the child's self-organization, emotion regulation and mother-child attachment (Meins et. al., 2001). Meins et al. (2002) found that the child's future performance of the theory of mind depended on the mother's early capacity for mind-mindedness. Also, they found that their mother's comments about the mind alone did not predict the child's future performance, but mind-minded comments about the child's mind were decisive in the child's performance in theory of mind tasks (Meins et al., 2002)

All these studies have illustrated the concept of parental reflective function. Parental reflective function is defined as the parent's ability to contain her own and her child's mind and feelings. This is referred to as a necessity for the development of a secure attachment and other healthy developmental consequences (Slade, 2005).

Slade (2005) also explained the relationship between reflective function and pathological conditions in her work. She stated that this capacity is a

cornerstone for the development of secure attachment. She added that when this capacity is problematic or inadequate in early parent-child relationship, it leads to psychopathologies that this child may have in the future. For example, she mentioned that when the mother's mind is preoccupied with traumatic and stressful experiences and she cannot separate the child's mind from her own, it will be very scary for the child's mind and problematic for the child's self-organization. She cannot mirror the child in a healthy way. She stressed that this frightening situation will also lead to the development of some nonadaptive defense mechanisms at an early stage, and the child will experience some difficulties in his/her future life. At the same time, Slade emphasized that the importance of this capacity is not limited to infancy. The child always needs to be mentalized in the mother-child relationship, in play or in conversations, to organize his or her own inner experience (Slade, 2005).

In Slade's research (2005), mothers were interviewed during pregnancy. Mothers whose attachment styles were classified as secure had a higher reflective functioning capacity when their children were 10 months old. In addition, their babies were found to have a secure attachment style when measured with the strange situation paradigm (Ainsworth & Witting, 1969) at 14 months of age (Slade, 2005). Many studies have shown a significant relationship between the reflective functioning capacity of the parent and the capacity to care for her child in a quality way, even in mother-child dyads in which child is experiencing clinical difficulties (Borelli et al., 2012; Huth et al., 2014; Stacks et al., 2014).

Many studies have also been conducted with school-age children and their parents to understand the reflective functioning capacity of the parent and its impact on the child (Esbjorn et al., 2013; Rosso et al., 2015; Scopesi et al., 2015; Ensink et al., 2015). A study by Esbjorn et al. (2013) showed that mother's low capacity in reflective functioning predicted anxiety in school-age children. The sample was a clinical one, and the children were referred for psychological treatment in their study. When they tested this relationship with fathers' reflective functioning capacity, they found that the father's reflective functioning capacity did not predict the child's anxiety (Esbjorn et al., 2013).

Rosso et al. (2015) investigated the effect of mother's own attachment style and her mentalization capacity on the child's mentalization capacity. The results showed that mother's mentalization capacity, rather than the mother's attachment style predicted the child's mentalization capacity in school-age children (Rosso et al., 2015). In another study, Scopesi et al. (2015) revealed a relationship between the mother's reflective functioning capacity and the use of mental state words in school-age children. Ensink et al. (2015) also found that there was a relationship between the school-age child's ability to reflect himself, understand emotions, intentions and thoughts beneath his own behavior and the mother's capacity for reflective functioning in their study (Ensink et al., 2015).

Halfon and Beşiroğlu (2020) investigated whether school age children's emotional and behavioral problems were negatively predicted by parental reflective functioning capacity. They measured parental reflective function by the Parent Development Interview-Revised (PDI-R; Slade et al., 2003). They examined PDI-R in two dimensions; child-focused PRF and self-focused PRF. They found that child focused PRF was negatively correlated with children's problem behaviors (Halfon & Beşiroğlu, 2020).

### **1.2.1.3.Trauma, Stress and Reflective Function**

Impairments occur in mentalization capacity in the context of the trauma. Edwards et al. (2005) showed that children who are exposed to maltreatment or abuse have difficulty in discrimination of emotions (Edwards et al., 2005). In another study with sexually abused girls, Shipman et al. (2000) found that when compared with their peers, sexually abused girls have difficulties in understanding emotions. These studies also showed that mentalization capacity is an active capacity. Bateman and Fonagy (2015) mentioned that mentalization capacity is dynamic and flexible, and in fact it is very much affected fundamentally by relational processes and related circumstances such as stress and high arousal (Bateman & Fonagy, 2015). Lassri and Desatnik (2020) explained how the mentalization capacity is affected in times of stress in their research. First, they

mentioned that when people experience very intense emotions, they return to the state of mind of an infant at the early period and cannot think that the opposite side's point of view may be different (*psychic equivalence*). Second, they noted that in these cases, people are unable to notice the states of mind underlying the behavior and they match the behavior of others with reality (*teleological mode*). Finally, they stated that people clung to emotional or cognitive narratives that are independent of reality in these cases (*pretend mode*) (Lassri & Desatnik, 2020).

#### **1.2.1.4.Improving Parental Reflective Function**

Slade (2007) explored how reflective functioning can be effectively improved when working with parents and children in clinical settings in her work. Parent's capacity to understand the emotions of herself and the child, their inner world, the mental processes that underlie behavior and the mental states itself makes an important contribution to the child's ability to regulate himself/herself effectively. It also develops the child's capacity to form healthy relationships (Fonagy et al., 2002; Slade, 2007).

When working with children and parents in the treatment process, it is necessary to transform the parent-child relationship and enhance the reflective function capacity of the parent for a more effective treatment (Slade, 2007). Oppenheim et al. (2004) found that improvements in children's internalizing and externalizing symptoms are possible only when the mothers' insightfulness increases in the therapy process. Zimmer-Gembeck et. al (2019) found that there is strong positive correlation between the improvement of the reflective function capacities of mothers and children's symptom reduction in parent-child interaction therapy.

Slade (2005; 2007) described how parents' reflective functioning capacities could be improved in clinical settings. She noted that the following stages are needed to develop reflective functioning:

- “Developing a reflective stance in the parent”,
- “Modeling reflectiveness”,

- “Facilitating wondering”,
- “Eliciting affect to mentalization”,
- “Holding the parent in mind”,
- “Working at a level the parent can manage”. (Slade, 2007, p. 643)

Developing a reflective stance is the first step in this development. This, in turn, refers to not only focusing on the child's behavior, but making the parent comprehend that there is an internal process underlying that behavior. Modeling reflectiveness indicates that the person working with the parent should show the parent a way of thinking by bringing up the emotional and mental processes behind the child's behavior. The foundation stone of the facilitating wonder step is the realization of the parent that parent and child's minds are separate. After this distinction is made, the most important part is making the parent curious about the child's experience. Eliciting affect to mentalization, in fact, means working with difficult situations and hot moments in a mother-child relationship exactly when these intense emotions are experienced. Holding the parent in mind suggests that the clinician should hold and regulate the mother in their dyadic relationship as therapist-mother. It emphasizes the fact that the mother's reflective functioning capacity will also improve in her relationship with the clinician. Last, the idea of working at a level the parent can manage indicates that reflective function is a complex process and starting with basics is essential (Slade, 2005; 2007).

The application of these steps has been found beneficial in some parenting programs (The Parents First Program; Goyette-Ewing et al. 2003; Slade 2007; Kalland et al. 2016; The Minding the Baby (MTB) Program; Slade, Sadler, et al. 2005; Sadler et al. 2013; New Beginning Program; Baradon et al. 2008; Sled et al., 2013). These intervention or prevention programs aimed to increase the mother's reflective functioning capacity to support the secure relationship between the child and the mother. For example, New Beginning Program was developed for mothers with borderline personality disorder by Baradon et al. (2008). They intended to increase the capacity of the mother to reflect on her own emotional states and her baby's emotional states as well. The results of a randomized control trial showed that reflective functioning capacities of the

mothers in the intervention group were higher than the mothers in the control group (Sleed, et al., 2013). Moreover, Minding the Baby (MTB) Program was developed for young mothers to support them by increasing their reflective functioning capacity for them to have a secure relationship with their infants. Results showed that mothers in the program got better at reflective functioning. In addition, they were able to form a secure attachment with their infants after the intervention (Sadler et al. 2013).

It is seen that reflective functioning capacity is a context related capacity that is harmed by stressful situations. Also, it is shown to be a protective factor in dealing with stressful and traumatic situations. A large body of research has also showed that it can increase in clinical settings.

COVID-19 process is described as very stressful and even traumatic for many people. Research has also showed that psychotherapy processes differ according to mentalization levels of the patients. However, there is no research that examines the processes and steps in parent psychotherapy sessions. The present study will bring together these findings and explore the baseline parental reflective functioning capacities of mothers during the COVID-19 pandemic. It will investigate whether collateral parent sessions of mothers in child and adolescent psychotherapy differ according to different parental reflective functioning capacities.

### **1.2.2. Capacity to Form Emotional Dialogues**

Emotional dialogues between the mother and the child are also one of the most important factors that enable them to cope with stressful or traumatic events. It was found that children whose mothers are able to construct elaborated, emotionally structured, and consistent dialogues have more secure internal working models (Bretherton & Munholland, 1999; Koren-Karie et al., 2003; Thompson, 2000, 2006; Waters & Cummings, 2000). Many studies have shown that attachment style plays a crucial role in creating narrative. Research based on Adult Attachment Interview (AAI) shows that adults with a secure attachment

style can create narratives that are more coherent and emotionally embedded than others (Crowell et al., 1999; Main et al., 1985; Pillemer, 1998).

A large body of research examined the relationship between attachment style and emotional dialogues. Hsiao et al. (2015) evaluated both mother's own attachment style and the child's attachment style in their study. The mother's attachment style was assessed with Adult Attachment Interview (AAI; George, Kaplan & Main, 1996). Children's attachment style was evaluated by using the Strange Situation Procedure (Ainsworth & Witting, 1969). Mother-child dyads with disorganized attachment style were unable to establish coherent emotional dialogues. It turned out that the dialogues of secure/autonomous mothers were coherent with their children. Children with a secure attachment style also showed a higher level of cooperation than others. In other words, the results of this study revealed a significant relation between attachment styles and emotional dialogues (Hsiao et al., 2015).

In one of the first studies that examined the relationship between emotional dialogues and attachment, it was found that child-mother dyads that had a secure attachment style during infancy had more emotionally expressive and fluid stories than insecure mother-child dyads (Strage & Main, 1985). Another study found that mothers who had the capacity to tell more elaborated and fluid stories were found that that they had more secure attachment style with their children (Fivush & Vasudeva, 2002).

Pennebaker (1997) stated that the way stressful events are explained is an important predictor for emotional and physical well-being. The results of his research showed that adults who described stressful events in more emotional and expressive ways were emotionally and physically in a better condition than others (Pennebaker, 1997).

Fivush (2007) mentioned that talking about particularly stressful and difficult situations makes the child feel safer. It helps him/her understand why and how things happen. In this way, the child can regulate himself more easily. In her study, she emphasized that it is very important how the mother communicates with her child about what they have experienced. She noted that how the event is

spoken and conveyed are very important for reinterpreting and making sense, especially in the shared experiences of the mother and child. She noted that children make sense of their own experiences through the framework formed by the parent. Through this framework, children create an autobiographical discourse. She emphasized that autobiographical discourse is also very important for a person to define himself/herself alone and in relationships, and in addition, to regulate himself/herself. Results of her study showed that mother's elaboration is very important for the child's narrative. Children whose mothers were more elaborative and sensitive when communicating could explain themselves in a more elaborated and coherent way, which is an important factor for emotion regulation. Also, results showed that mother-child's dyad emotional dialogues were related with attachment style. Dyads that were more securely attached formed more elaborated stories especially when talking about emotions (Fivush, 2007). Furthermore, it was found that children whose mothers told negative experiences in a more elaborated and emotional way were better at regulating emotions and had fewer internalizing and externalizing problems (Fivush & Sales, 2006; Sales & Fivush, 2005).

Gentzler et al. (2005) studied mother-child and father-child dyads. Their sample consisted of 75 school-age children and their parents. In this study, mother-child and father-child dyads were asked to explain an event that upset the child. The dialogues were encoded according to the following subdomains: parental acceptance, emotional encouragement, and child emotional openness. Child coping mechanisms were also included in the research via parental report. Results showed that emotionally open communication, parental acceptance, and encouragement are important for children to develop healthy coping mechanisms (Gentzler et al., 2005).

Ellis and Alisic (2013) also completed a work with mother and child dyads. Participants were 46-58-month-old children and their mothers in the study. However, these children were referred to the maltreatment service and considered to be traumatized. In this study, participants had two tasks to complete. One of the tasks was to together tell a story about which the child had recently been upset.

The other task was one in which the child participated alone, causing the child to become disappointed. It turned out that children whose were emotionally coached by their mother better regulated their emotions in a healthier way even though they have a traumatic experience (Ellis & Alisic, 2013).

The dialogue between the mother and the child is also affected by traumatic experiences (van Delft et al., 2018; DeVoe & Smith, 2002; Banyard et al., 2003; Overbeek et al., 2019). When the parent has a traumatic experience or going through a distressing process, this makes it difficult to support his/her child. However, it is emphasized that talking about traumatic and difficult situations is important for the child to have a healthy emotional and psychological development. It is important to make sense of these processes with emotionally meaningful and elaborated conversations, especially when there is a difficult situation such as domestic violence or sexual abuse (Wolf, 2003; Koren-Karie et al., 2004). How the children make sense of their own emotional experiences and whether they are able to express these experiences properly are also influenced by the parental attitudes. Children whose parents focus on their experiences and sensitively guide and support them to explore their inner world can create more comprehensible and structured narratives than others (Thompson, 2006; Bretherton & Munholland, 1999).

Overbeek et al. (2019) compared the emotional dialogues of mother-child dyads who were exposed and not exposed to a traumatic situation. The traumatic situation that mothers and children were exposed was interpersonal violence in their research. 213 trauma exposed mother-child dyads' emotional dialogues were compared with those of 86 non-trauma exposed one's dialogues. The quality of the dialogue between mother and child was measured using Autobiographical Emotional Events Dialogue (AEED; Koren-Karie et al., 2003). Coherence and adequacy subdomains of AEED were used for assessment. The results of the study revealed that mother-child dyads who had a traumatic experience told less coherent and elaborative stories than others. Mothers who were subjected to a traumatic experience were found to focus more on themselves than on the child when telling stories (Overbeek et. al., 2019).

Koren-Karie et al. (2008) investigated the effects of the mother's analysis of her own traumatic processes. They determined whether the mother's own traumatic experiences had been resolved or not by using Berkeley-Leiden Adult Attachment Questionnaire (BLAAQ-U; Main et al., 1993). They examined the dialogues between 33 mother-child dyads in the following 3 areas using AEED (Koren-Karie et al., 2003): Mothers' Sensitive Guidance, Child Cooperation and Exploration, and Coherent Narrative. It was found that mothers who resolved their own traumatic experiences guided the child more sensitively during emotional dialogues, and that their children scored higher in the child cooperation and exploration sub-area (Koren-Karie et al., 2008).

It is seen that the emotional dialogue between the mother and the child is very important for child's psychological development. Trauma-focused cognitive behavioral therapy (TF-CBT; Cohen et al., 2012), which is an effective approach when working with children exposed to traumatic events (eg: Deblinger et al., 2011; Mannarino et al., 2012) puts emphasis on developing a narrative about traumatic experiences, so the emotional dialogues are important in that context. However, there is no research that examined the importance of that capacity in COVID-19 pandemic and psychodynamic psychotherapy process. The present study will be the first to examine the effect of mother-child dyad's capacity to form an emotional dialogue, the mother's capacity to guide the child during the emotional dialogue and the overall characteristics of the dyad on collateral parent sessions in child and adolescent psychotherapy during COVID-19 pandemic.

### **1.3.PSYCHODYNAMIC PSYCHOTHERAPY & PSYCHOTHERAPY PROCESS RESEARCH**

Psychodynamic psychotherapies are effective in treating emotional disorders, disruptive disorders, depression, obsessive compulsive disorders etc. (see for reviews; Midgley & Kennedy, 2011; Midgley et al., 2017). There are many studies that show that psychodynamic psychotherapies are effective on children and adolescents with post traumatic symptoms (Lush et al., 1998;

Trowell et al., 2002; Heede et al., 2009; Gilboa-Schechtman et al., 2010). Trowell et al. (2002) randomly assigned sexually abused girls in the 6-14 age range to 2 groups. Individual psychodynamic psychotherapy sessions lasting 30 sessions were performed with the girls in one of the groups. 18 sessions of psychoeducational group psychotherapy were performed with the other group. Both processes were found to reduce the girls' symptoms of post-traumatic stress disorder (Trowell et al., 2002). Heede et al. (2009) also examined the effects of two-years psychodynamic psychotherapy on children aged 6 to 15 with traumatic histories such as early deprivation. Results showed that children improved in emotional functioning and self-expression and had healthier defense mechanisms.

All these studies show that psychodynamic therapy is effective when working with children and adolescents, and the techniques of psychodynamic work are well-known. Basic techniques are focusing on emotion and the way emotions are expressed, focusing on the attempts to suppress the painful feelings and emotions, exploring recurrent patterns, understanding the past experiences, exploring close relationships, giving importance to therapy relationship, and revealing dreams and fantasies (see for a review; Shedler, 2010).

However, there are very few studies that reveal how the psychotherapy process is shaped with parents in child and adolescent psychodynamic therapy processes. It is shown collateral parent sessions in child and adolescent psychodynamic psychotherapy generally emphasize the child's inner world (Slade, 2008; Midgley et al., 2017). Verheugt-Pleiter et al. (2008) framed the parent work in mentalization-based psychotherapy in their study. They stated that the most important factor is forming a cooperative relationship with parents in the parent sessions. They mentioned that mentalization is a context-related capacity, therefore it is important to form a secure and comfortable relationship with parents for mentalization to be possible. They specified four goals that are important in working with parents:

- 1) Making the parent realize that what is essential is the inner experiences of the parent and the child.

2) Working with the parent to develop the parent's capacity to observe and understand the child's internal processes.

3) Working through what is happening between the therapist and parent in the parent sessions genuinely.

4) Developing an attuned relationship between parent and therapist, understanding, and repairing misattunements.

However, there are no studies that examined the collateral parent sessions in child and adolescent psychotherapy. Hence, the application of these objectives is not properly known.

### **1.3.1. Psychotherapy Process Research**

Although the techniques and methods are determined, psychotherapy process research is carried out in order to be able to scientifically examine the techniques and structures in individual psychotherapy sessions. Process research allows to determine the differences between sessions that depend on different psychotherapy schools. At the same time, specific interaction structures which refer to the unique relationship features that have their own characteristics between the therapist and client are identified. Interaction structures that occur when working with different treatment modalities and different types of therapists and clients are identified within the process research. Also, main factors that bring about the therapeutic change are revealed. Moreover, the processes that affect psychotherapeutic work are discovered as a result of process research (Jones & Pulos, 1993; Ablon & Jones, 2005; Ablon et al., 2006).

One of the most common methods used to examine sessions is Psychotherapy Process Q-Set (PQS; Jones, 2000). PQS has been used to examine adult psychotherapy sessions, and after the creation of PQS, Child Psychotherapy Process Q-Set and Adolescent Psychotherapy Process Q-Set was developed respectively to evaluate the child and adolescent sessions (CPQ; Schneider & Jones, 2004; APQ; Bambery et al., 2007). PQS consists of 100 items that refer to

the therapist's attitudes, the client's attitudes, behaviors, feelings and the relationship between the therapist and the client during the session.

Another benefit of process research is to be able to determine what kind of interventions are applied and what is good for clients with different capacities. The starting point for this was based on extensive research by Fonagy and Target (1998). In their study, they compared the psychotherapy processes of children with more complex pathologies to children with smoother pathologies at the Anna Freud Center. As a result, they found that children with complex pathologies benefited less from the traditional psychodynamic approach. They noted that the main difference between these two groups, basically, were the mentalization capacities (Fonagy & Target, 1998).

Sharp and Venta (2013) stated that different mentalization capacities lie at the heart of different disorders in their study. However, there are few studies on how these different mentalization capacities shape and influence therapy processes. There is research that examined psychotherapy sessions with child and adult patients with different levels of mentalization. It is shown that the needs and processes differ when the mentalization levels change (eg; Müller et al., 2006; Taubner et al., 2011; Katznelson, 2014; Halfon et al., 2017; Ramires et al., 2020).

Halfon et al. (2017) examined the therapeutic processes of two children whose mentalization capacities were at different levels. The process of the child with lower mentalization skills was found to be more dissimilar to the classical psychodynamic approach and she made less progress after psychotherapy.

Ramires et al. (2020) examined psychodynamic psychotherapy processes of school-aged children with different mentalization capacities. They used CPQ to evaluate 273 psychotherapy sessions. Their sample included three children and their therapists. They found that different interaction structures emerged between the therapist and the child according to mentalizing profiles even though all were psychodynamic treatments. They found that therapists became more directive when the mentalization shut down in the sessions. They also found that when the patient had more resources, the therapist's technique was closer to psychodynamic approach. The results and different interaction structures in their study suggest

that therapists need to adapt their techniques according to different mentalization capacities (Ramires et al., 2020).

Müller et. al. (2006) investigated the relationship between the reflective function and structure axis of Operationalized Psychodynamic Diagnostics (OPD). Structure axis of OPD includes ego functions related to subject and object: self-perception, self-regulation, defense; object perception, communication, and attachment. Their sample included 24 female adult patients aged between 18 to 55. The patients were diagnosed with eating and depressive disorders. Participants' reflective functioning capacities and scores on structure axis of OPD were assessed with a 90-minute interview at the beginning of the three-month-psychotherapy process. Results showed that RF explained 26% of the variance in structure axis of OPD. Hence, it is seen that six ego functions and RF have a great deal in common. Also, it was seen that self-perception and better communication skills were associated with RF. Lastly, they revealed that RF predicted change in psychic organization within the three-month psychodynamic psychotherapy (Muller et. al., 2006).

Moreover, Taubner et al. (2011) investigated the psychoanalytic psychotherapy process of patients with chronic depression. They explored the role of reflective function in the process. They found that RF predicted reduction in general stress after 8 months of psychotherapy. Also, they revealed that patients with higher RF were better at forming therapeutic alliance with the therapist than patients with lower RF (Taubner et al., 2011).

Hence, it is seen that reflective function is an important factor in adult and child psychotherapy processes. However, there is not a tool or research that examines the processes in the collateral parent sessions in child and adolescent psychotherapy. There is only one study that examines parent sessions in Regulation Focused Psychodynamic Psychotherapy for children (RFP-C; Hoffman et al., 2016; Kufferath-Lin et al., 2021). Their first aim was to understand the least and most characteristic features of parent psychotherapy sessions in regulation focused psychodynamic psychotherapy. Second, they aimed to compare the characteristics of parent sessions with existing adult psychotherapy

process literature. Last, they intended to compare the characteristics of parent sessions with child sessions. They used CPQ (Child Psychotherapy Process Q-Set) to explore child sessions and PQS (Psychotherapy Q-Set) to examine parent sessions. Children were aged 5 to 12 in their study. There were 49 parent sessions. Results showed that parent sessions had common characteristics with an ideal cognitive behavior therapy (CBT) process prototype, reflective functioning (RF) and supportive expressive therapy (SET) process prototypes. It was seen that characteristics of parent sessions were not related with psychoanalytic therapy prototype. In addition, the strongest correlation was with the cognitive behavior therapy (CBT) process prototype. Moreover, it was revealed that the most characteristic feature of the therapists in the parent sessions were being supportive, empathic, and nonjudgmental. Also, the most uncharacteristic features of the therapists were being condescending and aloof (Kufferath-Lin et al., 2021).

### **1.3.1.1. Interaction Structure Studies: A Dyadic Perspective in Psychotherapy**

Interaction structures represent the unique relationship features between therapists and clients in psychotherapy sessions. They refer to repetitive relational patterns between the therapist and client (Jones, 2000). Interaction structures reveal the dyadic aspect of the psychotherapy process. There are some studies that have revealed different interaction structures between therapists and clients by using PQS and CPQ. Some studies examined the interaction structures in child psychodynamic psychotherapy process (eg; Goodman & Athey-Lloyd, 2011; Goodman, 2015; Halfon et al., 2020; Ramires et al., 2020). For example, Halfon et al. (2020) examined interaction structures in child psychodynamic psychotherapy. They coded 192 sessions of 52 children using Child Psychotherapy Q-set (CPQ). Results revealed four interaction structures that focused on therapeutic alliance, emotional expression, child centered and psychodynamic technique. They found that psychodynamic technique predicted symptom reduction (Halfon et al., 2020). Goodman and Athey-Lloyd (2011) investigated whether there was a difference between interaction structures in a

child's sessions with different therapists. They found that interaction structures differed when the therapist changed. Their results suggest that psychotherapy process is a dyadic process that is affected by patient and therapist (Goodman & Athey-Lloyd, 2011).

There are also studies that have examined interaction structures in adult psychotherapy using PQS. Ablon and Jones (2005) examined three different psychotherapy processes. First, they found that psychoanalysis is closer to ideal psychoanalytic treatment process than others. Later, they compared interaction structures in two different psychoanalysis sessions. They found that each client-therapist dyad had its own unique and different model of relationship even though the sessions were completed with the same treatment approach (Ablon & Jones, 2005).

In another study, Goodman et al. (2014) identified interaction structures in 127 sessions of five patients with borderline personality disorder (BPD) in psychodynamic psychotherapy. Their results revealed four specific interaction structures. They named the first interaction structure as "collaborative relationship with supportive, reassuring therapist", second one as "therapist empathic attunement", third one as "erotized therapeutic relationship" and fourth one as "directive therapist with compliant patient" (Goodman et al., 2014, p.23). For instance, first interaction structure included items that described therapist characteristics such as being supportive, being neutral and assuring the patient. Second interaction structure included items such as being sensitive, perceiving the therapeutic process and helping the patient to experience the emotions deeply.

Furthermore, Serralta (2016) identified five different interaction structures in short term adult psychodynamic psychotherapy; IS1: "resistance", IS:2 "alliance", IS3: "facing depression", IS4: "expectation of change", and IS5: "introspection" (Serralta, 2016, p.257). Similarly, interaction structure 2 included items that described therapist characteristics such as being sensitive, perceiving the therapeutic process and being neutral. Differently, interaction structure 4 included items such as discussing treatment goals and conveying positive expectations.

Laskoski et al. (2019) examined the interaction structures in long term adult psychotherapy. The patient in their study was diagnosed with a chronic disease and also had somatic complaints. They analyzed 113 sessions of the patient and identified four specific interaction structure. They found that there were interaction structures focusing on exploring negative emotions, strengthening alliance, therapeutic relationship, and physical signs.

Dandre'a and Pole (2012) examined the psychotherapy process of trauma survivors within a naturalistic design. Their participants were 27 women with violence histories. They utilized PQS to examine sessions and understand techniques that therapists benefited. Their results showed that clients whose therapists benefiting more from psychodynamic techniques were better improved in PTSD symptoms (Dandre'a & Pole, 2012).

Studies that are mentioned below showed that interaction structures differ across adult and child psychotherapy sessions. It is also shown that they also differ according to different pathologies, client characteristics and therapist characteristics. However, there is not a study that examined the interaction structures in collateral parent sessions in child and adolescent psychotherapy.

#### **1.4.TELEMENTAL HEALTH**

When considering the COVID-19 process and related protective or supportive mental health interventions, it is also important to emphasize that almost all mental health related services have been carried through online platforms or phone calls because of the restrictions or risks in this process. Performing psychotherapy or assessment sessions or any other related services through videoconferences, phone calls or texting is called telemental health (Hilty et al., 2013; Jones et al., 2014; Siemer et al., 2011; Madigan et al., 2020).

Considering the increased mental difficulties and stress in this process, this can be a very useful way to start or continue to receive psychological help in the time of COVID-19. Some studies highlighted the advantages and disadvantages of telemental health services during COVID-19 (Madigan et al., 2020; Racine et al., 2020). Advantages included receiving psychological support without risking

physical health and accessing mental health services that one does not have access physically in his/her area. However, it is also noted that there may be disadvantages such as not accessing the services one needs because of not having an internet connection or the necessary devices. In addition, home environment may not be suitable for the psychotherapy process, or the person may not feel comfortable because of the confidentiality related issues at home, problems can occur about the privacy in online platforms. Last, children or even adults may have difficulty in focusing on screen (Madigan et al., 2020; Racine et al., 2020).

Another important point to consider is that COVID-19 is a traumatic process for many people, and whether telemental health services are effective in traumatic situations. Although there were no studies conducted directly with parents in the literature, Stewart and colleagues (2017) investigated whether it would be effective to utilize Trauma-Focused Cognitive Behavior Therapy (TF-CBT) to reduce children's PTSD symptoms through telemental health services. Results showed that PTSD symptoms decreased as it did in (?) in-person therapy. In addition, telemental health services appeared to reduce drop-out rates (Stewart et. al., 2017).

Comer et al. (2015) conducted a study to assess the effectiveness of Parent-Child Interaction Therapy (PCIT). The sample included 3-5 years old children and their parents in their study. They found that PCIT was also effective when applied through telemental health services. It led to a decrease in children's symptoms and increase in positive parental engagement (Comer et al., 2015). However, there is no research that examined how the therapeutic process or relationship is affected in online psychotherapies. The present study will also be the first study that examines an online psychotherapy process during COVID-19 pandemic.

## **1.5.CURRENT STUDY**

Many studies have shown that the therapy processes of clients with different capacities are distinct, although working with same psychotherapy approaches. However, there is only one study conducted with parents that

examines the therapy process. Many studies have revealed the effects of the COVID-19 process on parents and children. At the same time, research has shown that mentalization capacity, trauma history, and the ability to form qualified emotional dialogues are important when dealing with stressful situations. It is known that these different capacities, especially different mentalization profiles, require different interventions and form different kinds of interaction structures in child and adult psychodynamic therapy processes. However, there is not a study that examines the structures that occur between the parent and therapist in the child psychodynamic psychotherapy process.

The first step of the present study will be examining the baseline mentalization level of mothers and the quality of mother–child emotional dialogues during COVID-19 pandemic. Reflective functioning capacity of the mothers is assessed via the Parental Reflective Functioning Questionnaire (PRF-Q; Luyten et al., 2017). The quality of emotional dialogues between mother-child dyads and dyadic characteristics will be evaluated with Autobiographical Emotional Events Dialogue (AEED; Koren-Karie et al., 2003). Effect of COVID-19 pandemic on mental health will be evaluated with The Impact of Events Scale-Revised (IES-R; Weiss and Marmar, 1997).

Secondly, using Psychotherapy Process Q-Set (PQS), teletherapy sessions of mothers will be analyzed to determine specific interaction structures. The relation between specific interaction structures, maternal reflective functioning capacity and quality of emotional dialogues will be examined.

It will be explored whether there will be meaningful interaction structures between therapists and mothers in parent sessions as shown in adult psychotherapy process research (e.g., Ablon & Jones, 2005; Goodman et al., 2014; Serralta, 2016)

To explore the relation between interaction structures and quality of emotional dialogues, sensitive emotional guidance, and emotionally coherent narrative scores of AEED (Koren-Karie et al., 2003) will be divided into two categories as low and high. Then, it will be explored that if there will be a difference in interaction structure scores between low and high categories. It will

also be explored whether there will be a difference in interaction structure scores between AEED classifications; emotionally matched, emotionally unmatched-flat, and emotionally unmatched-exaggerated.

Lastly, scores of three subscales of PRF-Q; pre-mentalization modes, certainty, and interest and curiosity will be divided into two categories as low and high. It will be explored that whether there will be a difference in interaction structure scores between low and high categories.

## **CHAPTER 2**

### **METHOD**

#### **2.1. DATA**

The data in the current study was collected via Psychotherapy Research Laboratory at Istanbul Bilgi University. Studies were carried out to better understand the mechanisms of psychotherapy sessions at the laboratory. Psychodynamic psychotherapy was offered to people who applied for psychological support. Psychotherapists were master level clinical psychology students.

Psychodynamic play or talk therapy was conducted for children aged 3 to 17, with the inclusion criterion being that the child had no psychotic symptoms, no severe developmental delays, no substance abuse, and no significant suicide risk. Parents were told about the research and given informed consent to participate in the study if they met the inclusion criteria. Research participation was voluntary and withdrawal from the research was possible in the process. For the present study, data from children, adolescents or parents who got psychotherapy in 2020 May-June was used. The research where the data came from was approved by the Istanbul Bilgi University Ethics committee.

#### **2.2. PARTICIPANTS**

20 (40% male, 60% female) children and their mothers who were referred to Psychological Counseling Center participated in this study. Children were aged between 5 to 13 ( $M = 7.90$ ,  $SD = 2.22$ ), and the mothers were aged between 30-51 ( $M = 38.68$ ,  $SD = 6.08$ ). See Table 2.1 for detailed information.

**Table 2.1.***Demographic Characteristics of Participants*

<b>Variables</b>	<b>Categories</b>	<b>Frequency (N)</b>	<b>Valid Percentages (%)</b>
Child's Age	5-9 Years Old	15	75
	10-13 Years Old	5	25
Child's Gender	Female	8	60
	Male	12	40
Mother's Age	30-40 Years Old	12	57.9
	40-51 Years Old	8	43.1
Socioeconomic Level	Low	3	15
	Low - Middle	3	15
	Middle	11	55
	Middle - High	3	15
Marital Status	Married	16	80
	Divorced / Other	4	20
Mother's Working Status	Working	10	50
	Not Working	10	50
Mother's Education Level	Elementary School	3	15
	Middle School	2	10
	High School	5	25
	University (2 Years)	1	5
	University (4 Years)	9	45
Child's Education Level	Preschool	1	5

	Elementary School	15	75
	Middle School	4	20
Sibling	No Sibling	6	30
	1 Sibling	12	60
	2 Siblings	2	10
Reason of Referral	Anxiety Related Problems	10	50
	Behavioral Problems	5	25
	Learning – School Related Problems	2	10
	Adjustment Problems	1	5
	Relationship Problems	1	5

*Note.*  $N=20$ .

### 2.3. THERAPISTS

Therapists (70% female; %30 male) in this study were Clinical Psychology master students in their first or second internship years. They were between the ages of 24 and 37 ( $M = 26,95$ ,  $SD = 3.84$ ). All therapists had the same theoretical background. They were trained to apply psychodynamic psychotherapy with mentalization principles. All the therapists got one hour of individual supervision and three hours of group supervision per week as a requirement of their master's degree in their first year. Those who preferred to continue their internship in the second year got one hour of individual supervision. Supervisors were licensed psychotherapists who had at least 10 years of experience. Therapists treated approximately five children/adolescents during their education as a requirement.

## **2.4. THERAPY SESSIONS**

Psychotherapy process within the context of Psychological Counseling Center (PDM) have a certain structure. Child therapy process begins with an intake session with mother and father. The process continues with Parent Development Interview (PDI; (Aber et. al., 1985)) with each parent. Then, mother-child, father-child and child play sessions are conducted, respectively. Finally, the therapist has a feedback session with the mother and father, and therapy process begins. A similar process is applied in adolescent psychotherapy, only at the beginning of the adolescent therapy process, mother-child and father-child play sessions are not held. Therapists arrange a parent session once in a month. Therapists follow the psychodynamic therapy school with mentalization principles (Verheugt-Pleiter et al., 2018) during the therapy process in accordance with their educational background. For each child/adolescent, the parent, child/adolescent, and therapist decide termination time. Sessions of 15 parents who continued the therapy process during pandemic and five parents who started the therapy process after the pandemic were used in this study. These sessions were conducted through online platforms such as Zoom or Skype due to the risks caused by the pandemic. During the transition period to the online therapy process, parents were informed about the online therapy conditions (room, confidentiality, privacy etc.) Procedures that were applied at PDM (parent-child play sessions, monthly parent sessions etc.) were applied to parents who started the process online in the pandemic.

## **2.5. MEASURES**

### **2.5.1. Parent Measures**

#### **2.5.1.1. Demographic Information**

Demographic information such as age, education, socioeconomic level, and marital status was acquired by using a standard intake form and from information obtained in the initial intake interview.

#### **2.5.1.2. Information about the Exposure Level of COVID-19 Pandemic**

It is obtained through a questionnaire. Parents are answered questions about the quarantine days, the effect of COVID-19 pandemic on their working conditions, financial situation, physical and psychological health (see Appendix A).

#### **2.5.1.3. The Impact of Events Scale-Revised (IES-R; Weiss and Marmar, 1997)**

IES-R is a self-report measure that is used to assess the effect of a traumatic event. In this research, traumatic event was considered as the COVID-19 pandemic. Participants were asked to answer the questions considering COVID-19 pandemic. Items were rated on a 5-point scale ranging from 0 ("not at all") to 4 ("extremely"). IES-R has three subscales and 22 items in total (see Appendix B)

1. Intrusion (e.g., I thought about it when I did not mean to)
2. Avoidance (e.g., I tried not to think about it)
3. Hyperarousal (e.g., I felt irritable and angry)

IES-R has high levels of internal consistency for all subscales; intrusion ( $\alpha = .87 - .94$ ), avoidance ( $\alpha = 0.84 - 0.87$ ) and hyperarousal ( $\alpha = 0.79 - 0.91$ ) and test-retest reliability ( $r = 0.89-0.94$ ). IES-R was adapted to Turkish by Çorapçioğlu et al. (2006) with high levels of internal consistency ( $\alpha = 0.93$ ) and good test-retest reliability ( $r = 0.70$ ). Internal consistency level is also high in the present study for the total score ( $\alpha =$

0.91). It also has good levels of internal consistency for all subscales; intrusion ( $\alpha = .0.85$ ), avoidance ( $\alpha = 0.75$ ) and hyperarousal ( $\alpha = 0.72$ ).

#### **2.5.1.4. The Parental Reflective Functioning Questionnaire (PRF-Q; Luyten et al., 2017)**

PRF-Q is a self-report measure that assess reflective functioning capacity of the parent. It consists of 18 items which are ranked on a 7-point Likert scale (1 = “*strongly disagree*” to 7 = “*strongly agree*”). It has three subscales:

1. Pre-Mentalizing Modes (e.g., “When my child is fussy, he or she does that just to annoy me”)
2. Certainty about Mental States (e.g., “I always know why my child acts the way he or she does”)
3. Interest and Curiosity (e.g., “I like to think about the reasons behind the way my child behaves and feels”)

Each of the subscales measures a different component of parental reflective functioning. At the pre-mentalizing modes and certainty about mental states subscales, higher scores indicate difficulties in reflective functioning. However, a higher score in the last one refers to a better mentalizing ability. Luyten et. al. (2017) reported good internal consistency for each of the PRF-Q subscales ( $\alpha = 0.70$ ,  $\alpha = 0.82$ , and  $\alpha = 0.74$ , respectively). Turkish adaptation of the subscale s completed by research team in Psychological Counseling Center (PDM) under the supervision of Sibel Halfon, PhD (see Appendix D).

Internal consistency scores of the subscales were 0.092, 0.80 and 0.37, respectively in the current study. Hence, only Certainty about Mental States subscale ( $\alpha = 0.80$ ) is applied in further analyses.

#### **2.5.2. Dyadic Task: The Autobiographical Emotional Events Dialogue (AEED; Koren-Karie et al., 2003)**

This task required the participation of mother-child or father-child dyads together. The researcher showed the dyad 5 feeling cards; sad, scared, happy, feeling safe

and angry. The dyad was expected to describe an event in which the child felt these feelings. For example, a mother-child or father-child dyad described an event in which the child felt angry when they choose the angry card. The dyad could start by choosing the emotion they wanted and moved forward the way they chose. During the task, researcher was obliged to show emotion cards without interfering. The task did not have a time limit.

After the task was completed, the dyad's dialogues were transcribed. These dialogues were scored between 1 and 9 based on 7 parallel parent-child subscales. Higher scores in sub-areas except boundary dissolution and hostility sub-areas indicate better capacity (See Appendix C).

The maternal subscales are:

1. *Shift of focus* (Higher scores indicate that the mother is task-oriented, does not give unnecessary details and does not get off the point. Lower scores indicate the opposite situations which the mother gives unnecessary details and get off the point.)
2. *Boundary dissolution* (Higher scores indicate that the mother does not perceive the child as a separate individual with his/her own feelings and desires. It can also imply that there is role reversal between the child and the mother. Lower scores indicate that the mother perceives the child as a separate individual and boundaries are clear.)
3. *Acceptance and tolerance* (Higher scores indicate that the mother accepts and does not criticize the stories the child wants to tell and acknowledges the feelings. Lower scores indicate the opposite situation in which the mother is judgmental and insensitive.)
4. *Hostility* (Higher scores indicate that the mother is angry with the child and has a negative attitude during the task. Lower scores indicate the opposite situation.)
5. *Involvement and reciprocity* (Higher scores indicate that the mother supports and encourages the child to tell stories and the mother actively contributes to stories. Lower scores indicate that the mother does not active and has no interest in the task.)

6. *Closure of negative feelings* (Higher scores indicate that when the dyad describes an event related to negative emotions (sadness, anger, and fear), the mother is able to reveal the positive parts and emphasize the strong sides of the child in that event. Lower scores indicate that the mother did not link the event to a positive conclusion or further exaggerates the negative emotion.)
7. *Structuring of the interaction* (Higher scores indicate that the mother organizes and structures the dyad's storytelling. Lower scores indicate that the mother cannot configure the process, especially when the child needs it.)

The child subscales are:

1. *Shift of focus* (Higher scores indicate that the child is task-oriented and does not get off the point. Lower scores indicate the opposite situations that the child gives unnecessary details and getting away from the subject.)
2. *Boundary dissolution* (Higher scores indicate that the child does not perceive the mother as a separate individual with her own feelings and desires. It can also imply that there is role reversal between the child and the mother. Lower scores indicate that the child perceives the mother as a separate individual and there are clear boundaries.)
3. *Acceptance and tolerance* (Higher scores indicate that the child accepts and acknowledges the feelings. Lower scores indicate the opposite situations in which the child is judgmental and insensitive.)
4. *Hostility* (Higher scores indicate that the child is furious and has a negative attitude during the task. Lower scores indicate the opposite situation.)
5. *Cooperation and reciprocity* (Higher scores indicate that the child is active and cooperative. Lower scores indicate that the child has no interest in the task.)
6. *Resolution of negative feelings* (Higher scores indicate that the child can resolve the stories that includes negative emotions with positive endings. Lower scores indicate that the child insists on negativity and even enhance negative feelings.)

7. *Elaboration of the stories* (Higher scores indicate that the child can actively elaborate the dyad's storytelling. Lower scores indicate that the child is not able to create and organize the stories.)

In addition, there are two scales that is used to score the overall narrative:

1. *Adequacy of the story* (Higher scores imply that stories are matched with the target emotions in four or five stories. Lower scores indicate that there is a confusion about the target emotion and the event that the dyad tells.)
2. *Coherence* (Higher scores indicate that the dyad is involved and tells appropriate and clear stories. Lower scores imply that the dyad does not able to construct appropriate stories or the stories are bizarre or confused.)

Furthermore, dialogues are categorized into four different classifications.

Classification systems:

1. Emotionally Matched

Dyads that fall into this category have a high capacity to describe an emotional event together. The dialogue is not dominated by one of the partners, and they are both actively involved in the task. These dyads are generally scored higher on *shift of focus, acceptance and tolerance, involvement and reciprocity and closure/resolution of negative feelings*. Quas and Fivush (2009) noted that children in mother and child twos that fall into this category position their mother as a psychological secure base and are able to explore comfortably (Quas & Fivush, 2007).

2. Emotionally unmatched – Exaggerated.

The main features of the stories of the dyads that fall into this category are that they are unstructured, incoherent, negatively charged and containing a lot of unnecessary details. The mother is unable to regulate the child by closing negative stories with a positive ending and the dyad can be distracted, hostile, and non-cooperative.

3. Emotionally unmatched – Flat

The main features of the stories of dyad in this category are that they are short and poor in content. Mother and child are not involved in the task. Mother does not encourage the child to participate, emotions are not explained in a detailed way.

#### 4. Emotionally unmatched – Inconsistent

The main feature of the dyads in this category is the mismatch between them. For example, one of the partners may be very active and inclined to the task, while the other may be very diffused, unwilling, and hostile.

Three collective dialogue scores are established based on the AEED rating scales. These are:

*Maternal Sensitive Guidance* (It is calculated based on the mean score of all the maternal scales. Hostility and boundary dissolution scales are inverted so that higher scores indicate lower hostility and boundary dissolution.)

*Child Cooperation and Exploration* (It is calculated based on the mean score of all the child scales. Hostility and boundary dissolution scales are inverted so that higher scores indicate lower hostility and boundary dissolution.)

*Emotionally Coherent Narrative* (It is calculated based on the mean score of the two narrative scales: *adequacy of the story* and *coherence*.)

Higher scores on these composite AEED scale scores reflect more optimal dialogues. Cronbach's coefficient alpha indicates good internal consistency of the composite scores ( $\alpha = 0.80$  for the maternal sensitive guidance;  $\alpha = 0.83$  for the child cooperation and exploration;  $\alpha = 0.91$  for the emotionally coherent narrative) (Koren-Karie et al., 2008).

Cronbach's coefficient alpha was in an acceptable level in the present study ( $\alpha = 0.68$  for the maternal sensitive guidance score;  $\alpha = 0.73$  for the emotionally coherent narrative score).

In the present study, six master level clinical psychology students were trained by Sibel Halfon, PhD who is in cooperation with Nina Koren-Karie, Ph.D. They coded training sessions until they reached the ICC of .70. Later, mother-child dialog transcripts are randomly assigned to reliable pairs. Aim of the study is not known by the coders. Scores were calculated by averaging two ratings of each

transcript. Interrater reliabilities of codings ranged between .71 to .97 ( $M = 0.89$ ,  $SD = 0.06$ ).

### **2.5.3. Therapy Process Measure: The Psychotherapy Process Q-Set (PQS; Jones, 2000)**

The Psychotherapy Process Q-Set (PQS; Jones, 2000) is one of the most important tools used in adult psychotherapy process research. It is used to reveal specific characteristics of the psychotherapy process, to investigate the characteristics of different modalities, and to explore common and different characteristics. PQS consists of 100 items that describe the therapist's attitudes, the client's attitudes, behaviors, feelings and the relationship between the therapist and the client during the session. Interrater reliability across items ranged between 0.83 and 0.89 (Ablon et al., 2011). For each encoded session, these 100 items were placed in nine categories in an ipsative forced-choice procedure. This procedure reveals the most and least characteristics of the session.

In the present study, because there is no other tool to investigate parent sessions, PQS was used to examine parent sessions in the child/adolescent psychotherapy process, which is a novel application of the tool. No items were added or removed to protect the integrity. The items that mentioned patient were coded as referring to parent (e.g., “Parent expresses, verbally or non-verbally, negative feelings toward therapist”; “Therapist is sensitive to the parent's feelings, attuned to the parent; empathic”). The coding of the items that were not specified by any subject included parent, child, or adolescent (e.g., “Self-image is a focus of the session”; “Memories or reconstructions of infancy and childhood are topics of discussion.”)

Another novelty in the present study was the use of PQS for the first time to investigate the online therapy process. Sessions that took place in May-September 2020 during the COVID-19 pandemic were coded. These sessions were carried out via online platforms such as Zoom or Skype because of the restrictions or risk factors. PQS encoders reached an agreement on the adaptation of items to the online process before coding. Comments including the parent's

coming out from the camera's point of view or turning the camera on and off were encoded as a characteristic feature of *Item 2* (“*Therapist draws attention to patient's non-verbal behavior, e.g. body posture, gestures, tone of voice*”). Also, it was decided that disagreements caused by connection problems should not be coded as a characteristic feature of *Item 5* (“*Patient has difficulty understanding the therapist's comments*”). The parent's desire to carry out the session face-to-face or her expression of longing the session room was coded as a characteristic feature of *Item 10* (“*Patient seeks greater intimacy with the therapist*”).

In the present study, six master level clinical psychology students were trained by Sibel Halfon, Ph.D who was trained by Geoffrey Goodman. Coders encoded training sessions until they reached the ICC of .70. Later, parent session transcripts were randomly assigned to reliable pairs. Aim of the study was not known by the coders. Scores were calculated by averaging two ratings of each transcript. Interrater reliabilities of codings ranged between .71 and .97 ( $M = 0.89$ ,  $SD = 0.06$ ).

## **2.6. PROCEDURE**

Approval was obtained for this research from clients who continued the psychotherapy process during April 2020 and who applied to PDM for psychotherapeutic support after April. A consent form was given, and master's level research assistants completed a Zoom meeting with mothers and children. Initially, the mothers completed the scales which was sent through a Qualtrics link in the presence of the assistant. After that, mother and child dyads completed Autobiographical Emotional Event Dialogues task (AEED; Koren-Karie et al., 2003). The emotion cards of AEED were shown in screen and parents and children were asked to tell stories as in the instruction. This online meeting was recorded and transcribed for coding. The sessions were also performed through online platforms such as Zoom. Later, the sessions that were conducted after this meeting were recorded, transcribed, and coded by educated research assistants.

## **2.7. DATA ANALYSIS PLAN**

A principal components analysis by the item scores of Psychotherapy Process Q-set (PQS; Jones, 2000) on SPSS will be conducted to reveal interaction structures between therapists and parents. After that, sensitive emotional guidance, and emotionally coherent narrative scores of AEED (Koren-Karie et al., 2003) will be divided into two categories as low and high. Then, Mann Whitney-U tests will be performed to reveal the differences of interaction structures on different low and high categories. Also, Kruskal Wallis Tests will be conducted to reveal the differences in interaction structures between AEED categories; emotionally matched, emotionally unmatched-flat, and emotionally unmatched-exaggerated. Lastly, scores of three subscales of PRF-Q; pre-mentalization modes, certainty and interest and curiosity will be divided into two categories as low and high. Then, Mann Whitney-U tests will be conducted to reveal the differences of interaction structures in low and high categories.

## **CHAPTER 3**

### **RESULTS**

#### **3.1. DESCRIPTIVE ANALYSIS**

Descriptive statistics for Parental Reflective Functioning Questionnaire (PRF-Q), Impact of Events Scale-Revised (IES-R) and The Autobiographical Emotional Events Dialogue (AEED) is displayed in the Table 3.1 with minimum and maximum scores, means, and standard deviations.

**Table 3.1**

*Descriptive Statistics for Parent Reflective Functioning Questionnaire (PRF-Q), Impact of Events Scale-Revised (IES-R) and The Autobiographical Emotional Events Dialogue (AEED)*

<b>Measures</b>	<b>M</b>	<b>SD</b>	<b>Minimum</b>	<b>Maximum</b>
<b>PRF-Q (N=19)</b>				
Certainty About Mental States	25.94	7.90	15	42
<b>IES-R (N=19)</b>				
Intrusion	.92	.96	.00	4
Avoidance	1.17	1.52	.00	7
Arousal	.99	1.61	.00	7
Total Score	3.09	4.01	.00	18
<b>AEED (N=16)</b>				
Maternal Sensitive Guidance	6.05	.62	4.71	7.29
Child Cooperation and Exploration	6.13	.93	4.36	7.57
Emotionally Coherent Narrative	6.54	.85	5.00	8

*Note.* PRF-Q refers to Parent Reflective Functioning Questionnaire. IES-R refers to Impact of Events Scale – Revised. AEED refers to Autobiographical Emotional Events Dialogue.

Also, mothers answered some questions about family's conditions in the COVID-19 process and effects of the pandemic. All mothers (100%) stated that they did not have to separate from their child in this process. None of them had a chronic illness. Half of the mothers (50%) stated that they expected moderate harm if they were to be infected. Also, more than the half of the mothers (63.2%) stated that they expected moderate financial harm during COVID-19 pandemic. In addition, most of participants (68.4%) confirmed that they were in quarantine which means they were isolating themselves for more than 30 days. 63.2% of the

participants stated that they or a relative of them were not diagnosed with COVID-19. Only 5.3% of the participants were health workers. 89.5% of the participants described their job as including lower infection risk for COVID-19. 42.1% of participants were not working, 36.8% of participants were working online and 21.1% of participants are working physically (See Table 3.2).

Lastly, distribution of AEED categories among participants is displayed in Figure 3.1.

**Table 3.2**

*Descriptive Statistics for the Information About the Exposure Level of COVID-19 Pandemic*

<b>Variables</b>	<b>Categories</b>	<b>Frequencies</b>	<b>VP</b>
		<b>(N)</b>	<b>(%)</b>
<b>Separation from Child</b>	Yes	0	0
	No	19	100
<b>Chronic Illness</b>	Yes	0	0
	No	19	100
<b>Expected Physical Harm</b>	Very Little	3	15.68
	A Little	5	26.3
	A Moderate Amount	10	52.6
	A Lot	1	5.3
<b>Variables</b>	<b>Categories</b>	<b>Frequencies</b>	<b>VP</b>
		<b>(N)</b>	<b>(%)</b>
<b>Expected Financial Harm</b>	Very Little	2	10.5

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	A Little	3	15.8
	A Moderate Amount	12	63.2
	A Lot	2	10.5
<b>Quarantine Day Number</b>	0	4	21.1
	15-21 Days	1	5.3
	22-28 Days	1	5.3
	More Than 30 Days	13	68.4
<b>COVID-19 Diagnosis</b>	Yes	7	36.8
<b>(Self or Relative)</b>	No	12	63.2
<b>Health Worker</b>	Yes	1	5.3
	No	18	94.7
<b>High COVID-19 Risk</b>	Yes	2	10.5
<b>(Job)</b>	No	17	89.5
<b>Working Online</b>	Yes	7	36.8
	No	4	21.1
	Not Working	8	42.1

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*Note.*  $N = 20$ . VP refers to Valid Percentages.

**Figure 3.1**

*Distribution of AEED Categories (N=16)*



*Note.* AEED refers to Autobiographical Emotional Events Dialogue.

## **3.2. RESEARCH QUESTIONS**

### **3.2.1. Exploring Interaction Structures**

Data included 38 sessions of 20 parent-therapist dyads. A principal components analysis with varimax rotation resulted in four interaction structures (IS) that accounted for 45.17% of the shared variance. Items that are loaded two or more factors placed into relevant factors according to their clinical significance. Mean values of interaction structures are calculated by averaging all sessions' mean values for each interaction structures. Each parent has approximately two sessions ( $M = 1.9$ ;  $SD = 0.91$ ). The average score of each interaction structure has calculated for every session of a mother. Then, these average scores are averaged again to create one average score for each mother for every interaction structure. Descriptive statistics of the interaction structures are shown in Table 3.3.

Factor scales were created using items that loaded above 0.40 (See table 3.4). IS 1 accounted for 16.9% of the variance ( $\alpha = 0.93$ ) and was labeled *Misattuned, Distant, Self-Focused Therapist - Disconnected and Misunderstood*

*Patient*. Positively loading items include therapist's characteristics such as being distant, disclosing personal information and having emotional conflicts that impair therapeutic relationship. Also, positively loaded items include patient's characteristics such as feeling misunderstood, animated, and seeking intimacy. Negatively loaded items include therapist's characteristics such as raising questions, identifying a recurrent theme and patient's characteristics such as bringing up significant issues (see table 3.4). IS 2 was labeled *Sensitive and Confident Therapist with Psychodynamic Stance - Expressive, Independent and Confident Patient* and accounted for 11.54% of the variance ( $\alpha = 0.90$ ). Positively loading items refer to therapist's traits such as being sensitive, confident, perceiving the therapeutic process accurately and rephrasing the patient's communication. Items that are determined as a part of ideal psychodynamic treatment are also loaded in this structure (Ablon & Jones, 1998). These items include therapist's characteristics such as speaking in a clear way, being sensitive, assisting patient's speech, mentioning changes, and drawing connections. Also, positively loaded items include patient's experience such as having a catharsis. Items with a negative loading include therapist's behaviors such as patronizing the patient and implying the meaning of others' behavior and patient's characteristics such as feeling insufficient, being self-accusatory and concerning about therapist's thoughts (see Table 3.4). IS 3 was labeled *Nondirective Therapist - Involved and Introspective Patient with Positive Expectations* accounted for %9.71 of the variance ( $\alpha = 0.88$ ). Items loading positively describe generally patient's positive attributes that include conveying positive expectations, being introspective, achieving a new understanding and feeling helped. Negatively loaded items include patient's experiences such as feeling anxious and sad, expressing anger and negative feelings and therapist's characteristics such as asking more information and focusing on patient's guilt (see Table 3.4). IS 4 labeled *Supportive and Accepting Therapist – Explorative Patient* accounted for %7.73 of the variance ( $\alpha = 0.86$ ). Positively loaded items refer to therapist's characteristics that being supportive, helping patient to experience feelings and encouraging independence and patient's features such as exploring interpersonal relationships

and testing limits of the therapeutic relationship. Negatively loaded items include therapist's features such as behaving in a didactic manner, giving explicit advice and patient's characteristics such as struggling to control feelings and feeling suspicious of the therapist (see Table 3.4)

**Table 3.3**

*Descriptive Statistics for the Four Interaction Structures (IS1, IS2, IS3, IS4)*

<b>Factor</b>	<b>Number of Items</b>	<b>Mean</b>	<b>Standard Deviation</b>	<b>Explained Variance</b>	<b>Cronbach's Alpha</b>
IS 1	19	3.85	.44	16.19	0.93
IS 2	23	5.34	.45	11.54	0.90
IS 3	21	5.26	.47	9.71	0.88
IS 4	20	5.27	.47	7.73	0.86

*Note.*  $N=38$ . IS = Interaction Structure.

**Table 3.4**

*Four-factor Solution and Item Loadings (N = 38).*

<i>PQS Item Definition</i>	<i>FL</i>
<b>IS 1: Misattuned, Distant, Self-Focused Therapist- Disconnected and Misunderstood Patient</b>	
<b>Positively Loaded Items</b>	
Item 21: Therapist self-discloses.	0,824
Item 47: When the interaction with the patient is difficult, the therapist accommodates in an effort to improve relations.	0,806
Item 14: Patient does not feel understood by therapist.	0,805
Item 9: Therapist is distant, aloof (vs. responsive and affectively involved).	0,671

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Item 13: Patient is animated or excited.	0,641
Item 19: There is an erotic quality to the therapy relationship.	0,585
Item 24: Therapist's own emotional conflicts intrude into the relationship.	0,536
Item 10: Patient seeks greater intimacy with the therapist.	0,536
Item 2: Therapist draws attention to patient's non-verbal behavior (e.g. body posture, gestures, tone of voice.)	0,508
Item 25: Patient has difficulty beginning the hour.	0,486
<b>Negatively Loaded Items</b>	
Item 36: Therapist points out patient's attempts to ward off awareness of threatening information or feelings.	-0,866
Item 99: Therapist raises questions about the patient's view (vs. validates the patient's perceptions).	-0,804
Item 62: Therapist identifies a recurrent theme in the patient's experience or conduct.	-0,797
Item 23: Dialogue has a specific focus.	-0,739
Item 67: Therapist draws the patient's attention to wishes, feelings, or ideas that may not be in awareness.	-0,732
Item 92: Patient's feelings or perceptions are linked to situations or behavior of the past.	-0,697
Item 89: Therapist intervenes to help patient avoid or suppress disturbing ideas or feelings.	-0,604
Item 88: Patient brings up significant issues and material.	-0,487
Item 74: Humor is used.	-0,442
<b>IS 2: Sensitive and Confident Therapist with Psychodynamic Stance - Expressive, Independent and Confident Patient</b>	
<i>PQS Item Definition</i>	<i>FL</i>
<b>Positively Loaded Items</b>	

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*Item 46: Therapist communicates with patient in a clear, coherent style.	0,753
Item 28: Therapist accurately perceives the therapeutic process.	0,723
*Item 6: Therapist is sensitive to the patient's feelings, attuned to the patient; empathic.	0,702
Item 60: Patient has cathartic experience (N.B. rate as uncharacteristic if emotional expression is not followed by a sense of relief).	0,681
Item 86: Therapist acts confident or self-assured (vs. uncertain or defensive).	0,66
Item 56: Patient discusses experiences as if distant from his or her feelings.	0,559
Item 98: The therapy relationship is a focus of discussion.	0,513
Item 65: Therapist restates or rephrases the patient's communication in order to clarify its meaning.	0,502
*Item 3: Therapist's remarks are aimed at facilitating patient speech.	0,502
*Item 79: Therapist comments on changes in patient's mood or affect that occur during the hour.	0,449
*Item 100: Therapist draws connections between the therapeutic relationship and other relationships.	0,416
<b>Negatively Loaded Items</b>	
Item 38: There is discussion of specific activities or tasks for the patient to attempt outside of session.	-0,647
Item 59: Patient feels inadequate and inferior (vs. effective and superior).	-0,612
Item 51: Therapist condescends to or patronizes the patient.	-0,573
Item 43: Therapist suggests the meaning of others' behavior.	-0,544
Item 71: Patient is self-accusatory; expresses shame or guilt.	-0,517
Item 80: Therapist presents a specific experience or event in a different perspective.	-0,507
Item 49: The patient experiences ambivalent or conflicted feelings about the therapist.	-0,458
Item 69: Patient's current or recent life situation is emphasized in the session.	-0,453
Item 53: Patient is concerned about what therapist thinks of him or her.	-0,438
Item 76: Therapist suggests that patient accept responsibility for his or her problems.	-0,431
*Item 11: Sexual feelings and experiences are discussed.	-0,42
Item 40: Therapist makes interpretations referring to actual people in the patient's life.	-0,417
<b>IS 3: Nondirective Therapist- Involved and Introspective Patient with Positive</b>	

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**Expectations*****PQS Item Definition******FL*****Positively Loaded Items**

Item 55: Patient conveys positive expectations about therapy.	0,735
Item 52: Patient relies upon therapist to solve his/her problems.	0,568
Item 4: The patient's treatment goals are discussed.	0,564
Item 97: Patient is introspective, readily explores inner thoughts and feelings.	0,546
Item 32: Patient achieves a new understanding or insight.	0,543
Item 78: Patient seeks therapist's approval, affection, or sympathy.	0,517
Item 95: Patient feels helped by the therapy.	0,503
Item 72: Patient understands the nature of therapy and what is expected.	0,483
Item 73: The patient is committed to the work of therapy.	0,476
Item 83: Patient is demanding.	0,443
Item 33: Patient talks of feeling close to or wanting to be close to someone (excludes therapist).	0,428

**Negatively Loaded Items**

Item 26: Patient experiences discomforting or troublesome (painful) affect during the session.	-0,711
Item 34: Patient blames others, or external forces, for difficulties.	-0,666
Item 7: Patient is anxious or tense (vs. calm and relaxed).	-0,618
Item 1: Patient expresses, verbally or non-verbally, negative feelings (e.g. criticism, hostility) toward therapist (vs. makes approving or admiring remarks).	-0,597
Item 29: Patient talks of wanting to be separate or distant from someone (excludes therapist).	-0,549
Item 94: Patient feels sad or depressed (vs. joyous or cheerful).	-0,509
Item 31: Therapist asks for more information or elaboration.	-0,484
Item 84: Patient expresses angry or aggressive feelings.	-0,48
Item 22: Therapist focuses on patient's feelings of guilt.	-0,416
Item 66: Therapist is directly reassuring.	-0,408

**IS 4: Supportive and Accepting Therapist – Explorative Patient**

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<i>PQS Item Definition</i>	<i>FL</i>
<b>Positively Loaded Items</b>	
Item 45: Therapist adopts supportive stance.	0,635
Item 5: Patient has difficulty understanding the therapist's comments.	0,605
Item 81: Therapist emphasizes patient feelings in order to help him or her experience them more deeply.	0,599
Item 93: Therapist refrains from stating opinions or views of topics the patient discusses.	0,502
Item 48: The therapist encourages independence of action or opinion in the patient.	0,482
Item 20: Patient is provocative, tests limits of the therapy relationship. (N.B. Placement toward uncharacteristic end implies patient behaves in a compliant manner).	0,481
Item 57: Therapist explains rationale behind his or her technique or approach to treatment or suggests that the patient use certain techniques.	0,469
Item 12: Silences occur during the hour.	0,449
Item 50: Therapist draws attention to feelings regarded by the patient as unacceptable (e.g. anger, envy, or excitement.)	0,429
Item 35: Self-image is a focus of the session.	0,428
Item 63: Patient's interpersonal relationships are a major theme.	0,417
Item 82: The patient's behavior during the hour is reformulated by the therapist in a way not explicitly recognized previously.	0,4
<b>Negatively Loaded Items</b>	
Item 85: Therapist encourages patient to try new ways of behaving with others.	-0,733
Item 37: Therapist behaves in a teacher-like (didactic) manner.	-0,725
Item 27: Therapist gives explicit advice or guidance (vs. defers even when pressed to do so).	-0,609
Item 70: Patient struggles to control feelings or impulses.	-0,593
Item 30: The content of the session centers on cognitive themes, i.e. ideas or belief systems.	-0,538
Item 44: Patient feels wary or suspicious of the therapist (vs. trusting and secure).	-0,514
Item 58: Patient does not examine thoughts, reactions or motivations related to his or her role in creating or perpetuating problems.	-0,448
Item 39: There is a competitive quality to the relationship.	-0,431

*Note.* FL = Factor Loading. IS = Interaction Structure. Items with (\*) in IS2 belong to expert clinicians prototype of ideal psychodynamic psychotherapy treatment (Ablon & Jones, 1998).

### **3.2.2. AEED and Interaction Structures**

#### **3.2.2.1. Maternal Sensitive Guidance Scores and IS1, IS2, IS3 and IS4**

Maternal sensitive guidance scores are divided into two groups by the mean score ( $M = 6.05$ ,  $SD = .62$ ). The scores of the participants that fall under the mean score are named as low in maternal sensitive guidance and above the mean are named as high in maternal sensitive guidance. Four different Mann Whitney-U tests are conducted to reveal if there is a difference in averaged values of IS1, IS2, IS3 and IS4 between low and high group.

Results showed that,

The averaged value of IS1 was not significantly different between low maternal sensitive guidance ( $Mdn = 3.89$ ;  $Mean Rank = 10.43$ ) and high maternal sensitive guidance group ( $Mdn = 3.87$ ;  $Mean Rank = 10.54$ ) ( $U = 45.00$ ,  $p = .968$ ).

The averaged value of IS2 was not significantly different between low maternal sensitive guidance ( $Mdn = 5.30$ ;  $Mean Rank = 9.43$ ) and high maternal sensitive guidance group ( $Mdn = 5.45$ ;  $Mean Rank = 11.08$ ) ( $U = 38.00$ ,  $p = .552$ )

The averaged value of IS3 was not significantly different between low maternal sensitive guidance ( $Mdn = 5.19$ ;  $Mean Rank = 8.36$ ) and high maternal sensitive guidance group ( $Mdn = 5.26$ ;  $Mean Rank = 11.65$ ) ( $U = 30.50$ ,  $p = .234$ )

The averaged value of IS4 was not significantly different between low maternal sensitive guidance ( $Mdn = 5.45$ ;  $Mean Rank = 9.86$ ) and high maternal sensitive guidance group ( $Mdn = 5.29$ ;  $Mean Rank = 10.85$ ) ( $U = 41.00$ ,  $p = .721$ ) (See Table 3.5).

**Table 3.5**

*Results of Mann Whitney-U Tests Examining the Averaged Values of IS1, IS2, IS3, IS4 According to Emotional Guidance Scores*

Averaged Values of IS1, IS2, IS3, IS4	Sensitive Emotional Guidance Category	<i>N</i>	<i>Mean Rank</i>	<i>U</i>	<i>Z</i>	<i>p</i>
Averaged Value of IS 1	Low in SEG	7	10.43	45.00	-.040	.968
	High in SEG	13	10.54			
Averaged Value of IS2	Low in SEG	7	9.43	38.00	-.594	.588
	High in SEG	13	11.08			
Averaged Value of IS3	Low In SEG	7	8.36	30.50	-1.189	.234
	High in SEG	13	11.65			
Averaged Value of IS4	Low In SEG	7	9.86	41.00	-.357	.721
	High in SEG	13	10.85			

*Note.* IS means Interaction Structure. SEG means Sensitive Emotional Guidance.

### **3.2.2.2. Emotionally Coherent Narrative Scores and IS1, IS2, IS3 and IS4**

Emotionally coherent narrative scores of mothers are divided into two groups by mean score ( $M= 6.54, SD =.85$ ). The scores of the participants that fall under the mean score are named as low in emotionally coherent narrative and above the mean are named as high in emotionally coherent narrative. Four different Mann Whitney-U tests are conducted to reveal if there is a difference in averaged values of IS1, IS2, IS3 and IS4 between low and high group.

Results indicated that,

The averaged value of IS1 was not significantly different between low coherent narrative ( $Mdn = 3.78; Mean Rank = 9.90$ ) and high coherent narrative group ( $Mdn = 3.91; Mean Rank = 11.10$ ) ( $U = 44.00, p = .650$ ).

The averaged value of IS2 was not significantly different between low coherent narrative (*Mdn*= 5.37; *Mean Rank* = 10.20) and high coherent narrative group (*Mdn* = 5.38; *Mean Rank* = 10.80) ( $U = 47.00, p = .821$ ).

The averaged value of IS3 was not significantly different between low coherent narrative (*Mdn*= 10.70; *Mean Rank* = 10.70) and high coherent narrative group (*Mdn* = 10.30; *Mean Rank* = 10.30) ( $U = 48.00, p = .880$ ).

The averaged value of IS4 was not significantly different between low coherent narrative (*Mdn*= 5.26; *Mean Rank* = 11.50) and high coherent narrative group (*Mdn* = 5.20; *Mean Rank* = 9.50) ( $U = 40.00, p = .450$ ) (See Table 3.6).

**Table 3.6**

*Results of Mann Whitney-U Tests Examining the Averaged Values of IS1, IS2, IS3, IS4 According to Coherent Narrative Categories*

Averaged Values of IS1, IS2, IS3, IS4	Emotionally Coherent Narrative Category	<i>N</i>	<i>Mean Rank</i>	<i>U</i>	<i>Z</i>	<i>p</i>
Averaged Value of IS 1	Low Group	10	9.90	44.00	-.454	.650
	High Group	10	11.10			
Averaged Value of IS2	Low Group	10	10.20	47.00	-.227	.821
	High Group	10	10.80			
Averaged Value of IS3	Low Group	10	10.70	48.00	-.151	.880
	High Group	10	10.30			
Averaged Value of IS4	Low Group	10	11.50	40.00	-.756	.450
	High Group	10	9.50			

*Note.* IS means Interaction Structure.

### 3.2.2.3. AEED Classifications and IS1, IS2, IS3 and IS4

Four Kruskal-Wallis Tests were conducted to examine if there is a difference between the averaged values of IS1, IS2, IS3 and IS4 on different AEED classifications; emotionally matched, emotionally unmatched-flat, and emotionally unmatched-exaggerated.

Results showed that,

There was not a significant difference between the averaged values of IS1 for different AEED classifications ( $H(2) = .623, p = .732$ ) with a mean rank of 10.23 for emotionally matched group, 7.94 for emotionally unmatched-flat group and 8.00 for emotionally unmatched-exaggerated group.

There was not a significant difference between the averaged values of IS2 for different AEED classifications ( $H(2) = 3.17, p = .204$ ) with a mean rank of 7.50 for emotionally matched group, 10.50 for emotionally unmatched-flat group and 5.50 for emotionally unmatched-exaggerated group.

There was not a significant difference between the averaged values of IS3 for different AEED classifications ( $H(2) = 5.27, p = 0.722$ ) with a mean rank of 13.00 for emotionally matched group, 7.69 for emotionally unmatched-flat group and 5.63 for emotionally unmatched-exaggerated group.

There was not a significant difference between the averaged values of IS4 for different AEED classifications ( $H(2) = 1.34, p = .512$ ) with a mean rank of 7.00 for emotionally matched group, 8.13 for emotionally unmatched-flat group and 10.75 for emotionally unmatched-exaggerated group (See Table 3.7).

**Table 3.7**

*Results of Kruskal-Wallis Tests Examining IS1, IS2, IS3 and IS4 according to AEED Classifications.*

Averaged Values of IS1, IS2, IS3, IS4	AEED Classification	N	Mean Rank	df	H	p
Averaged Value of IS 1	Emotionally Matched	4	10.13	2	.623	.732
	Emotionally Unmatched Flat	8	7.94			
	Emotionally Unmatched Exaggerated	4	8.00			
Averaged Value of IS2	Emotionally Matched	4	7.50	2	3.176	.204
	Emotionally Unmatched Flat	8	10.50			
	Emotionally Unmatched Exaggerated	4	5.50			
Averaged Value of IS3	Emotionally Matched	4	13.00	2	5.273	.072
	Emotionally Unmatched Flat	8	7.69			
	Emotionally Unmatched Exaggerated	4	5.63			

Averaged Value of IS4	Emotionally Matched	4	7.00	2	1.340	.512
	Emotionally Unmatched Flat	8	8.13			
	Emotionally Unmatched Exaggerated	4	10.75			

*Note.* IS means Interaction Structure.

### 3.2.3. PRF-Q Subscale (Certainty in Mental States) and IS1, IS2, IS3 and IS4

Because Cronbach's alpha levels of pre-mentalizing modes and interest and curiosity subscales of PRF-Q are not sufficient, only certainty in mental states subscale is used. The score of certainty in mental states subscale are divided into two groups by the mean score ( $M = 25.94$ ,  $SD = 7.90$ ). The scores of the participants that fall under the mean score are named as low and above the mean score are named as high. Mann Whitney-U tests are conducted to reveal whether there is a difference in averaged values of IS1, IS2, IS3 and IS4 between low and high groups.

Results of low and high certainty in mental states groups comparison showed that,

The averaged value of IS1 was not significantly different between low certainty in mental states ( $Mdn = 3.87$ ;  $Mean Rank = 10.05$ ) and high certainty in mental states group ( $Mdn = 3.89$ ;  $Mean Rank = 11.06$ ) ( $U = 44.50$ ,  $p = .704$ ).

The averaged value of IS2 was not significantly different between low certainty in mental states ( $Mdn = 5.45$ ;  $Mean Rank = 10.82$ ) and high certainty in mental states group ( $Mdn = 5.20$ ;  $Mean Rank = 10.11$ ) ( $U = 46.00$ ,  $p = .790$ ).

The averaged value of IS3 was not significantly different between low certainty in mental states ( $Mdn = 5.32$ ;  $Mean Rank = 11.86$ ) and high certainty in mental states group ( $Mdn = 5.19$ ;  $Mean Rank = 8.83$ ) ( $U = 34.50$ ,  $p = .254$ ).

The averaged value of IS4 was not significantly different between low certainty in mental states ( $Mdn = 5.29$ ;  $Mean Rank = 10.45$ ) and high certainty in mental states group ( $Mdn = 5.36$ ;  $Mean Rank = 10.56$ ) ( $U = 49.00$ ,  $p = .970$ ).

(See Table 3.8).

**Table 3.8**

*Results of Mann Whitney-U Tests Examining the Averaged Values of IS1, IS2, IS3, IS4 According to Certainty in Mental States Subscale of Parental Reflective Functioning Questionnaire (PRF-Q)*

Averaged Values of IS1, IS2, IS3, IS4	Groups in Certainty in Mental States Subscale	N	Mean Rank	U	Z	p
Averaged Value of IS 1	Low Group	11	10.05	44.50	-.380	.704
	High Group	9	11.06			
Averaged Value of IS2	Low Group	11	10.82	46.00	-.266	.790
	High Group	9	10.11			
Averaged Value of IS3	Low Group	11	11.86	34.50	-1.140	.254
	High Group	9	8.83			
Averaged Value of IS4	Low Group	11	10.45	49.00	-.038	.970
	High Group	9	10.56			

*Note.* IS means Interaction Structure.

## CHAPTER 4

### DISCUSSION

The aim of this study was to explore the differences in psychotherapy process as evaluated by interaction structures between therapists and mothers throughout the COVID-19 pandemic and to investigate if there is a difference in these interaction structures according to mothers' capacity in emotional dialogues, the overall nature of the mother-child emotional dialogues and coherence of the stories that are formed by the mother-child dyad.

The aim was also to investigate if there is a difference in these interaction structures according to Certainty in Mental States subscale of Parental Reflective Function Questionnaire (PRF-Q). To our knowledge, this was the first research that examined the therapeutic process of parents during COVID-19 pandemic. Also, the present study was the first to explore the differences in interaction structures according to mothers' capacities in different areas. The initial step was to examine the interaction structures that occurred in the parent sessions. The second step was to explore if there is a difference in interaction structures according to maternal emotional dialogue capacity, overall nature of the mother-child emotional dialogues and coherence of the stories. The last step was to explore if there is a difference in interaction structures according to maternal reflective functioning capacity in the Certainty in Mental States subscale of Parental Reflective Function Questionnaire (PRF-Q).

It is revealed that there are meaningful interaction structures between the mothers and therapists in the parent sessions. This research represented a first attempt at examining specific interaction structures in parent sessions in child and adolescent psychotherapy. Four specific interaction structures were identified:

- Misattuned, distant, self-focused therapist with disconnected and misunderstood patient.
- Sensitive and confident therapist with psychodynamic stance with expressive, independent, and confident patient.

- Nondirective therapist with involved and introspective patient with positive expectations.
- Supportive and accepting therapist with explorative patient.

Secondly, the differences in averaged scores of each interaction structure were investigated according to maternal sensitive emotional guidance, nature of the mother-child relationship and overall coherence of mother-child emotional dialogues that are classified by AEED (Koren-Karie et al., 2003). It is found that there is no difference in averaged scores of four interaction structures between the groups of mothers with high and low sensitive emotional guidance and overall coherence of emotional dialogues. In addition, it is also found that there is no difference in averaged scores of four interaction structures according to the nature of the mother-child relationship that was assessed by the AEED classifications: emotionally matched, emotionally unmatched-flat, and emotionally unmatched-exaggerated.

Thirdly, the differences in averaged scores of each interaction structure were explored according to reflective functioning capacity of the mother in the certainty in mental states subscale of the PRF-Q. Mothers are divided into two categories as low and high by the mean score in the sub-category. It is found that there is no difference in averaged scores of four interaction structures between the groups of mothers with high and low scores in certainty in mental states.

## **4.1. Research Questions**

### **4.1.1. Exploring the Specific Interaction Structures**

It is shown that COVID-19 pandemic is a unique process with all of its conditions. The disease has its own symptoms and risks. On the other hand, it brings lots of restrictions to our lives because of the speed of spread. Gruber et. al (2020) explained the difficulties in this process in three aspects: the uncertainty, multidimensionality, and the loss of the protective factors as such going out, socializing with friends etc. All of these had an impact on mental health. Research on this topic has been taking place, but it was shown that pandemic triggered

panic attack, depression, and anxiety in many people (Qiu et al., 2020). Quarantine processes were correlated with mental challenges (Brooks et al., 2020). This process caused increase in loneliness, self-harm or suicidal ideation and emotional stress (Lee et al., 2020; Luo et al., 2020). Studies that were conducted in Turkey revealed similar findings. It was shown that pandemic caused fear, anxiety symptom and fear of losing loved ones and increased psychological difficulties (Doğan & Düzel, 2020). Erdoğan et al., (2020) also found that anxiety and hopelessness levels increased.

One of the groups that were significantly affected by the pandemic process was parents. Spending longer hours with children at home, closure of schools, homeschooling of children, financial problems, increased responsibilities and changing roles have affected them, along with all the other effects of COVID-19. It was shown that pandemic caused stress and parents reported mental health difficulties, physical and educational problems, and conflicts between partners (Spinelli et al., 2020; Göl-Güven et al., 2020; Başaran & Aksoy, 2020; Yalçın et al., 2020; Usta & Gökcan, 2020).

All of these findings have revealed that supporting mental health, especially parents', is very important in this process. Therefore, it is necessary to examine therapeutic processes to explore what the output. The present study is the first study that examines specific interaction structures between mothers and therapists in child and adolescent psychotherapy during COVID-19 period. Another important feature of the therapeutic process in this period is that sessions are conducted via online platforms. As a result, it is also an important question how this affects the interaction structures. Interaction structures symbolize the unique relationship features that have their own characteristics between the therapist and client. They emerge during the sessions to describe the features of the dyadic relationship. As a result of psychotherapy process research, specific interaction structures can be identified between therapists and clients.

In the present study, four specific interaction structures were identified as mentioned above. First interaction structure was "Misattuned, distant, self-focused therapist with disconnected and misunderstood patient". It is an interesting finding

that include a negative transference-countertransference pattern. It is actually in line with some findings in the research of Goodman and Athey-Llyod (2011). They also found an interaction structure that represent the judgmental therapist and disconnected and distant client.

Second interaction structure was “Sensitive and confident therapist with psychodynamic stance with expressive, independent, and confident patient”. Communicating in a coherent way (item 46), perceiving truly the psychotherapy process (item 28), being sensitive (item 6), restating the patient’s words (item 65) and drawing connections (item 100) are important parts of this interaction structure.

These items showed that therapeutic relationship, sensitivity, coherence of the therapist became important in the COVID-19 pandemic as the previous periods. D’andrea and Pole (2012) examined the complex trauma-focused therapy processes within a naturalistic design. They also used PQS to examine psychotherapy session. Present study’s findings are in line with their findings as they also found that psychodynamic oriented items stood out in the sessions and predicted change (D’andrea & Pole, 2012). Slade (2007) also mentioned that it is important to enhance the reflective function capacity of the parent in the parent sessions. It can be argued that the items are in line with this argument.

It is also in accordance with recommended psychotherapeutic interventions in COVID-19 pandemic and it is also in accordance with parent work especially in mentalization based psychodynamic psychotherapies. Swartz (2020) mentioned that it is very important to be supportive and human centered as a therapist because of all the shared sufferings. Moreover, being sensitive as a therapist is the basic feature of all psychotherapy schools (Anderson & Perlman, 2019).

This finding is also in line with Kufferath-Lin et al.’s (2021) research results. They also examined parent sessions using PQS and found that the most characteristic feature of the therapists in the parent sessions were being supportive, empathic, and nonjudgmental. Also, the most uncharacteristic features of the therapists were being condescending and aloof (Kufferath-Lin et al., 2021).

The therapists in this study were educated to perform psychodynamic psychotherapy with mentalization principles. Verheugt-Pleiter et. al. (2008) mentioned that developing an attuned relationship between parent and therapist, understanding, and repairing misattunements are some of the basic principles in parent work. They also stated that the most important factor is forming a cooperative relationship with parents in these collateral parent sessions. They stated that reflective functioning is a context-related capacity, thus it is important to form a secure and comfortable relationship with parents for mentalization to be possible. Slade (2005) mentioned in her work that holding the parent in mind and working at a level the parent can manage are very important when working with parents in child and adolescent psychotherapy. As a result, this interaction structure supported these principles.

This finding is also in accordance with those of Halfon et al. (2020). They examined interaction structures in child psychodynamic psychotherapy within a similar sample. They coded 192 sessions of 52 children using Child Psychotherapy Q-set (CPQ). Results revealed four interaction structures that focus on therapeutic alliance, emotional expression, child centered and psychodynamic technique. They found that psychodynamic technique predicted symptom reduction (Halfon et al., 2020). The present study reveals the similarities between child and parent sessions in child and adolescent psychotherapy.

This interaction structure also revealed the reciprocity. When the therapist is sensitive and confident, the parent appears more expressive, independent, and confident. The psychodynamic stance of the therapist is also in accordance with previous literature. It has been shown that psychodynamic psychotherapies are used and effective when working with patients with emotional disorders, disruptive disorders, depression, and obsessive-compulsive disorders (see for reviews; Midgley & Kennedy, 2011; Midgley et al., 2017). It has also been shown that psychodynamic therapies are used and effective when working with PTSD symptoms (Lush et al., 1998; Trowell et al., 2002; Heede et al., 2009; Gilboa-Schechtman et al., 2010). Therefore, the interaction structure that includes

psychodynamic stance of the therapist in the COVID-19 process is not unexpected and in accordance with the previous literature.

In addition, this interaction structure shared some items with ideal psychodynamic psychotherapy session as determined by expert clinicians (Ablon & Jones, 1998). These items include therapist's characteristics such as speaking in a clear way, being sensitive, assisting patient's speech, mentioning changes, and drawing connections. Accordingly, the present study represents a first step in the literature that reveals psychodynamic features of parent sessions.

Third interaction structure was "Nondirective therapist with involved and introspective patient with positive expectations". Some items of this interaction structure are listed below: Conveying positive expectations (item 55), being introspective (item 97), achieving a new understanding (item 32), being committed to work (item 73), feeling helped by the psychotherapy (item 95) are the important features of this interaction structure. Positive expectations, committing to work of therapy and feeling helped are appeared to be in relation with being hopeful. Erdoğan et al. (2020) investigated hopelessness levels in people during COVID-19 pandemic. They found that about one in four participants showed symptoms of anxiety and about one in three participants showed symptoms of hopelessness at moderate to severe levels (Erdoğan et al., 2020). So, hope and hopelessness are important concepts in this process. This interaction structure supported this. This finding is also in accordance with previous research. It was shown that increasing hope is one of the most important features of trauma work regardless of therapy school (Snyder, 2000).

Features of this interaction structure are also similar with results of Serralta (2016). In his research, five different interaction structures were identified in short term adult psychodynamic psychotherapy, "resistance", "alliance", "facing depression", "expectation of change", and "introspection" (Serralta, 2016, p.257). The interaction structure 4 "expectation of change" in her research included similar items with our third interaction structure.

Considering the short-term nature of the psychotherapies in Psychological Counseling Center (PDM) in our study, it may be concluded that the nature of

adult and parent psychotherapy processes are similar in a few ways. However, more research is needed in that area.

Fourth interaction structure was “supportive and accepting therapist with explorative patient”. Supporting stance of the therapist (item 45), emphasizing feelings (item 81), drawing attention to unaccepted feelings (item 50), focusing on self-image (item 35) and interpersonal relationships (item 63) and reformulating behavior (item 2) are important parts of this interaction structure, and this is in line with the previous literature.

This interaction structure shares common items with IS1, “reassuring, supportive, non-directive therapist with compliant, curious child building insight and positive feelings” in Goodman and Athey-Lloyd’s research (2011). They identified this interaction structure in child psychodynamic therapy. Our findings present a new perspective that child and parent sessions have common features.

Moreover, in the present study, it was seen that most mothers were in quarantine for more than 30 days and not working. Findings in the literature showed that mandatory quarantine status (MQS) was correlated with mental challenges (Brooks et al., 2020). Lee et al. (2020) showed that there was an increase in depression symptoms. Luo et al. (2020) found that self-harm or suicidal ideation and emotional stress were considerably higher in quarantined people. Qiu et al. (2020) revealed that psychological distress increased during COVID-19 pandemic. They also found that women’s stress levels were higher than men in this process. The feature of this interaction may also relate to changing roles and increasing responsibilities of mothers in this period. It was shown that one in every three mothers experienced negative emotions during COVID-19 restrictions. In addition, 41% of the parents stated that they were responsible for all needs of their children.

It is seen that mothers are more responsible for the child's care during this process. Parents expressed that they have had difficulty in creating time for themselves and they felt unhappy about it (Göl-Güven et al., 2020). Other studies also found that mother’s stress levels and responsibilities increased in this process (Başaran & Aksoy, 2020; Yalçın et al., 2020; Usta & Gökcan, 2020). Hence,

supporting stance of the therapist, emphasizing feelings, drawing attention to unaccepted feelings, focusing on self-image and interpersonal relationships in the sessions are in line with these findings.

Also, therapists in this study are educated to conduct psychodynamic psychotherapy and follow mentalization principles. As mentioned above, Verheugt-Pleiter et. al. (2008) gave importance to an attuned relationship between the parent and the therapist, understanding, and repairing misattunements. They also indicated that the most important factor is forming a cooperative and secure relationship with parents in parent sessions. They emphasized that reflective functioning is a context-related capacity, so it is important to form a secure relationship with parents for mentalization to be possible (Verheugt-Pleiter et. al., 2008). So, it can be said that items in this interaction structure are in line with these principles.

#### **4.1.2. Exploring the Relationship between Specific Interaction Structures and Emotional Dialogues**

It has been mentioned repeatedly that COVID-19 process is very stressful and difficult to cope with for many people. One of the most important factors that enable mothers and children to cope with stressful or traumatic events is emotional dialogues and the capacity to form an emotional dialogue. It was found that children whose mothers could create elaborated, emotionally constructed, and coherent dialogues had more secure internal working models (Bretherton & Munholland, 1999; Koren-Karie et al., 2003; Thompson, 2000, 2006; Waters & Cummings, 2000). Hence, it is a very important capacity. Also, it was shown that children whose mothers were more elaborative and responsive when communicating with her child was better at explain themselves in a more elaborated and comprehensible way. This is also an important factor for emotion regulation (Fivush, 2007). Also, it was shown that mother-child's dyad emotional dialogues were related with attachment style. It was seen that more elaborated stories are formed by securely attached dyads. In addition, it was found that

children whose mothers explained negative experiences in a more elaborated and emotionally structured way were better at regulating emotions and had fewer internalizing and externalizing problems (Fivush, 2007; Fivush & Sales, 2006; Sales & Fivush, 2005).

Even though it is a very important capacity for emotion regulation, mother-child relationship and coping with stressful events, and its relationship with psychotherapy process were not examined before. The present study became the first step in the literature that examined the relation between interaction structures that are formed between therapists and mothers, and features of emotional dialogues. Differences in averaged scores of each interaction structure were explored according to maternal sensitive emotional guidance, nature of the mother-child relationship and overall coherence of mother-child emotional dialogues that are classified by AEED (Koren-Karie et al., 2003). It is found that there is no difference in averaged scores of four interaction between the groups of mothers with high and low sensitive emotional guidance and overall coherence of emotional dialogues. In addition, it is also found that there is no difference in averaged scores of four interaction structures according to the nature of the mother-child relationship that is assessed by the AEED classifications: emotionally matched, emotionally unmatched-flat, and emotionally unmatched-exaggerated. Even though this is not a significant finding, considering trending results it is seen that there are some trends in the results. For example, mothers whose AEED classification is emotionally matched have higher scores in IS3 which is “nondirective therapist with involved and introspective patient with positive expectations” than other mothers whose classifications are emotionally unmatched flat and exaggerated. The most important characteristic of an emotionally matched dyad is that they can create dialogues that are emotionally loaded, adequate, coherent, and structured. It is only a trending result, but it may indicate that mothers who have a capacity to form emotionally structured and coherent dialogues with their child may be more introspective and positively involved in the sessions. It may be in line with the literature that indicate the mothers who have a secure attachment style are more able to create coherent and

emotionally meaningful stories with their children and they feel secure for exploration (Crowell et al., 1999; Main et al., 1985; Pillemer, 1998). So, nondirective therapist and involved and introspective mother with positive expectations may be seen as a dyad who has a secure relationship that can create dialogues that are coherent and introspective. Nondirective feature of the therapist may indicate that the mother feels secure in the sessions to explore herself as in line with her emotionally matched relationship style with her child.

The nonsignificant results can be discussed with small sample size of the data in the present study. Because it is a naturalistic study that is conducted with real-world psychotherapy sessions, there are twenty mothers and thirty-eight sessions in total. So, the nonsignificant results can be explained with the sample size. In addition, even though there is not a significant result, it is seen that there are some trends in the results. For example, mothers who are in high sensitive emotional guidance level group have higher scores in IS2, IS3 and IS4. When considering the features of these interaction structures, it may indicate that mothers who are better at sensitively guiding their children are more introspective, committed, and explorative in the sessions. However, this is just a trending result, so more research needs to be conducted to explore these relations. Further studies that take emotional dialogues between mothers and their child into account will need to be undertaken. We hope that our research will serve as a base for future studies on this topic.

#### **4.1.3. Exploring the Relationship Between Specific Interaction Structures and Parental Reflective Functioning**

Many studies showed that there is a significant relationship between the reflective functioning capacity of the parent and the capacity to care her child in a quality way. This relationship was even found in mother-child dyads in which child is suffering from clinical difficulties (Borelli et al., 2012; Huth et al., 2014; Stacks et al., 2014). Studies that were conducted with school-age children and their parents showed that low reflective functioning capacity of the parent predicts

difficulties of the child (Esbjorn et al., 2013; Rosso et al., 2015; Scopesi et al., 2015; Ensink et al., 2015).

The present study is the first that examines the collateral therapy process of the mothers in child and adolescent psychotherapy. The differences in each four-interaction structure between mothers who have reflective functioning capacity and low reflective functioning capacity in the certainty in mental states area were explored. It is found that there is no difference in averaged scores of four interaction structures between the groups of mothers with high and low scores in certainty in mental states. Even though there is not a research that examines the relation between the reflective functioning capacity of the mother and psychotherapy process, it can be said that this finding is not in line with the previous literature. Because it is found that the needs of the patients and psychotherapy processes differ when the mentalization levels change (eg; Müller et al., 2006; Taubner et al., 2011; Katznelson; 2014; Halfon et al., 2017; Ramires et al., 2020). Ramires et al., (2020) found that different interaction structures emerged between therapists and children according to children's reflective functioning capacities. Their findings indicated that therapists became more directive when there was a mentalization deficit. They also found that the therapist's technique was closer to psychodynamic approach when the patient possessed more resources (Ramires et. al., 2020).

Unlike other research carried out with adults and children in this area, we did not find a significant difference in averaged scores of IS1, IS2, IS3 and IS4 between low and high group mothers in certainty in mental states. As mentioned above, the nonsignificant results can be explained with small sample size of the data in the present study. In addition, because of the insufficient scores of other PRF-Q subscales, only certainty in mental states subscale is used. This may also be inefficient to assess the overall parental reflective functioning capacity.

Moreover, PQS (Jones, 2000) is a tool that is used to examine adult psychotherapy sessions in adult psychotherapy process. There is just one study that is used this tool to examine parent sessions in child and adolescent psychotherapy (Kufferath-Lin et al., 2021). So, the nonsignificant results may be

explained with the lack of a tool that is designed for parent sessions. The items were adapted for the present study, but it may not be enough to catch differences in interaction structures. In addition, PQS was designed to examine face to face psychotherapy sessions. There are not any studies in the literature that examined an online psychotherapy process with PQS. This is a fundamental concern for future research.

#### **4.2.LIMITATIONS AND FUTURE RESEARCH**

This paper sheds new light on parent psychotherapy processes. It was the first study that examines the psychotherapy process of parents during COVID-19 pandemic. Also, it was the first study that examined the relation between mother's emotional dialogues capability, mentalization capacity and psychotherapy process. The characteristics of collateral parent sessions have not been dealt with in depth in the literature before.

We are aware that our research may have some limitations. The first is the small sample size of the data. The data was divided into groups in some areas. For example, the participants were divided into two groups in sensitive emotional guidance and coherence scores. There were also three classifications of AEED: emotionally matched, emotionally unmatched-flat, and emotionally unmatched-exaggerated. There were not equal number of participants in each category. Also, mothers were divided into two groups in PRF-Q subscales. So, different, and limited number of the participants in these areas could be a limitation. Despite these limitations, this research can be seen as a first step toward integrating two lines of research, [parental capacity in mentalization, emotional dialogue and parent psychotherapy process research], that, to our knowledge, have not been directly linked. Our results can be seen as an initial step and should be worked with a larger sample size in the future.

Second limitation is that timing and frequency of parent sessions are different for each therapist and parent dyad. Also, as mentioned above PQS is a tool that was designed for adult face to face psychotherapy sessions. The lack of a tool to examine parent psychotherapy sessions is also an important limitation.

However, this research was a first step for examining parent sessions. In terms of future research, it would be useful to develop a tool to examine parent psychotherapy sessions. The lack of an adapted tool for examining online psychotherapy sessions was also another limitation. Future work should also concentrate on online psychotherapy processes. Additionally, future research may benefit from a larger sample and reveal the differences in repetitive relationship patterns according to different capacities. It also may focus on establish links to outcomes both within and outside of sessions. Future research may also be conducted within a mixed design. Assessing maternal capacities with a qualitative method could be beneficial.

### **4.3.CONCLUSION AND CLINICAL IMPLICATIONS**

The aim of this study was to examine parent psychotherapy processes during COVID-19 pandemic. In addition, it was the first study that examined the relation between mother's emotional dialogue and mentalization capacity and psychotherapy process.

To summarize, findings of the study were that; (a) Four specific interaction structures were identified in the psychotherapy processes of the mothers: (1) Misattuned, distant, self-focused therapist with disconnected and misunderstood patient, (2) Sensitive and confident therapist with psychodynamic stance with expressive, independent, and confident patient, (3) Nondirective therapist with involved and introspective patient with positive expectations, (4) Supportive and accepting therapist with explorative patient, (b) there was no significant difference in averaged scores of four interaction structures between the groups of mothers with high and low sensitive emotional guidance and overall coherence score of emotional dialogues, (c) there is no difference in averaged scores of four interaction structures according to AEED classifications: emotionally matched, emotionally unmatched-flat, and emotionally unmatched-exaggerated, (d) there was no difference in averaged scores of four interaction structures between the groups of mothers with high and low scores in in pre- certainty in mental states subscale of PRF-Q.

Results of this study could help opening a newer page in understanding collateral parent sessions. We hope that our research will be a helpful and valuable addition to the literature that give importance to parent work in child and adolescent psychotherapy. The present study also sheds light to the importance of supporting mental health during COVID-19 pandemic. It is a very difficult and uncertain time that includes a lot of stress factors. This research may be a first step that help the understand the nature of psychotherapy processes throughout pandemic. Results of the present study may also help psychotherapists to extend their perspectives when working with parents. Results also shed light into the importance of assessing parental capacities while working with children and adolescents. So, psychotherapists may also give importance to assessing different capacities of parents in addition to children and adolescents in the psychotherapy process. Findings also revealed that parent work is inseparable part of child and adolescent psychotherapy.

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## APPENDICES

### APPENDIX A: Information About the Exposure Level of COVID-19 Pandemic

1. Salgın nedeniyle çocuğunuz ile ayrı bir yerde yaşamak zorunda kaldınız mı?  
 Evet  
 Hayır
2. Kronik rahatsızlığınız var mı? (Örneğin; diyabet, kalp hastalığı, astım vb.)  
 Evet  
 Hayır
3. Korona virüs/COVID-19 pandemisinin uzun vadede FİZİKSEL SAĞLIĞINIZA olan etkisini nasıl tanımlarsınız?  
 Çok Az  
 Az  
 Ne Az Ne Fazla  
 Fazla  
 Çok Fazla
4. Korona virüs/COVID-19 pandemisinin uzun dönemde maddi olarak sizi ne kadar etkileyeceğinizi düşünüyorsunuz?  
 Çok Az  
 Az  
 Ne Az Ne Fazla  
 Fazla  
 Çok Fazla
5. Kaç gündür evde tecrit halindesiniz ya da karantinadasınız?  
 0  
 1'den az  
 1-7  
 8-14  
 15-21  
 22-28  
 Bir ay ve daha fazlası
6. Siz ya da tanıdığınız biri korona virüs/COVID-19 tanısı aldı mı?  
 Evet  
 Hayır
7. Görevini sürdürmekte olan bir sağlık çalışanı mısınız?  
 Evet  
 Hayır

## APPENDIX B: The Impact Of Events Scale-Revised (IES-R)

Aşağıdaki listede stresli/zorlu yaşam olaylarına maruz kalan insanların ifade ettikleri bazı açıklamalar yer almaktadır.

Lütfen **Korona virüs/COVID-19** salgınıyla alakalı olarak **son bir hafta içinde** aşağıdaki zorluklardan her birini ne sıklıkla yaşadığınızı belirtiniz.

Bu ifadelerde belirtilen hususlardan son bir hafta içinde yaşamadıklarınız varsa, söz konusu ifade için 'Neredeyse Hiç' kutucuğunu işaretleyiniz.

	Neredeyse Hiç (1)	Çok Az (2)	Orta Seviyede (3)	Fazla (4)	Çok Fazla (5)
1. Benzeyen her şey, olayla ilgili duygularımı aklıma getiriyor ve hatırlatıyor.					
2. Uykumu sürdürmekte, kesintisiz ve derin bir uyku uyumakta zorlanıyorum, uykum bölünüyor.					
3. Olayla ilgisiz ve farklı şeyler dahi bana olayı hatırlatıyor, aklıma getiriyor ve düşündürüyor.					
4. Kendimi huzursuz ve öfkeli hissediyorum.					
5. Olayı düşündüğümde, olayı hatırlatan şeylerle karşılaştığımda keyfimin kaçmasına canımın sıkılmasına izin vermiyorum.					
6. İstemediğim halde olay aklıma geliyor ve onu düşünmek zorunda					

kalıyorum.					
7. Sanki olayı yaşamamışım, olmamış ve gerçek değilmiş gibi hissediyorum.					
8. Olayı hatırlatan durum, yer ve koşullardan uzak duruyorum, kaçınıyorum.					
9.Olayla ilgili görüntüler fotoğraf gibi, film gibi gözümün önünde canlanıyor.					
10. Ani ses, görüntü ve hareketlerden çabuk irkiliyorum ve abartılı tepkiler veriyorum.					
11. Olayı düşünmemeye çalışıyorum.					
12. Olayla ilgili birçok duyguyu hala taşıdığımı fark ettim fakat bunların üzerinde durmuyorum ve çözmeye çalışmıyorum.					
13. Sanki bütün duygularımı kaybetmiş gibi hissediyorum. Kendimi hissizleşmiş ve donuklaşmış gibi algılıyorum.					
14. Zaman zaman olay sırasındaki duygularımı yeniden hatırlıyorum ve sanki o anı yeniden yaşıyormuş gibi tepkiler gösteriyorum.					

15. Uykuya dalmakta zorluk çekiyorum.					
16. Olayla ilgili yaşadığım duyguları o kadar canlı hatırlıyorum ki, sanki dalga dalga üzerime geliyorlar.					
17. Olayı hafızamdan silmeye ve unutmaya çalışıyorum.					
18. Dikkatimi toplamada ve yoğunlaşmada zorluk çekiyorum.					
19. Olayı hatırlatan şeylerle karşılaştığımda, terleme, kızarma, titreme, çarpıntı, nefes alma güçlüğü, göğüste baskı hissi gibi bedensel belirtiler yaşıyorum.					
20. Olayla ilgili rüyalar görüyorum.					
21. Kendimi tetikte ve diken üstünde hissediyorum, güvenliğimle ilgili endişeler duyuyorum.					
22. Olay hakkında konuşmamaya çalışıyorum.					

## APPENDIX C: The Autobiographical Emotional Events Dialogue (AEED)

Yönerge:

Burada 5 kartımız var. Her bir kartta bir duyguya ait bir kart göreceksiniz.

Kartlardaki duygulara tek tek bakalım;

- “Mutlu”
- “Üzgün”
- “Kızgın”
- “Korkmuş”
- “Güvende Hisseden”

Şimdi sizden \_\_\_\_\_ ile ilgili bir hikâye anlatmanızı ve bunu birlikte yapmanızı isteyeceğim.

\_\_\_\_\_'nın mutlu hissettiği gerçek (yaşanmış) bir olay, üzgün hissettiği başka bir olay şeklinde bütün duygularla ilgili birer yaşanmış olay anlatacaksınız. Toplamda beş duyguyla ilgili beş farklı olay anlatmanız gerekiyor. Bu hikâyeler her ikinizin içinde bulunduğu olaylarla ilgili de olabilir, sadece \_\_\_\_'nın içinde bulunduğu bir olayla (okulda, arkadaşlarıyla vb.) ilgili de olabilir.

Acele etmeden anlatın ve her duygu için anlattığınız hikâyede ne olduğunu ve \_\_\_\_'nın ne hissettiğini ne düşündüğünü ve ne yaptığını anlayabilelim.

İstedığınız duyguyla başlayabilir ve istediğiniz sırayla devam edebilirsiniz, belirli bir sırayı takip etmeniz gerekmiyor, bütün duygularla ilgili hikâye anlatmış olmanız gerekiyor.

Hikâyeyi bitirdiğinizde bana haber verin ve anlatmak istediğiniz bir sonraki duyguyu söyleyin ki size o kartı gösterebileyim.

Sormak istediğiniz bir şey var mı?

## APPENDIX D: The Parental Reflective Functioning Questionnaire (PRF-Q)

Aşağıda çocuğunuzla ve sizinle ilgili bir dizi ifade bulunmaktadır. Her bir ifadeyi okuyup, o ifadeye ne kadar katılıp katılmadığınızı belirtiniz. Lütfen hiçbir soruyu boş bırakmayınız.

Aşağıda gösterilen puanlama sistemini kullanınız.

Bu sistemde 7; “tamamen katılıyorum”, 1; “hiç katılmıyorum” demektir; eğer kararsız veya yansızsanız, orta nokta 4’tür.

	1 “Hiç Katılmıyorum”	2	3	4	5	6	7 “Tamamen Katılıyorum”
1. Çocuğumun beni sevdiğinden emin olduğum tek zaman, onun bana gülümsediği zamandır.							
2. Çocuğumun ne istediğini her zaman bilirim.							
3. Çocuğumun davranışlarının ve duygularının ardındaki nedenler hakkında düşünmeyi severim.							
4. Çocuğum beni utandırmak için yabancıların yanında ağlar.							
5. Çocuğumun zihnini (aklını) tamamen okuyabilirim.							
6. Çocuğumun ne düşündüğü ve ne hissettiğini hep merak ederim.							
7. Çocuğumun mış gibi yaptığı oyunlarına aktif olarak katılmakta zorluk çekerim.							
8. Çocuğumun ne yapacağını her zaman tahmin edebilirim.							
9. Çocuğumun ne hissettiğini bulmak konusunda genellikle meraklıyım.							

10. Çocuğum bazen beni yapmak istediğim şeyden alıkoymak için hasta olur.							
11. Bazen çocuğumun tepkilerini yanlış anlayabilirim.							
12. Durumları çocuğumun gözünden görmeye çalışırım.							
13. Çocuğum huysuzken bunu sadece beni sınırlendirmek için yapar.							
14. Çocuğuma yaptıklarımı neden yaptığımı her zaman bilirim.							
15. Çocuğumun yaramazlık yapmasının sebeplerini anlamaya çalışırım.							
16. Genelde çocuğumun davranışlarını çözümlemekle uğraşmak fazla kafa karıştırıcı.							
17. Çocuğumun bir davranışı neden sergilediğini her zaman bilirim.							
18. Çocuğumun ne hissettiğini anlamaya çalışmanın hiçbir anlamı olmadığını düşünüyorum.							

## I. ETHICS BOARD APPROVAL

Ethics Board Approval is available in the printed version of this dissertation.