ISTANBUL BILGI UNIVERSITY

INSTITUTE OF GRADUATE PROGRAMS

CLINICAL PSYCHOLOGY MASTER’S DEGREE PROGRAM

A QUALITATIVE STUDY ON THERAPEUTIC ALLIANCE IN PSYCHODYNAMIC PLAY THERAPY DURING THE COVID-19 PANDEMIC

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İSTANBUL

2022

A Qualitative Study on Therapeutic Alliance in Psychodynamic Play Therapy During the Covid-19 Pandemic

Covid-19 Salgını Sırasında Psikodinamik Oyun Terapisinde Terapötik İttifak Üzerine Bir Araştırma

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Tezin Onaylandığı Tarih: 29.06.2022
Toplam Sayfa Sayısı : 195

Anahtar Kelimeler (Türkçe)	Anahtar Kelimeler (İngilizce)
1) COVID-19 Salgını	1) COVID-19 Outbreak
2) Terapötik İlişki	2) Therapeutic Relationship
3) Psikodinamik Oyun Terapisi	3) Psychodynamic Play Therapy
4) Çevrimiçi Terapi	4) Online Therapy
5) Çocuk-Ergen Psikoterapistleri	5) Child-Adolescent Psychotherapists

ACKNOWLEDGEMENTS

First, I would like to thank Zeynep Maçkalı for supporting me and sharing her positive comments without any hesitation to encourage me in this extremely overwhelming process. I would want to thank my supervisor, Şeniz Pamuk for helping me to find my jury member. I am also grateful for İrem Erdem Atak with her acceptance of being part of my jury member and for creating time for my thesis defense in her busy schedule. I also appreciate the presence of Yudum Söylemez for her precious comments on my thesis presentation. I would want to thank Esra Akça for holding and containing me during the toughest times of my graduate education.

I am grateful to have such friends, Eda Erdivanlı and Hande Burcu Şimşek who have stood by me whenever I need them. I cannot imagine how I would handle all the compelling sides of thesis writing without their presence. I also feel blessed for my classmates who were willing to find me when I was hidden. They helped me a lot in the data collection process. I am thankful for having such friends and colleagues whom I trust their way of working, professional ethics, and dedication to improving themselves.

I would also thank my cousin, Zeynep Baş for bearing me when I was too anxious. She made everything easier with her compassion, patience, and supportiveness. She made everything easier with her compassion, patience, and supportiveness. I am grateful to my family members, especially my mother for standing by me when I was feeling too anxious. Graduate education in clinical psychology became possible thanks to her presence.

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ABSTRACT

The covid-19 outbreak has affected the lives of many people and many areas of life including health systems, the economy, and education globally. Contrary to the dominance of in-person modalities of everyday life, online alternatives emerged with the sudden and unpredictable change the pandemic brought. Online therapy substituted for face-to-face therapy as an indispensable option during the pandemic. Even though online therapy with adults was preferable before the pandemic, online therapy with children and adolescents was a new experience for psychotherapists and clients. Despite the growing number of research about online therapy, there is limited research on how child and adolescent therapists who work with psychodynamic play therapy experience online therapy and establishing a therapeutic relationship with children, adolescents, and their families. In the present study, the main aim is to understand the experiences of child-adolescent psychotherapists from the psychodynamic play therapy modality. More specifically, their experiences of conducting online therapy sessions during the Covid-19 outbreak and the effect of the transition to online therapy on therapeutic alliance are explored. Eight child-adolescent therapists working with psychodynamic play therapy were recruited for the present study. The mean age of participants was 31 (from the age of 28 to 49) and the mean duration of experiences as a therapist was 5 (from 2.5 to 15 years). Semi-structured interviews were conducted with each participant through online channels, and they took approximately one hour to complete. Based on the thematic analysis of the interviews, main themes were identified, namely a) an outlook on online therapy with children and adolescents before Covid-19, b) difficulties of online therapy with children and adolescents, c) facilities of online therapy with children and adolescents, d) contributions of online therapy with children and adolescents and e) suggestions for child and adolescent therapists. The findings demonstrated that child-adolescent therapists who work with the psychodynamic approach experienced online therapy with children and adolescents both positively (e.g. keeping the relationship with clients) and negatively (difficulty in keeping

therapeutic framework). These experiences were influential in their preferences for online therapy following the transition to the "new normal". Even though they experienced difficulties with online therapy during tough times of the pandemic, online therapy contributed to their professional development as well (e.g. increase in professional assurance). Online therapy affected therapists' professional satisfaction due to their doubts about its effectiveness. However, they all agreed that being a constant object and not disappearing with the emergence of the pandemic was good for their clients. They made suggestions about online therapy with children and adolescents for their colleagues depending on their own experiences (e.g. creating a separate space for therapy, and being flexible). The results of the study are expected to inform the perspectives and practices of therapists who work with children and adolescents through online therapy. Discussions of the findings in relation to the existing literature, limitations, and suggestions for further studies are presented.

Keywords: Covid-19 outbreak, online therapy, psychodynamic play therapy, child-adolescent psychotherapists, therapeutic relationship

ÖZET

Covid-19 salgını sağlık sistemi, ekonomi ve eğitimle birlikte pek çok insanın hayatını küresel boyutta etkiledi. Günlük yaşamda yüz yüze yaklaşımların hakim olmasının aksine salgının getirdiği ani ve öngörülemez değişim çevrimiçi seçenekleri ortaya çıkardı. Çevrimiçi terapi salgın boyunca vazgeçilemez bir seçenek olarak yüz yüze terapinin yerini aldı. Salgından önce yetişkinlerle çevrimiçi terapi tercih edilebilir iken çocuk ve ergenlerle çevrimiçi terapi terapistler ve danışanlar için yeni bir deneyimdi. Çevrimiçi terapi ile ilgili artan araştırmalara rağmen, psikodinamik oyun terapi ile çalışan çocuk ve ergen terapistlerinin çevrimiçi terapi ve terapötik ittifak deneyimleri ile ilgili sınırlı sayıda araştırma bulunmaktadır. Bu çalışmanın temel amacı, psikodinamik oyun terapisi yaklaşımı ile çalışan çocuk ve ergen terapistlerinin deneyimlerini anlamaktır. Daha spesifik olarak, Covid-19 salgını sırasında terapistlerin çevrimiçi seansları yürütme deneyimleri ve çevrimiçi terapiye geçişin terapötik ittifak üzerindeki etkisi araştırılmaktadır. Bu çalışma için psikodinamik oyun terapisi ile çalışan sekiz çocuk ve ergen terapisti ile görüşme yapılmıştır. Katılımcıların ortalama yaşı 31 (28-49 yaş arası) ve ortalama deneyim süresi 5 yıldır (2.5-15 yıl arası). Yarı-yapılandırılmış görüşmeler çevrimiçi kanallar aracılığıyla gerçekleştirilmiştir ve görüşmeler yaklaşık 1 saat sürmüştür. Tematik analize dayalı olarak, a) Covid-19 salgınından önce çevrimiçi terapiye bakış, b) çocuk ve ergenlerle çevrimiçi terapinin zorlukları, c) çocuk ve ergenlerle çevrimiçi terapinin kolaylıkları, d) çocuk ve ergenlerle çevrimiçi terapinin katkıları ve e) terapistlere öneriler isimli beş tema belirlenmiştir. Bulgular psikodinamik yaklaşımla çalışan çocuk ve ergen terapistlerinin çocuk ve ve ergenlerle çevrimiçi terapiyi hem olumlu (terapötik ilişkiyi devam ettirebilmek) hem de olumsuz (terapötik çerçeveyi sürdürmekte zorlanmak) bir şekilde deneyimlediğini göstermiştir. Bu deneyimler "yeni normale" geçildikten sonra terapistlerin çevrimiçi terapiyi tercih etmelerinde etkili olmuştur. Pandeminin çetin zamanlarında çevrimiçi terapinin zorluklarını deneyimlemelerine rağmen çevrimiçi terapi terapistlerin mesleki gelişimlerine katkıda (mesleki özgüvenin artması) bulunmuştur. Çevrimiçi terapi çevrimiçi

terapinin etkililiği hakkındaki şüpheleri nedeniyle terapistlerin mesleki tatminini etkilemiştir. Bununla birlikte katılımcıların hepsi sabit bir nesne olmanın ve pandeminin ortaya çıkmasıyla birlikte kaybolmamanın danışanlara iyi geldiği konusunda hemfikir olmaktadır. Katılımcılar kendi deneyimlerine dayanarak meslektaşlarına çocuk ve ergenlerle çevrimiçi terapi hakkında önerilerde (örn. çevrimiçi terapi için ayrı bir alan oluşturmak, esnek olmak) bulunmuşlardır. Bu çalışmanın sonuçlarının çocuk ve ergenlerle çevrimiçi seans yapan terapistlerin yaklaşım ve uygulamalarını geliştirecek doğrultuda bilgi vermesi beklenmektedir. Bulgular mevcut literatür bağlamında tartışılmış, çalışmanın sınırlılıkları ve sonraki araştırmalar için öneriler sunulmuştur.

Anahtar Kelimeler: Covid-19 salgını, çevrimiçi terapi, psikodinamik oyun terapisi, çocuk-ergen terapistleri, terapötik ilişki

CHAPTER ONE

INTRODUCTION

Therapeutic alliance which is a key element for all therapy orientations is a fruitful topic for researchers. Studies on therapeutic alliance paves the way for understanding its components and its significance for psychotherapy with both adults and children. Therapeutic alliance is defined as a collaborative relationship between the client and the therapist (Bordin, 1979). Bordin (1979) categorized three dimensions of therapeutic alliance as goal, bond and task. Both client's and therapist's agreement on expectations of therapy refers to the *goal* component of therapeutic alliance. While the *bond* component of therapeutic alliance denotes a warm and accepting relationship between therapist and client, the *task* component is defined as agreement on the techniques and behaviors that will be helpful for change. Studies that focused on factors affecting change in therapy emphasized the importance of therapeutic alliance (Elvins & Green, 2008; Priebe & McCabe, 2006).

Adults talk about their problems and feelings with their therapists while play is the language of children in sessions. Children display their world through play (Lowenfeld, 1935), and in psychodynamic play therapy, free and spontaneous play is important for accessing their unconscious (Klein, 1932). The therapist's empathic attunement to nonverbal communication while being present and engaged with the child is an important aspect of the therapeutic alliance (Meissner, 2007). Besides the therapist's approach in sessions, the therapeutic framework is essential in psychodynamic play therapy (Franch, 1996). Scheduled sessions for a predetermined length of time are done in the same room with toys, drawing, and painting materials. The therapeutic framework supports a psychic setting which is the therapist's ability to communicate at all levels and to contain the child's emotions (Franch, 1996).

The sudden transition from face-to-face therapy to online therapy with the emergence of the COVID-19 outbreak has changed the therapeutic framework.

While child and adolescent therapists have face-to-face sessions in their offices, they started to set up online sessions and their clients attended the sessions mostly from their homes due to lockdown, social distancing, and isolation. Thus, some issues like sufficient equipment for remote therapy, proficiency in technological skills, access to reliable WIFI service, and confidentiality protections related to privacy in online psychotherapy sessions emerged. Austrian psychotherapists who started to use video conferencing during the pandemic stated that they have better actual experiences than their expectations (Humer, Stippl, Pieh, Pryss, & Probst, 2020). Therapists experienced videoconferencing as "a pleasant surprise" due to the ease of use and functionality of remote psychotherapy (Connolly, Miller, Lindsay, & Bauer, 2020). However, therapists found technical problems, confidentiality issues, and the reduction of interpersonal cues such as gestures, and body language in online setting challenging (Békés, Aafjes-van Doorn, Prout, & Houfman, 2020; McBeath, du Plock, & Bager-Charleson, 2020). Also, establishing a good working alliance is a significant concern for therapists (Connolly, et. al, 2020). Analytic therapists evaluated therapeutic alliance in online sessions as strong as in-person sessions for most of their clients (Békés, et. al, 2020). While tele-mental health is good with adolescents, it is experienced as a struggle with children from therapists' perspectives (Hoffnung, Feigenbaum, Schechter, Guttman, Zemon, & Schechter, 2021). Although there are different studies related to the therapeutic alliance and videoconferencing, they mainly focus on adults (McBeath et. al, 2020; Simpson, Richardson, Pietrabissa, Castelnuovo, & Reid, 2021). A study about children and tele-mental health compares the difference between adults' and children's preference for tele-mental health with a little emphasis on therapeutic alliance (Hoffnung, et. al, 2021). The sudden transition to online psychotherapy with the emergence of COVID-19 showed the importance of having training about online psychotherapy sessions and building therapeutic alliance with clients in online sessions as well as face-to-face sessions. A study that was conducted with graduate student therapists and outpatients in Virginia Commonwealth University Primary Care Psychology Collaborative emphasized the importance of further research for determining best

practices in the training and application of tele-health for psychologists (Perrin, Rybarczyk, Pierce, Jones, Shaffer, & Islam, 2020). Also, another study concluded that it would be good for further research to understand the impact of therapists' readiness and confidence on utilizing tele-mental health and assessing therapeutic alliance (Frye, Gardner, & Mateus, 2021). Even though various research focused on children and tele-mental health, the research on therapeutic alliance with children and online therapy during COVID-19 is very limited. Also, there is no qualitative study that investigates building a therapeutic alliance with children during COVID-19 regarding child and adolescent therapists' perspectives.

Considering the existing evidence, it is required for child and adolescent therapists to have training in conducting online sessions, especially with children due to the emergence of a possible crisis like the COVID-19 outbreak. Therefore, the topic of establishing a therapeutic alliance with children and adolescents in online therapy will get more attention in clinical settings. As explained above, the literature about establishing therapeutic alliance in online settings is mostly concerned with adults, and studies examining online therapy and therapeutic alliance from therapists' perspectives are very limited. Thus, this thesis aims to deeply investigate child and adolescent therapists' experiences of establishing therapeutic alliance regarding the psychodynamic perspective. Based on research findings, implications for an effective therapeutic alliance in online therapy with children and adolescents will be developed.

1.1. THERAPEUTIC ALLIANCE

Therapeutic alliance traces back to the psychoanalytic theory which highlights transference and countertransference as core features of process and change in psychoanalysis (Freud, 1912). In *The Dynamics of Transference,* Freud (1912) stated that an analyst's empathic stance could let the client form a positive attachment with the analyst (p. 105). Also, Freud (1913) evaluated a therapist's supportive attitude toward a client would lead him to associate the therapist with "the images of the people by whom he was accustomed to be treated by affection."

(pp. 139-140). He stated that attachment between client and therapist can be considered a form of positive transference (Freud, 1913, pp. 99-108). Even though the interpretation of the client's projections is essential, Freud (1913) emphasized the importance of the relationship between the client's conscious self and the "real" therapist. Zetzel (1956) found the term *therapeutic alliance* in order to refer to the relationship between therapist and client.

While different theoreticians were trying to understand the concept of the alliance, there was a big discussion regarding transference and alliance. Depending on the concept of reality-based relationship, Greenson (1965) created the term *working alliance.* He added that the client's motivation and ability to cooperate with the therapist are important elements of a working alliance. Also, in the course of time, well establishment of the alliance is much possible if the therapist recognizes and interprets the client's transference. Zetzel (1956) made a clarification between working alliance and transference and stated that in a successful analysis, alliance lets the client use the therapist's interpretations to make a difference between his or her past relationships and real bond with the therapist. Also, there are periods when the relationship between client and therapist oscillates between transference and alliance (Zetzel, 1956). Object relationists evaluate the therapeutic relationship as a new object relationship for the client (Bibring, 1937; Bowlby, 1988; Gitelson, 1962; Horwitz, 1974). They suggested that the therapy process leads the client to develop the capacity to form a positive relationship with the therapist. This attachment to the therapist is different from his or her early childhood experiences. Zetzel (1956) stated that a client's early developmental experiences have an impact on building a stable and trusting relationship in the therapy process. Also, the level of development of object relations was found to be linked to the strength of working alliance in the early phases of therapy (Ryan, 1973). Horwitz (1974) suggested that the capacity of the patient to perceive a therapist as a good object may impact the establishment of a strong working alliance.

While these theorists (Bibring, 1937; Bowlby, 1988; Gitelson, 1962; & Horwitz, 1974) asserted that alliance and transference are different constructs, some

argued that each aspect of the therapist-client relationship is related to transference. Thus, they proposed that the client's alliance serves as a function of an unconscious wish to gain the therapist's approval. Clients transfer their unresolved emotions and thoughts with significant others to the therapist. Thus, in this sense the relationship between therapist and client is unreal (Gelso & Carter, 1985, p. 170). While some argued that the relationship between therapist and client is just transference (Brenner, 1979), others asserted that all relationships reflect prejudices based on past interpersonal relationships (Hatcher, 1990). Those who advocate the latter view stated that therapeutic alliance depends on the interpersonal relationship between therapist and client but at the same time client reflects on his or her unresolved previous relationships. Thus, the main issue is the degree to which a client's past relationships impact the alliance (Piper, Azim, Joyce, & McCallum, 1991a).

Theoreticians' studies to develop a reliable assessment tool for therapeutic alliance contributed to understanding its components. It was found that personal attachments and the client's wish to invest in therapy are joint elements in different instruments to assess therapeutic alliance (Hansell, 1990; Hartley, 1985; Marziali, 1984). Rogers (1965) highlighted the patient's experience of therapist empathy as a core characteristic of alliance in his work to recognize it as a concept in humanistic psychotherapy. A moderate to strong relation was found between the client's perception of empathy and alliance, especially in the early stages of therapy (Greenberg & Adler, 1989). Anderson put together empathy and rapport under the umbrella of "therapeutic bond" to make it functional as a concept (Anderson & Anderson, 1962).

Various studies consistently showed that different psychotherapeutic orientations have nearly the same amounts of therapeutic gains (Luborsky, Singer, & Luborsky, 1975; Smith & Glass, 1977; Stiles, Shapiro, & Elliott, 1986). Thus, therapeutic alliance engaged researchers' attention as a common factor for all forms of therapy. At the beginning of the studies for developing the concept of the alliance, Luborsky (1976) suggested that alliance has a dynamic nature that is affected by changing demands of different phases of therapy. Luborsky (1976)

divided the working alliance into two categories as Type 1 working alliance and Type 2 working alliance. Type 1 alliance which is the client's perception of the therapist as a supportive other becomes apparent especially in the early phases of therapy, whereas Type 2 alliance which is both therapist’s and client’s common goal for working on treatment goals is more typical in later phases of treatment (p. 94). Operationalization of the alliance continued with the studies of Orlinsky and Howard (1975) who suggested three dimensions of the alliance as a working alliance, empathic resonance, and mutual affirmation.

Bordin (1979) divided therapeutic alliance into three dimensions as task, goal, and bond, which is known as Bordin’s pan-theoretical perspective, and stated that it is applicable to various psychotherapeutic orientations (Summers & Barber, 2003). The *task* component of the alliance refers to an agreement on the technique and behavior that will be helpful for a change. In a good working alliance, both client and therapist see tasks as relevant and efficient. Also, both parties take responsibility to perform tasks. The *goal* component of the alliance is agreement on expectations about the accomplishments of therapy. The *bond* component is forming a warm relationship which includes mutual trust, acceptance, and confidence (Bordin, 1979). Positive developments in each component facilitate the other’s growth (Bordin, 1989). Thus, a client's assessment of tasks and interventions as relevant and efficient impacts his or her attachment with the therapist.

In contrast to Rogers (1965) who suggested that a client's response to positive attitudes of the therapist is automatic, it is stated that clients assess therapy based on their expectations besides therapist factors (Hill & O’Grady, 1985; Horvath, Marx, & Kamann, 1990). Thus, the therapist’s communication with the client about the significant link between therapeutic tasks and goals of the therapy and helping the client to be aware of his or her commitment to these activities is essential (Horvath & Luborsky, 1993). Also, a client's willingness to be committed to tasks partly depends on the acceptance of the goals of the therapy (Horvath & Luborsky, 1993). For instance, while the therapist and client have an agreement on long-term goals, acceptance of short-term goals may be different.

Generally, clients want to relieve their suffering immediately whereas therapists see treatment as a process that brings about an eventual relief (Horvath & Symonds, 1991, p. 620). Therapists specify goals based on theory, but this may not be understandable for clients. Therefore, it would be good for therapists to make the association between short-term goals and lasting relief of the client's sufferings clear to establish a strong alliance. This association facilitates the client's following of these objectives, in other words, an alliance that results in effective coping with immediate gratification (Horvath & Luborsky, 1993).

1.1.1. Client and Therapist Factors Influencing the Development of the Alliance

The client's and therapist's personal histories influence their capability to develop good or poor alliances. As a result of the investigation of various studies to understand client characteristics, Horvath (1991) divided the variables into three categories: interpersonal capacities, intrapersonal dynamics, and diagnosis of the client. Interpersonal capacities refer to the quality of the client's social relationships (Moras & Strupp, 1982) and family relations (Kokotovic & Tracey, 1990). Intrapersonal dynamics consist of quality of object relations (Piper, Azim, Joyce, McCallum, & Nixon, Segal, 1991b), client's motivation (Marmar, Weiss, & Gaston, 1989) and psychological status (Ryan & Cicchetti, 1985). Diagnostic features include the severity of the client's symptoms in the early phase of therapy.

Depending on these variables, the effect of interpersonal and intrapersonal variables on developing a good alliance is similar and significant. It is less likely to develop a good alliance for clients who have difficulty maintaining social relationships (Moras & Strupp, 1982). There is a strong relationship between a good alliance and a patient's capacity to engage in interpersonal relationships (Marmar, Weiss, & Gaston, 1989; Marziali, 1984). Defensive interpersonal style is linked to the poorer alliance as well (Gaston, Thompson, & Gallagher, 1988). The client's positive expectations about therapy in the intake and motivation for

psychotherapy are correlated with the development of good alliance in dynamic therapy (Joyce & Piper, 1998; Marmar, Gaston, Gallagher, & Thompson, 1989). Also, clients who are not hopeful for success (Ryan & Cicchetti, 1985) and clients with poor object relations (Piper et al., 1991b) are likely to have a poor alliance. In contrast to interpersonal and intrapersonal variables, symptom severity had a small impact on the capacity to develop a good therapeutic alliance. It was found that there is a strong relationship between the client's early object relations and the quality of the alliance, as well as the outcome (Piper et al., 1991a). There is no significant relationship found between the client's current relations and alliance. The study showed that alliance is a quite strong predictor of outcome rather than the quality of object relations. Based on this result, it can be suggested that object relations impact the alliance but do not determine its quality.

Therapist's interventions which include collaboration, using the therapy relationship and interpretation influence the development of the alliance. Therapist's supportive and empathetic attitude toward the client is advantageous for the early alliance (Greenberg & Adler, 1989; Horvath, 1981; Kokotovic & Tracey, 1990). Various findings supported the significant correlation between early alliance and empathy (Adler, 1988; Horvath & Greenberg, 1989; Moseley, 1983). Besides collaboration between client and therapist, the function of the therapeutic relationship is important. Therapeutic relationship reactivates client's dysfunctional interpersonal relationship schemas. If the therapist's response confirms the client's schema, the cycle is repeated. However, if the therapist recognizes the client's pattern and talks about the client's negative feelings toward himself or herself, the possibility of change in client's perspective regarding his or her morbid ideas increases (Bordin, 1979; Luborsky, 1977). Also, therapist's challenging approach toward therapeutic relationships contributes to the improvement of alliance compared to therapists who do not talk about the current relationship (Kivlighan & Schmitz, 1992). A curvilinear relationship between frequency of interpretations and quality of alliance was found in a study conducted by Piper (1991b). Timing and type of interpretation, client's response are indicative elements to understand the relation between interpretation and quality of alliance. As mentioned above,

therapist's interpretations about the current difficulties in the relationship between therapist and client have a significant effect on improving the alliance in contrast to interpretations about out-of-therapy events (Foreman & Marmar, 1985; Reandeau & Wampold, 1991).

1.1.2. Critical Alliance Phases

It is considered that there might be two critical phases of alliance: development of the alliance in the first sessions and the therapist's challenging attitude toward the client's old patterns in progressive sessions. The first phase involves the first five sessions, and the third session is probably the peak point for the development of the alliance (Horvath, 1981; Saltzman, Leutgert, Roth, Creaser, & Howard, 1976). Also, a meta-analytic review on therapeutic alliance shows that alliance seems to develop around the third or fourth session (Horvath & Luborsky, 1993; Horvath & Symonds, 1991). The establishment of collaboration and trust, agreement on accomplishments of therapy, client's attendance as therapist's participant in the process and accepting therapeutic framework are essential in the first phase. Second phase refers to the therapist's challenging client's old patterns. Clients may approach therapist's interventions with decreased sympathy and support, which could lead to reactivation of client's dysfunctional patterns and ruptures in the alliance, respectively. Depending on the verbal interaction between high-alliance and low-alliance therapist-client pairs, Reandeau and Wampold (1991) found that high-alliance clients involved in therapist's challenging interventions whereas low-alliance clients avoided in response to these situations. This study showed that therapist's emphasis of client's conflictual relationship patterns and client's response with involvement rather than avoidance give rise to better alliance.

Some asserted that alliance has fluctuations during the therapy process (Horvath & Marx, 1991) while others argued that alliance has a positive slope in the course of time (Adler, 1988). Zetzel (1956) and Bordin (1989) mentioned rupture and repair cycles in successful therapies. Repairment of therapeutic

relationships is important for the successful continuation of therapy (Crits-Cristoph, Barber, & Kurcias; 1993, Safran, Muran, Walner, & Samstag, 1992). Ruptures can occur in different phases of therapy and depending on the phase when these ruptures happen, the therapeutic alliance can be affected in various ways (Hovarth & Luborsky, 1993). If difficulties in developing a positive relationship and having an agreement over procedures of the therapy happen in the beginning, it is not much more possible for the client to continue and premature termination is highly probable (DeClericq, Goffinet, Hoyois, & Brusselmans, 1991; Horvath, 1991; Kokotovic & Tracey, 1990). Lack of experience of ruptures in the alliance may be a sign of either therapist's failure to challenge the client to face his dysfunctional patterns and thoughts or the client's idealization of the therapist. Thus, therapy can have a circular pattern that reflects past unresolved issues (Henry & Strupp, 1994). Also, if the severity of challenges in the second phase is too much, healing of the alliance rupture is not possible (Safran, Crocker, Mcmain, & Murray, 1990). Fluctuations especially in the middle phase seem to show that client's dysfunctional relationship patterns emerge again and the therapist's ability to recognize and resolve these issues is critical (Horvath & Luborsky, 1993). While there was discussion regarding whether the therapeutic alliance is a by-product of the process (Horvath, 1991), it was found that there was a close relation between positive outcomes and repairs of alliance ruptures (Safran et. al, 1990). Thus, ruptures and repairs are the essences of the course of the alliance in an efficient therapy (Horvath & Marx, 1991).

1.1.3. Impact of Therapeutic Alliance on Psychotherapy with Adults

Bordin (1979) stated that a working alliance is a key component of change. Even though different psychotherapy orientations have various modes of working alliance, the strength of the alliance will be a significant component of change rather than the kind of working alliance (Bordin, 1979). There is a partial relationship between the effectiveness of therapy and the strength of the alliance which is a function of the goodness of fit between requirements of working

alliance and characteristics of patient and therapist. Depending on the review of the process and follow-up data of a long-term study which was conducted with forty-two patients, Horwitz (1974) stated that therapeutic alliance is not only a requirement of therapy but also it is the main agent of change.

Horvath and Symonds (1991) found a strong correlation between therapeutic alliance and the outcome of the therapy depending on a meta-analysis of the quantitative research. Also, in a study that was conducted with 42 patients during 20 sessions of psychodynamic therapy, the alliance was assessed from the perspectives of the patient, therapist, and independent raters (Marziali, 1984). A significant correlation was found between patient ratings of alliance and psychotherapy outcome. Both therapist and independent evaluator ratings of alliance and outcome were similar to patient's ratings, as well. Also, the client's ratings of therapeutic alliance predicted outcomes better than either therapists' or observers' ratings (Horvath & Luborsky, 1993; Horvath & Symonds, 1991). To understand the relation between alliance and outcome, it is essential to consider the factors influencing it. The type and length of the treatment were evaluated as factors that might be affecting the link between alliance and outcome (Horvath & Luborsky, 1993). There was no significant relationship between different treatment approaches in terms of alliance-outcome relations (Horvath & Symonds,1991; Krupnick, Stotsky, Simmens, & Moyer, 1992). A strong alliance seems to have a positive contribution in all therapies based on alliance research including different treatment orientations such as Gestalt therapy, behavioral therapy, cognitive therapy and psychodynamic therapy (Horvath & Symonds, 1991). Also, all theoretical orientations have an equal degree of prediction for the alliance on outcome (Horvath & Luborsky, 1993). Depending on the quality of the alliance, the therapist's strategy can have an impact on the outcome. If the therapist uses exploratory interventions in the presence of a good alliance, it affects the outcome positively whereas in the context of poor alliance supportive interventions are effective for a better outcome (Gaston, Marmar, Gallagher, & Thompson, 1991).

Horvath and Symonds (1991) found that early and late alliance predicts

outcomes better than sessions toward the middle of treatment. Failure to develop a strong alliance in the beginning of the therapy impacts the outcome of the therapy detrimentally (DeClericq et al., 1991; Kokotovic & Tracey, 1990). Some research on early alliance showed that the client's approval of tasks and the client's feeling of collaboration with the therapist has a strong link with the positive outcome (Adler, 1988; Horvath & Greenberg, 1989). Also, the strength of the Type 2 alliance which is both therapist's and client's common goal for working on treatment goals was associated with the quality of outcome in dynamic therapy (Luborsky, 1976). Besides the impact of therapeutic alliance on the outcome, in a study which was conducted with 62 patients in a psychodynamic therapy, it was found that there is a significant relationship between alliance and the client's general symptomatology after treatment (Piper et. al, 1991).

1.2. THERAPEUTIC ALLIANCE WITH CHILDREN AND ADOLESCENTS

Following the research on adult therapeutic alliance Kazdin, Siegel, and Bass (1990) asked child therapists to rate factors that affect the degree of change in therapy. Therapists' responses showed that therapeutic alliance significantly impacts change. There were two outstanding views on therapeutic alliance with children in the early years of research. Anna Freud (1946) emphasized the importance of "affectionate attachment" between therapist and child as a "prerequisite for "all later work" in child therapy (p. 31). Her distinction between bond and work maintained its importance as the distinction between emotional relationship and collaborative relationship (Estrada & Russell, 1999; Shirk & Saiz, 1992). An emotional bond allows the child to work on tasks of therapy intentionally. Rather than considering the alliance itself as curative, it is seen as a facilitator in therapeutic work. This view is mentioned in the later cognitive-behavioral formulations of the therapy relationship such that children participate in therapy tasks by means of alliance (Kendall, Comer, Marker, Creed, & Puliafico, 2009; Shirk & Karver, 2006).

Contrary to this view, the curative nature of the therapy relationship is emphasized by play therapists (Axline, 1947). Empathy, authenticity, and positive regard are active components of therapy from a relational perspective (Shirk, Karver, & Brown, 2011). A child's perception of a therapist as empathic, supportive, and attuned is critical for therapeutic change (Shirk & Russell, 1996; Wright, Everett, & Roisman, 1986). Also, the therapist's warmth, empathy, and positive regard affected children's statements about themselves positively in the middle phase of therapy (Siegel, 1972). However, a child's relationship with the therapist may have different reasons. According to Anna Freud's observations, a child can see a therapist as a playmate and a grown-up who pays attention to him if the home environment does not support the child's needs (Sandler, Kennedy, & Tyson, 1980, p. 47). Thus, a child's positive feeling for therapy can be related to the degree of how fun, stimulating, or rewarding a therapist is rather than considering the therapist as an ally in therapeutic work (Shirk, Karver, & Brown, 2011). Anna Freud (1946) made a distinction between this type of relationship and a therapeutic relationship by defining it like a therapist is experienced as *someone who can be counted on for help with emotional and behavioral problems*. Depending on his works, Rogers (1957) sees therapy as a child's opportunity for growth rather than as a treatment, in other words, the therapist's active and child's passive role in the therapy process. In this view, there is a direct relation between bond and outcome instead of the mediating role of therapeutic work.

A positive therapeutic alliance including task, bond, and goal components of the alliance is defined as *"A contractual, accepting, respectful, and warm relationship between a child-adolescent and a therapist for the mutual exploration of, or agreement on, ways that the child-adolescent may change his or her social, emotional or behavioral functioning for the better, and the mutual exploration of, or agreement on procedures and tasks that can accomplish such changes."* (DiGuiseppe, Linscott, & Jilton, 1996, p. 87). In the development of a scale for measuring therapeutic alliance depending on Bordin's pan-theoretical model (1979), Shirk and Saiz (1992) found that a child's affective experience of therapy has a significant effect on the child's collaboration with the therapeutic

task. Children who had positive feelings toward therapy were more willing to talk about problems and feelings compared to children who had negative feelings toward therapy (Shirk & Saiz, 1992, p. 720)

Emotional bond is evaluated as the crucial component of the alliance with children (Shirk, Gudmundsen, Kaplinski, & McMakin, 2008; Shirk & Saiz, 1992; Shirk & Russell, 1996). Emphasis on the emotional bond is criticized because of ignoring the task and goal component of the therapeutic alliance with the rise of behavioral treatments for children (DiGiuseppe, Linscott, & Jilton, 1996). However, children and adolescents are generally referred to therapy by their parents which makes having an agreement on goals difficult and significant at the same time (Shirk, Karver, & Brown, 2011). It would be good to examine Prochaska and DiClemente's (1988) research on people's attitudes toward change to understand the importance of referral. In this model, change is divided into four categories: pre-contemplative stage, contemplative stage, action stage, and maintenance stage. In the pre-contemplative stage, people have no desire to change whereas in the contemplative stage people are eager to discover whether they want to change or not in the action stage people try to change, and in the last stage they keep practicing about change to strengthen it. In contrast to self-referred clients who have an idea about their emotions and behaviors before entering therapy, children, and adolescents are mostly forced into therapy against their wishes and have no insight into their problems. Thus, in the light of this change model children and adolescents often do not enter the therapy willingly and that makes the establishment of a therapeutic alliance difficult because it can be tough to come to an understanding about the goals of the therapy for child or adolescent (DiGuiseppe et. al, 1996; Kazdin, 1988; Kendall, 1991; Koocher, 1976; Shirk, 1990; Tuma, 1983).

Children's lack of insight into their problems and wish for change is the most obvious factor that prevents their motivation for treatment (Freud, 1965; Meeks, 1971; Mishne, 1983). To understand children's and adolescents' difficulty in maintaining alliance Shirk and Saiz (1992) proposed a social-cognitive model. According to their developmental schema, a child's attachment style, self-

evaluation, being able to create internal attributions for behavior, and contingency of problem solutions have an impact on a child's ability to form a therapeutic alliance. If a child or adolescent has a positive schema for attachment with others, it positively affects therapeutic alliance. Self-evaluation has a significant role in agreement on the goals such that in the absence of it participating in therapy long enough may not be possible. Since self-evaluation has a developmental sequence, many children are referred to therapy before they are mature enough for realizing the need for change. (DiGuiseppe et. al, 1996).

The developmental stage of children may affect which component of the therapeutic alliance is of the most importance for them. For instance, the bond may be the one and only factor in developing therapeutic alliance for preschool and early elementary school children. It is highly possible that they are not interested in the social contract of therapy. Besides, in the concrete operations of stage, children are inclined to consider causes of behavior as external and situational rather than evaluating the role of inner psychological constructs (Shirk, 1988). Therefore, depending on young children's cognitive limitations on self-evaluation, understanding the goals of the therapy as insight is an unrealistic expectation for young children (Jurkovic & Ulrici, 1982; Nannis, 1988; Nuffield, 1988; Shirk, 1988).

Unlike children, agreement on tasks and goals of the therapy is important for adolescents due to the growing significance of dependence, independence, and self-determination issues for them. Adolescents want to do things in their own way rather than someone's imposition of their decisions on them. Thus, therapists may have difficulty in establishing agreement on goals and tasks with adolescents compared to younger children (DiGuiseppe, Linscott, & Jilton, 1996). Adolescents' reason for referral may influence which components of the alliance are related to outcome and easier to form as well. Establishing agreement on goals and tasks may be much easier for adolescents with internalizing disorders since it is less likely to have problems with authority figures for them. Also, they may be open to forming therapeutic alliance due to decreasing emotional discomfort related to internalizing disorders. However, adolescents with externalizing disorders such as

oppositional and conduct disorder are not motivated to change, and thus they are not open to entering any contract with the therapist (Sherwood, 1990). Also, adolescents with oppositional and conduct disorder may not get along with authority figures and that can affect agreement on goals and tasks of therapy (DiGuiseppe et. al, 1996). Thus, it would be good to imply various techniques depending on the age, presenting problems, motivation to change and personality structure of the child or adolescent to form a therapeutic alliance. Besides the impact of the referral on agreement on tasks and goals of the therapy, literature on therapy with children and adolescents finds the reflective, supportive, and non-directive techniques sufficient for forming a bond and evaluating it sufficient for change while de-emphasizing the importance of tasks and goals of the therapy (Axline, 1947; Buxbaum, 1954, Freud, 1964; Moustakas, 1953; Reisman, 1973). However, agreement on the goals of the therapy is seen as an essential component of the alliance. Various psychotherapy orientations approach the goal component of the alliance differently. In traditional psychodynamic therapy discrepancy between the client's and therapist's goals may be controversial. Since others often decide goals on behalf of a child, specifying goals clearly is avoided (Hare-Mustin, Marecek Kaplan, & Lis-Levinson, 1979; Koocher, 1976; Weinberger, 1972). Thus, most professionals who work with children and adolescents do not request children to construct goals (Carek, 1979; Freud, 1964; Tuma, 1983). In behavioral or family-oriented approaches goals are more likely to be discussed and the possibility of a child's or adolescent's recognition of the goals of therapy increases. However, discussing goals does not guarantee agreement with the goals because parents or therapists decide the goals and tasks of therapy (Haley, 1976; Minuchin, 1974). In the cognitive approach, a specific discussion of goals and a child's understanding of target behavior is crucial. Also, having a clear goal for each session is significant in cognitive therapy whereas in traditional psychodynamic therapy setting goals in the first session and determining what will be done in the following sessions regarding the needs of the child or adolescent have a pivotal role (Axline, 1947; Freud, 1964; Kendall, 1991; Linscott & DiGuiseppe, 1994; Moustakas, 1953; Reisman,

1973).

In terms of the task component of the alliance children and adolescents do not have much idea about the relation between tasks and goals of their therapy. Even though most adults know that the therapy process includes introspection and talking about dreams and feelings as a part of obtaining therapy goals. On the contrary children and adolescents generally do not have any previous experiences with therapy. Therefore, the link between tasks and goals of the therapy may not be understandable for children and adolescents. The therapist's effort to establish an agreement on goals may also lead to a positive therapeutic alliance. Besides, the therapist's role as an ally who tries to understand a child's and adolescent's perception of goals may provide them concern and respect they have not experienced before (DiGuiseppe et. al, 1996). Holmes and Urie (1975) argued that a therapist's explanation of the therapy process clearly and providing the chance to discuss decreases the probability of premature termination.

Therapy with adolescents has its own ups and downs in managing the alliance (Meissner, 2007). Thus, having an introduction phase is essential for building a positive relationship (Nicoli, 1988). It is suggested that explaining the initial goals related to referral to adolescents is indispensable for reaching an agreement on the goals of therapy (DiGuiseppe et. al, 1996). However, parents, therapists, and adolescents may have different goals. In a study with clinic-referred clients, it was found that the child-adolescent, parent, and therapist triad could not agree on even one target problem (Hawley & Weisz, 2003). Also, therapists tended to agree on goals with parents. Thus, it is highly possible that adolescents have a disagreement with their therapists on the goals of the therapy (Johnson, Rasbury, & Siegel, 1986). It seems extremely important for therapists to take both parents' and adolescents' perspectives about goals into account and have a treatment plan that reconciles both perspectives.

1.2.1. Parent-Therapist Alliance

Building an alliance with parents is an undeniable part of therapy since parents bring the child or adolescent over to therapy and make payment. Youth-therapist and parent-therapist alliances have different dynamics and effects on outcome. For example, Hawley and Weisz (2005) found that parent alliance predicted better therapy participation while youth alliance predicted symptom change. These findings suggest that a strong alliance with parents is important for treatment continuation, whereas the youth alliance may be more critical for treatment outcomes. A study with adolescents between 11 and 18 years old showed that there was a significant relation between parent-therapist alliance and a decrease in externalizing symptoms (Hawley & Garland, 2008). Alliance also improves parents' interaction with their children at home as well (Kazdin, Whitley, & Marciano, 2006). Kazdin and his colleagues (2006) found that if parents practice parenting skills they learned during therapy sessions in the home environment, it contributes to improvement in the child's behavior. Thus, the parent-therapist alliance leads to therapeutic changes in children.

The alliance between parents, child, and therapist has a significant role in termination issues as well (Glenn, Sabot, & Bernstein, 1978). Parents' ratings of their alliance with therapists estimate treatment completion (Hawley & Weisz, 2005) and the alliance between parents and therapist minimizes parents' disruption of treatment (Glenn, 1987). In a study conducted with families, children, and adolescents in community mental health clinics to understand the factors behind dropout it was found that lack of rapport between therapist and client is significantly linked to termination (Garcia & Weisz, 2002). Most of the parents explained the reasons for termination as a child's dislike of the therapist and the therapist's emphasis on wrong problems. Also, another study with families of children and adolescents referred to the Yale Child Conduct Clinic showed that parents' feelings of poor therapeutic alliance such as not liking therapists, lack of perceived support, and bonding predicted dropout (Kazdin, Holland, & Crowley, 1997). Hawley and Weisz (2005) conducted a study with 65 children and

adolescents between 7 and 16 years old, their families, and therapists. They measured therapy retention, symptom improvement, satisfaction with services, and family participation. Results showed that if there is a positive alliance between therapist and parent, parents' participation, and satisfaction increase. Also, parent alliance was negatively correlated with the cancellation rate. A positive alliance between youth and therapist decreased symptom severity whereas the parent-therapist alliance had no direct effect on it. Even though parents provide the child and adolescent transportation and a financial basis for attendance, a working alliance that is related to motivation and active participation in therapy tasks is mostly dependent on the child or adolescent. Thus, tasks of therapy and motivation to participate in them may mostly be related to decreased symptom severity (Stark, Rouse, & Livingston, 1991).

1.3. PSYCHODYNAMIC PLAY THERAPY

1.3.1. Importance of Play

Play is a voluntary, symbolic, and meaningful activity in which a child gets involved joyfully, and play contributes to the child's physical, psychomotor, social, cognitive, and language development (Compas, Rodrigues & Pinto, 2010; Kargı, 2007; Öğretir, 2008). From the child's perspective play is the most important occupation and toys are the most important medium of play. Play is as much as necessary as other needs such as sleep and nourishment for a child's healthy growth (Bekmezci & Özkan, 2015).

Play, which is a bridge between a child's fantasy and reality, has a significant role in a child's mental health and in solving psychological difficulties (Gray, 2011; Özer, Gürkan, & Ramazanoğlu, 2006). Play helps children find solutions to their problems and regulate their emotions (Gray, 2011; Kıran, Çalık, & Esenay, 2013; Landreth, 2012; Whitebread, 2012). Also, play affects a child's current and future relationships. In this context, play is used as a medium of treatment while working with children (Burns, 2016; McMahon, 2005).

1.3.2. Play Therapy

In addition to the contribution of play to a child's physical and mental health, it also has a therapeutic effect. Children face their fears, enhance their coping skills and express their worries through play. Hence, it has led up to the utilization of the curative nature of play since the 1900's (Teber, 2015). Play therapy is a psychotherapy approach including expression and discovery of self through the medium of play between therapist and child (Landreth, 2012). Play therapy allows therapists to understand the children's inner world.

Behavioral problems (Lawner & Blankenship, 2008), trauma (Locatelli, 2020), somatic complaints (Schottelkorb, Swan, Jahn, Hass & Hacker, 2015), traumatic loss (Turner, 2020), and internalizing problems such as anxiety and depression (Brandt, 2001) are target subjects for play therapy. Also, social, and academic difficulties, sleep problems, issues related to separation and divorce, difficulties in making friends, bullying, physical, psychological, and sexual abuse, death and loss, attachment disorder, eating disorders, and selective mutism are included in treatment areas.

Research shows that there is an obvious decrease in clients' anxiety, depression, attention difficulties, internalizing behavioral problems, aggressive behaviors (Candan, 2017), and social anxiety levels (Teke & Sürücü, 2020), and behavioral problems (Montemayor, 2014). Also, emotions and behaviors related to attention deficit and hyperactivity disorders are influenced positively (Abdollahian, Mokhber, Balaghi & Moharrari, 2013; Ray, Schottelkorb & Tsai, 2007; Zorlu, 2016). In addition to these, it was found that the client's suicidal risk (Shen, 2002), the intensity of depression (Lin & Bratton, 2015), aggression (Ritzi, Ray & Schumann, 2017), and parents' stress level (Brandt, 2001) decreased following play therapy.

Only professionals who have sufficient education and training can utilize play therapy. Having knowledge about the components of play therapy and benefiting from these components are essential. Playroom, materials in the room, therapist, child or adolescent, and therapeutic relationship are the components of

play therapy (Teke, 2019).

1.3.3. History of The Psychodynamic Play Therapy

The basis of psychodynamic therapy techniques for children started to be formed with Freud's case of Little Hans (1909) and he emphasized the importance of play for understanding the conscious and unconscious which is the most distinctive feature of psychodynamic therapy. Besides Freud, various theoreticians made contributions to the development of psychodynamic play therapy which is a psychological treatment approach developed by pioneers such as Anna Freud (1946), Melanie Klein (1932, 1961), and Donald Winnicott (1977). Anna Freud (1926, 1931, 1937) and Melanie Klein (1929, 1930, 1932) aimed to support orphan children due to World War II and realized the importance of play for children who grew up in a disadvantaged environment. A child displays his world through play (Lowenfeld, 1935) and Axline (1947) points to the importance of following a child's play without interruption. Also, Freud (1909) mentioned the contribution of play to the children's capacity to handle life events. Anna Freud (1927) and Melanie Klein (1932) evaluated free and spontaneous play as a way of accessing a child's unconscious. According to Anna Freud (1965), the play makes children independent and helps them gain self-confidence and socialize. Anna Freud (1965) also emphasized that play facilitates a child's separation from his mother and distinction between fantasy and reality.

Also, theoreticians' ideas about the relationship between mother and child in infancy and early childhood affected their opinions regarding therapy with children. Mahler (1972, 1974, 1975) was one of the major theoreticians who highlighted the importance of early relationships in a human being's life. For Margaret Mahler (1974) relational patterns in the early years of life are internalized and these patterns are activated when one becomes an adult. For instance, a child's relationship with early caregivers significantly impacts his or her willingness to establish a relationship with the therapist. An infant's interactions with an early caregiver and caregiver's emotional availability and responsiveness form core

beliefs about the availability of others (Guidano & Liotti, 1983). That is called the internal working model of the self (Bowlby, 1973; Main, Kaplan, & Cassidy, 1985). Also, a child's affective orientation to therapy is related to the child's internal working model of the self which is shaped by interactions with early caregivers.

Ego development, adaptive capacity, and defense mechanisms in childhood are major concepts that affected the formation of psychodynamic child therapy (Freud, 1965). Melanie Klein (1946) who is known for object relations theory stated that emotional traumas in the early years of life affect people's psychology negatively and therapists should pay attention to defense mechanisms that were developed in those years. Bion (1962b) pointed to the mother's containment which is the mother's capacity to feel the child's intolerable emotions and to give the child the feeling back in a contained form. Mother's containing role helps a child develop the capacity to contain his own emotions. Bion (1962b) highlights that it is vital for therapists to be contained in therapy.

According to Winnicott (1971), play is a transitional area where a child's unconscious wishes meet reality. Play is significant for a child's ego development, and it provides the child an opportunity to experience "me" and "not me". Also, the concept of the "transitional area" highlights the importance of the relationship between therapist and child. Winnicott's thoughts about the infant-mother relationship affected the therapist's role as well. Winnicott emphasized the importance of good- enough mothering and the mother's mirroring of the infant for the distinction between "me" and "not me" (Winnicott 1960a, 1964, 1971). These concepts are represented in psychodynamic therapy as being a good-enough therapist and the significance of mirroring the child's emotions. Play is significant for a child's ego development, and it provides the child an opportunity to experience "me" and "not me". For Winnicott (1971) creativity is important and he developed a drawing game known as "Squiggle Game" aiming to reach children's unconscious world.

1.3.4. Therapist’s Role and Therapeutic Framework

In psychodynamic play therapy, the therapist's role is to provide an environment where the child expresses himself through play and to interpret the child's play through the lens of psychodynamic play therapy (Meissner, 2007). The therapeutic framework includes price, space, time, and details about delay and cancellation. In the beginning, therapists should inform both child-adolescent and parents about the date and frequency of sessions. Considering ethical principles is highly critical. Both children and adolescents and their families are informed about the privacy through verbal assent or a written consent form. A therapist does not share a client’s information without his or her permission. In this sense, the therapist should not narrate the child's play directly during the sessions with the parents.

In psychodynamic play therapy, the frequency of sessions is generally 1 or 2 days a week. However, therapists can increase the number of sessions if it is needed. Therapists have a session with parents as well as children due to the importance of a neutral stance toward both the child and parents. Therapist and child play together at the same time, the same place for about 45 or 50 minutes every week. It is important to remind the child or adolescent of the last 5 or 10 minutes depending on the child’s or adolescent’s age and emotional maturity. When the time is up, the child or adolescent and the therapist leave the room. Also, space and time regulations remind the child of the realities of time and space and that prepares the child for separation. Also, the therapist explains the rules of the gaming room and sets limits when a child wants to harm toys or the therapist. Limit setting is especially necessary for children with aggressive behaviors. Children cannot take the toys in the room away. Finding the toys in the same place would increase the child’s trust in the room and therapist. Limit setting can frustrate the child and the therapist can understand the degree of frustration the child can tolerate (Chused, 1988). That forms a therapeutic framework that supports a psychic setting (Franch, 1996).

A psychic setting is the therapist’s ability to communicate with a child at

all levels and to contain the child's emotions (Franch, 1996). Understanding a child's nonverbal communication is essential in a therapeutic setting. The therapist's holding capacity creates a sense of safety and that paves the way for building an effective therapeutic alliance. A positive alliance between a child and therapist is a facilitator for the therapist's interpretation. Also, the therapist's availability, tolerance, and supportive nature of the therapeutic environment minimize embarrassing and painful effects (Blum, 1997). For instance, a therapist for a depressed child becomes a significant other who listens and tries to understand him (Abrahams, 1988). Thus, the progress of therapy is linked to the relationship between therapist and child.

1.3.5. Transference-Countertransference in Psychodynamic Play Therapy

The relationship between therapist and child has been a central concern of psychodynamic child therapies. Even though the importance of the therapist's neutral stance is emphasized, transference and countertransference will be determinants for the quality of the early therapeutic relationship and the outcome of therapy. Both therapists' and clients' conscious and unconscious processes have a role in forming the relationship. Besides the relationship between the therapist and child or adolescent, parents' unconscious processes should be evaluated. Thus, the relationship in the room is a multidimensional and dynamic process. This relationship constantly changes and shapes. Each togetherness and every new information bring a new dimension to the relationship between therapist and client. (Halfon, Coşkun-Toker, & Akdağ-Göçek, 2021, pp.24-27).

A safe and containing relationship in the room is the first condition for providing therapeutic development. The therapist's holding capacity creates a sense of safety and that paves the way for building an effective therapeutic alliance. The relationship between client and therapist plays an active role in the client's psychic world. Besides verbal communication, understanding a child's nonverbal communication is essential in a therapeutic setting. Recent research shows the importance of synchronization of the verbal and nonverbal behaviors between

therapist and client (Fogel, 1993, Wilberg, 2004). Since children do not have an extensive vocabulary, paying attention to their play, usage of toys and bodily expression is critical. Their relational patterns, emotions, and memories in the unconscious are hidden in the child’s or adolescent’s facial expression, vocal toning, physical expression, and mimics (Halfon et al., 2021, p. 27). Also, therapist’s availability, tolerance and supportive nature of the therapeutic environment minimize embarrassing and painful effects (Blum, 1997). For instance, a therapist for a depressed child becomes a significant other who listens and tries to understand him (Abrahams, 1988). A positive alliance between a child and therapist is a facilitator for the therapist’s interpretation. Thus, the progress of therapy is linked to the relationship between therapist and child.

It is significant for a client to form a much more different relationship with a therapist than his relationship with his parents in the past (Fonagy & Target, 2003). Also, if a child meets a therapist who is positively different from the child’s caregivers, that affects therapy progress and the outcome of the treatment (Gillman, 1987). While working with children, therapists may act like adults who educate and direct them without conscious awareness (Chused, 1988). However, the effectiveness of therapy depends on the degree of the therapist’s awareness of his countertransference and his capacity to relate with the child. Children, especially ones with dependent personality organization, can tend to please their therapists. If the therapist permits a child’s pleasing behavior without any therapeutic intervention, the child can have difficulty in expressing his rebellion or defiance which is linked to the development of autonomous functioning (Chused, 1988).

Therapists’ and clients’ attachment patterns are decisive for the quality of therapeutic relationship and the speed of forming it. The therapeutic relationship is quickly and positively established between the therapist-client dyad who have a secure attachment pattern. However, if a client has an insecure attachment pattern, it makes it difficult to trust and form a therapeutic alliance. Also, the client's resistance toward the therapist's interpretations would be tougher. A therapist who has insecure attachment patterns would have difficulty in understanding and

containing the client's negative emotions as well.

There is a reciprocal affection between therapist and client in therapy. A dynamic process that creates lasting interaction between both client’s and therapist’s emotions. Although therapists can easily acknowledge basic emotions known as anger, disgust, fear, happiness, sadness, and confusion (Ekman, 1992, 1999), they realize the presence of complex emotions in the relational processes of transference and countertransference. Children’s or adolescents’ emotions for a therapist as part of transference include the unconscious elements which come from the client’s history. Nonetheless, a therapist who contains the client’s emotions has hidden memories and unconscious emotions, too. Thus, recognizing the feelings embedded in his or her past well is essential for a therapist to understand the feelings projected by the client. Therapists who went through their own therapy process can have increased control over their reactions related to negative feelings and thoughts projected by clients and focus on the client's reactions better. Winnicott (1971) stated that therapists need to be open and flexible with the emotions that play evokes in them. A therapist’s being authentic, realistic, warm, and containing is quite significant in therapy. (Siegel, 2007). Being in the moment, focusing on verbal and nonverbal expressions, and having a responsive attitude provide an authentic stance. Containing the child’s or adolescent’s emotions, accepting the emotions, and holding them are necessary for psychodynamic play therapy. A therapist also gives back the client his or her contained emotions.

The therapist’s awareness of both his or her and the client’s defense mechanisms becomes more of an issue. Defense mechanisms are the reflection of a client's way of coping with problems. If a client has primitive defense mechanisms such as regression, denial, and splitting, it shows the intensity of relational traumas related to the early period. Also, primitive defense mechanisms can be compelling for therapists. The therapist’s supportive and patient attitude is critical for therapy with clients who have primitive defense mechanisms. The degree of defense mechanisms determines the development and outcome of a child’s play, usage of toys and materials, and the quality of the relationship between therapist

and client.

1.4. COVID-19 AND ONLINE THERAPY

1.4.1. Covid-19 and Its Effect on People's Mental Health

The World Health Organization (WHO) announced the emergence of a global pandemic due to Coronavirus disease which is infectious on March 11, 2020. Following the declaration of the COVID-19 outbreak, countries put prevention plans such as lockdown, social isolation, and wearing face masks into action in the first phase of the pandemic. It has affected the economy, global market, and human's physical and mental health. The covid-19 outbreak has brought along exposure to trauma and other psychological difficulties, grief, and adapting to the rapid change in social and economic conditions. Lockdown led to panic buying and hoarding essential things because of the possibility of shortages. During the lockdown, people started to work from home and children participated in courses via online platforms and so the whole family had to stay at home for a while. On the other hand, women and children who were exposed to domestic abuse had no option to escape from their abusers due to lockdown (Abramson, 2020; World Health Organization, 2020a).

Self-isolation and quarantine had a negative impact on the routines and livelihoods of people. Some people lost their jobs and experienced the death of their loved ones with intense grief (Kawohl & Nordt, 2020; Khan, Mamun, Griffths, & Ullah, 2022). That sudden, unpredictable, dramatic change and uncertainty have caused an increase in anxiety, depression, alcohol and drug use, obsessive-compulsive behaviors, and the worst of all suicidal behavior, especially among those who had preexisting mental health problems (World Health Organization, 2020c). A review on the psychological impact of quarantine showed that posttraumatic stress symptoms following low mood, irritability, insomnia, anger, and emotional exhaustion increased (Brooks, Webster, Smith, Woodland, Wessely, & Greenberg, 2020). Some factors such as lower socioeconomic status, resilience, social support, and frequent social media use may be related to the rise

of such conditions. Fear of the unknown also negatively affected both healthy people and those who have mental health problems (Mowbray, 2020).

Children and adolescents have also been impacted by the closure of schools, limited social contacts, and changes in daily routines (Fegert, Vitiello, Plener, & Clemens, 2020). With more time spent online, the probability of online sexual exploitation increased as well. All those factors mentioned above are risk factors for mental health problems in children and adolescents. Also, maltreated children and children with existing mental health problems were at high risk. Thus, both getting access to psychotherapy and fighting against coronavirus have been significant and tele-mental health services emerged as the best option for people in remote locations including children and adolescents (Zhou, Snoswell, Harding, Bambling, Edirippulige, Bai, & Smith, 2020).

1.4.2. Online Therapy

Online therapy includes a wider range of technologies such as telephones, videoconferencing and e-mail to enable psychotherapy from a distance (Grady, Myers, Nelson, Belz, Bennett, Carnahan, Decker, Holden, Perry, Rosenthal, Rowe, Spaulding, Turvey, White, & Voyles, 2021). Online therapy is an option for the ones who live in remote or rural areas before the pandemic (Thomas, Ellis, Konrad, Holzer, & Morrissey, 2009). Covid-19 made it inevitable because therapists were also at risk like their clients. It was shown that therapists slowly adopted technology compared to their clients (Simpson & Reid, 2014a). Thus, some issues like proficiency in technological skills, sufficient equipment for remote therapy, access to reliable Wi-Fi service, managing crises, protections related to confidentiality and establishing rapport with clients emerged (Simpson, Richardson, Pietrabissa, Castelnuovo, & Reid, 2020).

Access to the clients who are digitally illiterate and those who do not have suitable technology was a huge problem for the availability of psychotherapy services in the pandemic. Thanks to mobile phones, an increase in accessibility to even the most disadvantaged became possible. On the other side, clinical and

counseling programs that include training on online and videoconference-based therapies were very few (Dunstan & Tooth, 2012; McCord, Saenz, Armstrong & Elliot, 2015; Richardson, 2011; Simpson, Rochford, Livingstone, English & Austin, 2014). Video-therapy requires special skills and practical, ethical and legal challenges (Pierce, Perrin, & McDonald, 2020).

Since both therapist and client do not share the same room, confidentiality is the main issue in remote therapy (Glueck, 2013). Clients may wonder whether there is anyone else in the therapist's room. Putting on headphones would be helpful for therapists to provide confidentiality. Recording is also another topic that needs to be discussed. If a therapist wants to record a session, the client will be informed about recording with a consent form or a verbal assent.

1.4.3. Online Therapy with Children

While mostly adult therapists prefer remote psychotherapy before pandemic, with the spread of coronavirus all over the world, a sudden end universal shift from choice to necessity happened and child and adolescent therapists started to set sessions via remote therapy due to lockdown, social distancing, and isolation (Humer, Stippl, Pieh, Pryss, & Probst, 2020). Online sessions with children are different from sessions with adult clients. Children may leave the room without saying anything or have emotional outbursts. Guiding caregivers on how to deal with difficult behaviors would be helpful (Glueck, 2013). Even where client and therapist look at matters during an online session. During video conferencing both parties see themselves on the screen. Children are generally pleased with seeing themselves on camera, especially in the full screen mode. Despite its positive impact on increasing self-awareness about facial expressions, a child who is easily distracted may spend the entire session making faces at themselves. Therapists can play hide and seek with younger children. Oppositional children can purposefully turn off the camera to challenge the therapist. Child's challenging behavior can provide clinically useful data (Goldstein & Glueck, 2016).

Also, camera placement and use, sufficient lightning and the size of the room have a pivotal role. An adequate space allows the child to move, and the therapist can observe the child's gross motor skills. When working with a child, a room should be large enough for a child and two adults and small enough for the child not to be disengaged (Gloff, LeNoue, Novins, & Myers, 2015). A child may find distracting or over-stimulating a very large room or a room with irrelevant materials (American Academy of Child and Adolescent Psychiatry 2008). Besides difficulties of online sessions with children, it also gives opportunity to observe children and parent-child interaction in a naturalistic setting (Gloff, et. al, 2015).

Unlike children, adolescents are familiar with technology, and they do not need their parents for technical support. However, confidentiality is very important for them in online sessions. Rules of confidentiality are the same in online sessions like face-to-face therapy unless there are specific concerns about safety. Also, it is significant for adolescents that no one will be allowed to enter or observe their sessions in a tele-mental health setting. They want to know that their sessions will not be recorded or shared with their parents (Goldstein & Glueck, 2016). Since verbal communication can be compelling for adolescents, offering alternatives can facilitate engagement of adolescents. If both therapist and patient connect via computer, they can share their screens and play the same game together for building rapport. Since children and adolescents are familiar with technology for gaming and communication, therapists find it easier to communicate with them in video therapy (Himle, Freitag, Walther, Franklin, Ely, & Woods, 2012).

1.4.4. Therapeutic Alliance in Online Therapy with Children

One of the biggest concerns of therapists is establishing therapeutic alliance with their patients in remote therapy (Glueck, 2013). Inexperienced therapists perceived the screen as a "barrier" between therapist and client and concerned about inhibition of therapeutic alliance (Rees & Stone, 2005; Suler, 2004). Significant effect of therapeutic alliance on therapy process shows the importance of understanding possible negative impact of remote therapy on the ability to develop

an alliance (Glueck, 2013). While keeping eye contact is easy in a face-to-face setting, the therapist and client often look at the screen rather than looking at the camera directly. That can affect the establishment of therapeutic relationship. Besides the negative effect of technology on tele-mental health, most clinicians stated that establishing rapport is not impossible and not much different from face-to-face therapy (Bishop, O'Reilly, Maddox, Cook, & Doyle, 2002, & Hutchhinson, 2002). Rather than perceiving rapport as a fixed concept, accepting its dynamic nature would be helpful.

Review on therapeutic alliance in an online setting showed that therapists and clients rated high levels of therapeutic alliance, especially in the bond and presence. There is no significant difference between in-person therapy and videoconferencing in terms of quality of alliance (Reese, Mecham, Vasilj, Lengerich, Brown, Simpson, & Newsome, 2016). A recent study found a better alliance for video-therapy with clients with generalized anxiety disorder (Watts, Marchand, Bouchard, Gosselin, Langlois, Belleville, & Dugas, 2020). Therapists and clients rapidly adapted to the pace and pattern of communication early in online therapy. (Simpson & Reid, 2014a). Also, clients' investment in therapy process and tolerance in the case of disruptions in sessions increased with video-therapy (Bischoff, Hollist, Smith, & Flack, 2004).

Technical features such as camera and sound also impact the establishment of rapport and observation of clients (Glueck, 2013). Subtle body movements are significant to understand a client's affective state. Adequate band-with that affects the high resolution allows the therapist to observe subtle changes in facial expressions. Disrupted internet band-with can reveal feelings of helplessness and frustration especially if it happens during client's intense emotional sharing (Captari, 2020). Desynchronization of verbal and visual input makes it difficult to have smooth communication in contrast to real settings. Loss of internet connection, camera and microphone problems affect the flow of therapy sessions, too. Thus, establishing a backup system would be helpful for completing the session.

In contrast to difficulties of online therapy, most of the therapists and clients

experience low arousal levels in online therapy that leads to experiencing the online setting more comfortable and less threatening than face-to-face sessions. In the pandemic context, it may be comfortable for the ones with anxiety-based disorders, social phobia, obsessive compulsive disorder (Reynolds, Stiles, Bailer, & Hughes, 2013). Also, clients' feeling of online therapy as less confronting can facilitate disclosure of difficult experiences and feelings especially for those who have history of sexual abuse and avoidant personality traits (Simpson, Doze, Urness, Hailey, & Jacobs, 2001; Simpson, 2005).

Online therapy has changed the nature of boundaries as well. Clients started to attend sessions from their homes where they have more access to immediate triggers and transference reactions. However, emergence of more reality based, and meaningful transference reactions can happen in the presence of a more neutral online therapeutic environment (Dunn, 2012; Mitchell, 2020; Quackenbush & Krasner, 2012). Therapeutic relationship is closely related to trust and ethical conduct (Badawi, 2016; Brown & Stobart, 2018). Hence, boundary related issues are dynamic and up to therapists' own professional judgments. (Hermansson, 1997). However, in online therapy sufficient flexibility of boundaries in company with stability of containment, attunement, safety and affective attachment is needed (Sabin & Harland, 2007). It would be good to discover the meaning of flexible boundaries, presence of screen as a medium in therapeutic relationship, feeling of safety and intimacy related to location and level of eye contact. Keeping a professional attitude without being informal or casual is critical for therapeutic relationship and therapy outcomes. Professional training, clinical supervision and peer consultation may guide therapists to do no harm to their clients (Anthony & Goss, 2009; Anthony & Nagel, 2009; Drum & Littleton, 2014; Luxton, Nelson, & Maheu, 2016; Simpson, Richardson, & Reid, 2016).

1.4.5. Therapists' Experiences of Online Therapy

Even though video conferencing is the best alternative to face-to-face psychotherapy during the pandemic, psychotherapists approach it with hesitation

(Schuster, Pokorny, Berger, Topocoo, & Laireiter, 2018). Therapists' doubts arise from lack of verbal communication such as gestures and body language and having difficulty dealing with crises from a distance (Schuster et. al, 2018). Nonverbal behavior such as stomping feet or having a stretched posture has a pivotal role for psychodynamic psychotherapy. In remote therapy nonverbal behavior is difficult to understand even using cameras (Perle, Langsam, Randel, Lutchman, Levine, Odland, Nierenberg, & Marker, 2013). Most therapists did not find remote psychotherapy comparable with face-to-face psychotherapy (Humer, et. al, 2020). While experienced therapists have a positive approach toward transition to online therapy, most therapists felt less confident, competent, genuine and connected in online sessions (Békés & Aafjes-van Doorn, 2020).

Besides, technical problems were experienced more difficult by therapists than by patients (Schopp, Johnstone, & Merrell, 2020). Various studies found that therapists prefer face-to-face therapy rather than remote therapy (Connolly, Miller, Lindsay, & Bauer, 2020). A qualitative study to understand psychotherapists' experiences in Canada, Australia, Russia and Japan showed that therapists experienced working under uncertain conditions, using tele-health platforms in an efficient and flexible way, managing the online psychotherapy process and benefitting from peer supervision (Jurcik, Jarvis, Doric, Krasavtseva, Yaltonskaya, Ogiwara, Sasaki, Dubais, & Grigoryan, 2020).

A study including 355 psychotherapists aimed at understanding the experiences and challenges of therapists who work remotely during the COVID-19 outbreak using the mixed analysis method (McBeath, du Plock, & Bager-Charleson, 2020). %46 of participants used video-based therapy such as Skype and %80 of participants found remote therapy challenging. Online therapy experiences of the clients were divided into three categories as adaptation, challenges and opportunities.

In the adaptation process, those who do not have previous experience of remote therapy stated that online therapy did not have the same level of job satisfaction for them. Initial technical difficulties such as the therapist's worry about technical problems and time lags between visual image and sound impacted the

therapist's ability to get involved with the client. Few therapists stated that they had positive experiences in contrast to their bias against online therapy. Using Zoom in the beginning was difficult for therapists and their openness to adapt made online therapy manageable. Self-care is an important issue for therapists and so they found new coping strategies like the expanded interval between sessions and decreased number of clients per day to relieve anxiety.

Perceived reduction in interpersonal cues (%24), technical issues (%14) and finding remote working an isolated way of therapy (%10), limited view of the client (%9), and the decreased sense of confidence (%8) were the reasons behind finding the online therapy challenging. Client's attendance to sessions from their own space, perceiving the ending of sessions awkward and the therapist's concern about a third party's access to remote sessions were the remaining reasons related to the challenging part of the remote therapy. Some clients did not have confidential space, or they had difficulty talking about the person they are living with. Therapists also mentioned the tiring side of the remote therapy along with the intensity of concentration needed and were concerned about the client's safety and inability to see the client's potential distress following the end of the session. While there was a journey between home and therapy sessions in face-to-face therapy, in online therapy only a door separated the therapist mode and other roles at home. The absence of sharing a physical environment and having difficulty in maintaining boundaries were added as challenging. Therapists stated the strangeness of both being intimate and distant at the same time. The therapist witnessed the home environment of the client but also it was hard to relate with the two-dimensional disembodied client. Therapists reported the difficulties of creating a private space for sessions and feeling physical tension on the body, head, neck, and shoulders when using videoconferencing platforms such as Skype or Zoom.

When therapists were asked about the advantages of remote working, they stated respectively that access of those who live in rural areas, clients' broader options for choice of therapists, no time spent traveling to sessions, and client's heightened feeling of security in their homes which is seen as a positive therapeutic

factor. Moreover, it provided an opportunity to maintain therapy sessions in case of a therapist's or client’s movement to another city or country. Using video as a new medium of providing therapy facilitated the therapeutic relationship through the client’s assistance with technical issues as well. Therapists who have children added that remote therapy was beneficial for them for childcare in addition to the flexibility of it. For some who conducted their sessions predominantly face-to-face, online therapy was the opportunity they were seeking for. Most of the therapists (%88) found remote therapy effective and evaluated teaching remote working skills as important. Also, they thought that %61 of the clients was comfortable with remote therapy. Therapists added that remote therapy would be the essence of clinical practice in the future even after the pandemic.

Besides therapists’ experiences of online therapy, Covid-19 has been a collective traumatic event for both clients and psychotherapists (Captari, 2020). Therapists were a witness to clients’ grief, and trauma, while they were experiencing the same (Walsh, 2020). Client’s concerns paved the way for therapists’ deep understanding of clients but also over-identification and burnout. Clients’ fear about their health, effects of isolation on them, and feelings of physical separation from others may evoke anxiety, feelings of loneliness, and all the other things related to the pandemic. Experiencing a global trauma with clients at the same time created new relational experiences in therapy, changed power dynamics, and enacted a healing experience. Even though conducting sessions with clients provided predictability, routine, and a sense of purpose amidst global chaos, it also required much self-care.

Studies mostly focused on establishing a therapeutic alliance with adults in tele-mental health (Simpson, Richardson, Pietrabissa, Castelnuovo, & Reid, 2021; McBeath et. al, 2020). A study about children and tele-mental health compared the difference between adults’ and children’s preference for tele-mental health with a little emphasis on therapeutic alliance (Hoffnung, Feigenbaum, Schechter, Guttman, Zemon, & Schechter, 2021). Also, there is no qualitative study that investigates building a therapeutic alliance with children during COVID-19 regarding child and adolescent therapists’ perspectives. Regarding the literature on

tele-mental health and therapeutic alliance, this thesis aims to deeply understand the experiences of child and adolescent therapists with a psychodynamic perspective including establishing a therapeutic alliance with children and adolescents via tele- mental health service during the COVID-19 pandemic in Turkey. Based on research findings, implications for an effective therapeutic alliance in online therapy with children and adolescents will be developed. The present study, based on a qualitative research methodology, intends to answer the following research questions:

a) How do child and adolescent therapists experience online sessions with children and adolescents?

b) How do online sessions affect the therapeutic alliance between therapists and children?

c) What are their views regarding the effectiveness of online therapy with children and adolescents?

CHAPTER TWO
METHOD

2.1 DATA COLLECTION

Following the approval of the Istanbul Bilgi University Ethics Committee, the researcher used selective sampling for the recruitment of participants. Announcement of the study was made via professional and personal accounts on Instagram, graduate students' thesis support groups in WhatsApp, and a professional e-mail group which includes clinical psychologists. 8 child and adolescent therapists (6 females and 2 males) who utilize psychodynamic play therapy participated in the study. Inclusion criteria are as follows: a) having at least two years of experience, b) being graduated from a clinical psychology master's degree program, c) having training in psychodynamic play therapy, d) conducting sessions via videoconferencing with the Covid-19 pandemic under supervision, e) having at least three face-to-face sessions with children and adolescents. It was shown that alliance started to develop in the third or fourth sessions (Horvath & Luborsky, 1991; Horvath & Symonds, 1993). Also, it was found that early therapeutic alliance with children and adolescents is a significant predictor of treatment outcomes and the therapeutic alliance in early sessions predict therapeutic outcomes better than therapeutic alliance in middle sessions (Bickman, Andradre, Lambert, Doucette, Sapyta, & Boud, 2004; Meier, Barrowclough, & Donmall, 2005). Since these studies are based on face-to-face sessions with clients, this thesis aims to investigate therapists' experiences regarding the transition to online therapy and its impact on therapeutic alliance following at least three face-to-face sessions. Besides, it is obvious that getting clinical supervision helps therapists to minimize difficulties in online therapy (Drum & Littleton, 2014; Luxton, Nelson, & Maheu, 2016).

Child and adolescent therapists who fulfilled the inclusion criteria and accepted voluntary participation were recruited as participants. Each participant

was interviewed online via Zoom due to the pandemic. An interview guide was prepared and followed in the interviews (Appendix A). Informed consent forms (Appendix B) and demographics forms (Appendix C) were taken via e-mail since the interviews were carried out through online channels. Before the interview, participants were expected to clearly state their consent for participating in the study and to reply to the e-mail stating that "I read the consent form and agreed to participate in this study." Demographics forms (Appendix C) were filled out via Google Forms with nominated participant numbers. In the demographic form, participants were expected to answer questions related to their age, gender, where they live, educational background (Master or doctoral degree), date of their graduation, the length of their practices as a child and adolescent therapist, training, supervision, education, and practice about online therapy before the pandemic, their and clients' preparation of transition to online therapy, where they attended the sessions from, video conferencing platforms they used.

Following their approval of the informed consent form, structured in-depth interviews were scheduled and conducted via Zoom, a video conference platform. Since the informed consent forms were filled out before the interviews, the researcher started to record at the beginning of the interviews. The researcher explained the aim and process of the study and asked whether participants had any questions. They were reminded of their right to leave or stop the interview any time they wanted. The interviews lasted between 40 to 70 minutes.

The researcher both audio and video recorded all the interviews since Zoom does not have only an audio recording option. Only audio recordings were kept, and video recordings were deleted. Then, all transcripts were transcribed verbatim. The researcher will keep all-voice recordings and transcriptions in a password-protected computer to which only the primary investigator has access. Audio recordings will be deleted following the thesis approval.

2.1.1. Data Collection Tool

For the structured interviews, an interview guide including the questions about child and adolescent therapists' experiences of the pandemic, online therapy, and establishing a therapeutic alliance with children and adolescents and their parents was prepared (Appendix A). Based on the literature about conducting sessions and establishing therapeutic alliance in tele-mental health settings, the questions on subjective experiences of child and adolescent therapists were specified under the headings such as the transition to online sessions, experiencing the pandemic as a therapist, therapeutic framework, therapeutic alliance in the online setting and the future of the online therapy with children and adolescents. The questions were reviewed with the thesis advisor and revisions were made through the recommendations of the thesis advisor. The interview consisted of 24 open-ended questions which acquired information about the narrative of the therapists' approach toward online therapy before the pandemic, their feelings about online therapy, and working with children, adolescents, and their families via videoconferencing. At the beginning of the interview, questions related to the therapist's opinions about online therapy with adults before Covid-19 were asked to familiarize them with the topic. However, their responses were not coded and included in the results.

2.2 PARTICIPANTS

Eight child and adolescent therapists (6 females, 2 males) were participants in the present study. Their ages ranged from 28 to 49 (M = 31). The length of their experiences ranged from 2.5 to 15 years, with an average of 5. All participants were living in İstanbul. They all had master's degrees in clinical psychology. Seven therapists had graduate study related to psychodynamic play therapy and one participant had additional training in psychodynamic play therapy following a master's degree in clinical psychology. They had no training in online therapy. Only two therapists had online therapy experience before the pandemic. Seven therapists talked with their colleagues and supervisors in transition to online

therapy. Only four therapists read articles about online therapy. They all made their clients ready for online therapy talking about it before the first session. Three participants talked about online therapy in the first session and provided technical support. Only one participant sent clients an informed consent form for online therapy. They conducted sessions in their homes and only three therapists used their office alternatively. All therapists preferred Zoom and three participants preferred Skype. Detailed demographics about participants are presented in Table 1.

Table 2.1.

Demographic Information of the Participants

ID	Age	Education	City of Residence	Experience Duration
1F	29	Master	İstanbul	2
2F	29	Master	İstanbul	2
3F	31	Master	İstanbul	3
4F	28	Master	İstanbul	3
5M	29	Master	İstanbul	3
6F	29	Master	İstanbul	5
7F	29	Master	İstanbul	2.5
8M	49	Master	İstanbul	15

*M=Male F=Female

2.3 DATA ANALYSIS

To understand child and adolescent therapists’ experiences about online therapy and establishing therapeutic alliance, Thematic Analysis (Braun & Clarke, 2006) was used. Thematic analysis can be defined as “a method for identifying, analyzing, and reporting patterns (themes) within data” (p.76). In the present

study, thematic analysis was applied to manifest the content of the interviews from a psychodynamic clinical psychology perspective. In this perspective, the attention was given to how therapeutic frames and therapists' ways of working with children-adolescents and their parents were shaped with the impact of the pandemic. The researcher was attentive to cues about the effect of Covid-19 pandemic on participants' online therapy experiences with children and adolescents. There were also specific questions in the guideline that directly asked participants about their perceptions and experiences of being a therapist who conducts online sessions with children and adolescents during a global crisis. Six steps were followed for the analysis based on Braun and Clarke's recommendations (2006). First, the researcher transcribed the data and read and re-read transcriptions to familiarize herself with the data. In the second step, initial codes were developed using the MAXQDA Software program. At this step, the researcher tried to capture participants' experiences and perspectives, and codes were produced based on these experiences. Next, the researcher searched for candidate themes and collected codes under potential themes and subthemes. If at least three participants mentioned similar things, they were evaluated as a sub-category. Also, if one participant mentioned his or her experiences that were significant for the results, they were included in the data. The researcher decided on the inclusion of data only one participant mentioned depending on its importance for clinical implications and further research. For instance, one participant mentioned that clients who had an abuse history felt comfortable when they turned off their cameras. That was included in the results since it can be beneficial for therapists who work with clients with abuse history. Then, the candidate themes were reviewed to check whether they were relevant to the codes and a thematic map was generated. In the fifth step, a clear definition for each theme was developed and the themes were named. Before the final step, which was about reporting the analysis, the researcher reached the participants again for member-checking in order to validate and explore whether themes were credible and reflective of their experiences.

2.4 THE RESEARCHER'S PERSPECTIVE

I experienced pandemic and online therapy at the same time as a graduate intern working with children and adolescents. I have had 7 months of experience since I started to practice. I heard about online therapy with adults before I did not have any idea about online therapy with children. While I was with my friends at the school, suddenly I started to practice working with children and adolescents online without having a chance to talk with my colleagues during the break between sessions. Even though we talked about our experiences of online therapy and pandemic, I wondered how child and adolescent therapists' experiences of online therapy have changed over time and how they experienced it in their home environment.

The Covid-19 pandemic was a new and unknown thing to the whole world. Listening to the news about the pandemic while trying to adapt to online therapy with doubts about it was too tiring for me. I was in Istanbul before the pandemic and with the sudden emergence of the pandemic I went to my family's home, and I had to attend the sessions from the home where I lived with them. Thus, keeping confidentiality was difficult for me sometimes. Even though I tried to create a space for online therapy, it could be difficult due to an unstable internet connection. I found a solution by reminding family members of my program before attending the sessions and trying to collaborate with them. One of the children I worked with face-to-face wondered about my home and her insistent questions about my private life made keeping neutrality compelling. Also, I realized that there isn't a door in the child's room and that was an important observation about the child's home environment since I was working with the child about separation-individuation. I was concerned about the child's confidentiality because her mother was wondering about the child's session. However, attending the sessions online was good for that child because she felt safe in the home and the flow of the sessions became varied. I felt the difficulty of not being in the same room because children were leaving the room suddenly without saying anything. Sometimes they were turning off the camera and I was wondering where they were at that moment. A 5-year-olds

child I started to work with online therapy was referred because he had difficulty establishing a bond with family members. As I worked with the child, I realized that he was exposed to the screen too much. So, working with that child in online therapy was maintaining the same pattern with him. I included the mother and the father in the therapy process and observing their play and talking about it was beneficial. All those experiences have made me flexible and thought about alternatives depending on the nature of the case. All the difficulties and facilities of online therapy strengthened my curiosity about the topic, especially about my colleagues' preference for online therapy even after the "new normal".

Even though I felt confident at the beginning of the study about finding participants, it became difficult to reach participants who work with psychodynamic play therapy. There were more females, but I tried to find male participants to investigate their experiences of online therapy. At the end of each interview, all participants mentioned how they felt about the interview. Talking about the pandemic rather than the difficulties of online therapy was difficult for some of them. I realized that while some participants were comfortable with talking about their vulnerabilities, some had difficulty talking and they either gave superficial answers or externalized the problems rather than thinking about their internal experiences. I realized that each participant's reaction to questions were different.

For instance, one participant was overwhelmed by working with families who demanded online therapy insistently while another one was very paranoid about confidentiality of the client. Questions related to their professional experiences helped them remember the positive sides of the experience. However, all participants stated that they have never thought about their experiences of online therapy in such a detailed and organized way which led them to higher awareness about the topic and themselves.

From my perspective, my position as a child and adolescent therapist could have some effect on the process. I had a limited experience in qualitative research when I was an undergraduate student, but I had no experience in qualitative research as I had experienced the same things with participants. In one-to-one sessions, I used to sit in the chair with my psychotherapist identity. While

conducting the interviews, it was challenging not to be directive at the beginning, since my experiences of the pandemic and online therapy aroused. From time to time, I found myself asking more detailed questions about the participants' experiences, but I tried to observe my reactions without being directive. On the other hand, having experience as a child and adolescent therapist became beneficial such as understanding participants' unique experiences by posing questions. Overall, preparing a guideline and questions and keeping the interview setting in a standardized way helped me to balance the situation and made me more confident as a researcher.

CHAPTER THREE
RESULTS

With using thematic analysis, six main themes were generated based on interviews with eight child and adolescent therapists who utilize psychodynamic play therapy. The main themes were named as “an outlook on online therapy with children and adolescents before Covid-19”, “transition to online therapy with children and adolescents", “difficulties of online therapy with children and adolescents”, “facilities of online therapy with children and adolescents”, “contributions of online therapy with children and adolescents" and “suggestions for therapists”. These six themes included two to five subthemes within (see Table 3.1.).

Table 3.1.

Themes and Subthemes of the Research

Themes	An outlook on online therapy with children and adolescents before Covid-19	Transition to online therapy with children and adolescents	Difficulties of online therapy with children and adolescents	Facilities of online therapy with children and adolescents	Contributions of online therapy with children and adolescents	Suggestions for therapists
Sub Themes	Being Open to Online Therapy	A Huge Hollowness and Obscurity: A State of Freezing and Shock	Loss of The Space: Deprivation of Containment	Creating Togetherness in Online Therapy	Increase in Professional Assurance	Face-to-face versus online therapy
	Having A Strict Stance about Online Therapy	Transition to Online Therapy: What Will Online Therapy Be Like?	Recreating Therapeutic Framework	Keeping The Relationship with Clients	Flexibility	Preparation and Evaluation
		Clients' Attitude toward Online Therapy	Therapeutic Relationship: Will It Stay the Same?	Saving of Time		Establishing Therapeutic Framework
			Technical Difficulties	Accessibility		Being Flexible
			Screen: A Third Party in Online Therapy	A New Alternative		Change in Professional Needs

3.1. AN OUTLOOK ON ONLINE THERAPY WITH CHILDREN AND ADOLESCENTS BEFORE COVID-19

In the interviews, participants expressed their opinions about online therapy with children and adolescents before the Covid-19 outbreak. This theme covered their preconceptions about conducting online sessions with children and adolescents. Based on their accounts, two sub-themes emerged as "being open to online therapy" and "having a strict stance about online therapy". While they regarded online therapy with children as almost impossible, they found online therapy with adolescents attemptable.

3.1.1. Being Open to Online Therapy

Three participants (P4, P6, P7) mentioned that they have positive feelings about online therapy with adolescents especially. Since adolescents talk in the sessions rather than playing as children do, participants find online therapy with them possible.

"I was feeling positive about online sessions with adolescents since therapy with them is a space out of play. You are doing something based on talking." (P7)

"I thought it could be possible with adolescents, but I did not think about it actually." (P6)

Also, taking responsibility for attending sessions in contrast to parents' guidance is a reason for the preference for participants.

"I am regarding online therapy with adolescents like online therapy with adults. I think online therapy with adults is quite possible. I know that from my therapy process, it is possible, it is not bad or good, but it is possible because their age is controllable. I mean they can connect and take responsibility. It is about the process. Thus, online therapy with adolescents is always possible." (P4)

Only one participant showed interest in online therapy with children who are above 7-8 years old and able to sit and focus on the screen depending on children's

familiarity with computers.

"I was thinking that therapy is applicable for children who can sit in front of the computer and talk mostly because they are familiar with the screen and building a relationship via screen compared to us. It takes away something, but it brings something, too. I thought, "Why not?" but I feel close to the age 7-8 and above." (P4)

3.1.2. Having a Strict Stance about Online Therapy

All the participants found online therapy with children, especially little ones under 6 years old impossible. For some, online therapy with children was not a dream of doing something. Even though they knew about online therapy with adults, they did not hear of any instance of online therapy with children till the pandemic.

"I was thinking that it is not possible with children such that it was not a dream of doing something." (P5)

Since therapy with children depends on play, they do not have an idea about playing with a child from separate settings.

"I mean we are utilizing play while working with children. Play should happen in a room, in a physical space. It cannot happen in an online setting." (P7)

Online therapy with little children seemed possible especially with those above a specific age and their parents, in other words, parent counseling.

"I was saying that it cannot be possible with children under 7-8 years old. It is like parent counseling at best." (P4)

One participant added that sharing the same environment and also each material in the room is important for transference-countertransference and that makes therapy efficient from a psychodynamic perspective.

"I did not find online therapy with children efficient because I work with psychodynamic play therapy, and I was thinking that being in the same room and each material in the room reveal issues related to transference-countertransference

better." (P2)

3.2. TRANSITION TO ONLINE THERAPY WITH CHILDREN AND ADOLESCENTS

All participants explained how they experienced the pandemic at the beginning of it and the transition to online therapy with children and adolescents. First, they stated how the emergence of the Covid-19 outbreak affected them and other aspects of their lives. In the second step, the participants narrated the process in which they decided to conduct sessions via online therapy. Even though there was consensus about the transition to online therapy following the two weeks break, they did not have any experience in online therapy with children and adolescents. In contrast to the recognition of online therapy with adults, child and adolescent therapists learned how to conduct online sessions with children and adolescents while doing it. Participants' experiences of the Covid-19 pandemic and online therapy changed over time. Based on the reflections of participants, three sub- themes were identified about the transition to online therapy with children and adolescents as "a huge hollowness and obscurity: a state of freezing and shock", "transition to online therapy: what will online therapy be like?" and "clients' attitude toward online therapy".

3.2.1. A Huge Hollowness and Obscurity: A State of Freezing and Shock

All participants stated that they felt an intense worry about their everyday lives and practicing their professions with the sudden emergence of the Covid-19 outbreak. Before the announcement of the first Covid-19 case in Turkey, they heard the news about the spread of the virus across the globe. Since Covid-19 was a new and unknown virus to the world, they worried about not knowing anything about it.

"Since it could not be seen and known it made me anxious of course but it had almost become clear when it came to Turkey." (P5)

Thus, they mentioned that Covid-19 was much more frightening at the beginning. In this sense, fear of the unknown was real, and the outer world was insecure independent of internal reality.

"There was mistrust for the outer world, but it was normal. I mean, the world was literally dangerous for all of us at that time." (P1)

Everything was too uncertain after the announcement of the first Covid-19 case in Turkey. Therapists decided to put a hold on their sessions for about two weeks to observe the situation and the number of cases. Everything changed suddenly and they were confused and worried. Experiencing uncertainty was very difficult for therapists as well as clients.

"I remember that I was working in another office those days. I did not have my order and we were like, "What will we do? What will happen?", they decided to put a hold on sessions for about 15 days because nobody knew what to do." (P4)

Rather than conducting online sessions, therapists preferred waiting to evaluate the spread of the virus. As the course of events became clear, they considered transition to online therapy seriously.

"However, I observed that the situation was getting serious, and the dimensions of the disease were not clear, and nobody knew anything. Thus, I did not switch from face-to-face therapy to online therapy. I mean, I ceased processes. I said that I won't conduct sessions for one or two weeks." (P5)

Two participants (P5, P8) added that they denied the pandemic and possible change in their daily lives during the two-weeks break. They did not want to believe in the spread of coronavirus and expected to go back to routine in a week. They thought that everything would change for the better. Even though they have an intuitive sense that the virus will spread, and everything will change, they denied it as a defense mechanism.

"It was as if I knew that pandemic would become so widespread, but I did not foresee it, or I did not believe it, I acted as if it had not happened. When the first case emerged, I thought that it would probably pass in a week. My first reaction was this. I thought I'd continue with the clients anyway." (P5)

"Therefore, at first, there was a period of anger, and confusion, in fact, a period of denial, so this will take a week or two to pass, it's not as big as it is exaggerated." (P8)

Following the announcement of the first Covid-19 case in Turkey, gradual restrictions happened, and people started to stay at their homes with the declaration of lockdowns. Therapists who live with their families got anxious about being infected with coronavirus and contaminating their family members.

"So, it was a very frightening experience at the beginning of the pandemic of course. There were lockdowns besides an invisible and unknown virus. You could get infected at any moment, infect anyone and be the death of somebody." (P3)

Ruminations related to infecting family members were too tiring for therapists at the beginning of the pandemic. They found their worry about infection intense compared to two years following the beginning of the pandemic.

"I was living with my family, and I was constantly thinking about what if I infect them and if something happens to them how can I live with the burden of it. That was too exhausting." (P3)

"Thus, in the beginning, my worry was very intense, and I was living with my family. I was deep in thought that what if something happens to my family and I infect them." (P4)

Fear of getting infected brought the fear of death over. Even though there is always the risk of death independent of the pandemic, the Covid-19 outbreak made it obvious profoundly. One participant (P3) stated that she was constantly thinking about what would happen to clients' information in case of her death. Also, she added that she worried about her clients' health. Even though one participant stated those, I find it very important to understand how the Covid-19 outbreak affected a therapist's preoccupation with her clients beyond the time they shared the same setting.

"*Something may happen to you. These parts made me think about what if something happens to my client, what if something happens to me, and what will my clients' information be if something happens to me? For me, all these*

were processes hanging in the air. I mean, the risk of death was involved." (P3)

Staying at home was experienced as a suffocating situation with the increase in restrictions over time. Self-care activities like exercising outside or meeting friends are important for therapists to recharge and practice their occupations better. Lockdowns also restricted the self-care activities of therapists.

"Being confined in a house while trying to cope with all the compelling situations was something we all experienced for the first time, and it was very tiring." (P7)

"We do our self-care with sports, friends, and social settings. Since these were very restricted, we got bored. I mean that there was a limitation in every step." (P8)

Plus, some participants (P1, P2, P3, P6, P7, P8) had to stay at home with their family members. There was not even one more room to separate spaces for online therapy sessions and personal life. Participants had difficulty balancing between their professional life and daily lives. One participant (P1) resembled staying at home with whole family members to being in the same room in family therapy.

"I just got bored, it was very difficult for me to stay at home because it was good for me to keep sessions with my clients and to continue my social life, but all the systems mixed." (P2)

"Its difficult part was that you are just at home, you cannot go out of the house. Besides, your work was stuck at home. I don't feel like that now." (P7)

Besides the difficulty of staying at home, two participants (P5, P8) stated that they spared time for their hobbies, watching movies, or reading the books they could not have time for before the pandemic. In this context, staying at home was good for some at the beginning of the pandemic.

"As you know there were times for reading books and watching movies that I couldn't watch, but this is also a bit about my personality." (P8)

Rather than perceiving it as confinement, they saw it as an opportunity to rest. Being a homebody affected coping with the pandemic. As time passed, participants who love staying at home started to get bored and missed going outside.

"I am a homebody; I mean I spend time on my own at home…I didn't have difficulty staying at home and even I liked it so much in the beginning. I was glad I have more time to do the things I already love to do." (P5)

One participant (P8) mentioned that a complete change of routines and bearing the consequences without having any voice about the changes evoked anger and confusion. In this sense, loss of control and the omnipotent and sudden influence of an invisible virus on people's lives triggered different emotions.

"I perceived that this was a situation where our order changed completely, and I did not take part in that change and that aroused anger in me." (P8)

The distinctive feature of Covid-19 was that everybody experienced it at the same time rather than a personal loss only a client experiences and the therapist witnesses the client's suffering. In this sense, the Covid-19 outbreak was a collective trauma. Thus, containing clients became hard since therapists had to deal with their own difficulties.

"Clients encountered a pandemic for the first time in their lives, but we encountered a pandemic for the first time, too and we did not know how long it would take and how long we would remain separated from our rooms. There was uncertainty for us too." (P6)

"I mean you are experiencing the same difficulties, same tough situation at the same time as well. That is the main difficulty. The client has difficulty, and you are not in the part to contain him and to give room. There we came up to clients. The pandemic is called a traumatic period on the one hand. We all went through that traumatic period at the same time." (P7)

Therapists experienced fear, anger, and confusion like the stages of mourning concurrently.

"To sum up we can say that at first, we experienced confusion, anger, and annoyance like the stages of grief." (P8)

There was a phrase going viral on social media "We're in this together." to emphasize the collective trauma. Being aware of experiencing the same difficulties helped therapists to cope with that painful transition process.

However, the pandemic triggered therapists' own emotions such as fear, anger, and confusion. Even though they tried to handle their own traumas or compelling experiences in their therapy process, they did not know what the pandemic could evoke in them.

"I mean that it was like we were struggling with something together, it was like we were sharing the same thing." (P1)

However, the pandemic triggered therapists' own emotions such as fear, anger, and confusion. Even though they tried to handle their own traumas or compelling experiences in their therapy process, they did not know what the pandemic could evoke in them.

"To help someone who gets through the same trauma somehow, to carry out a therapy process. How good do I feel about it? So, this is something we've always been through. Supposing that I am an anxious person, working with a child with an anxiety disorder is also a trigger for me. However, as we go through the pandemic together, I don't know that nothing will happen to someone I love. I had a client who lost his father due to Covid-19." (P4)

In this sense, being a resource for clients was very difficult for therapists who were experiencing the same pandemic. They experienced emotional difficulties in their personal lives while being a resource for their clients in a time when they could not meet their needs for self-care.

"At such a time, you are trying to create resources and space for other people. It was hard at first, you know, I had a feeling that you had to create other spaces and resources for yourself, but even that wasn't enough." (P7)

They stated this situation was tiring and overwhelming for them adding that they were self-sacrificing. Self-awareness, in other words thinking about the therapist's own experience, has been a resource for therapists while they were a resource for their clients.

"I remember that I got tired, and I felt suffocated. It was really difficult. In an extremely altruistic state, we continued." (P1)

"It is more about being a clinician, being aware of yourself, and the capacity to think about how I feel and think. That capacity was a resource in that

period." (P7)

3.2.2. Transition to Online Therapy: What Will Online Therapy Be Like?

Following the two weeks break child and adolescent therapists decided to conduct their sessions via online platforms. For some participants, there was not any idea of online therapy with children and adolescents till they heard about online therapy as an option from their colleagues.

"There was no such thought. I mean, we always talked about online therapy with adults. I've never heard about online therapy with children and adolescents. I've never heard of it; I had no idea. I've never heard of such a thing." (P1).

Even though they felt close to online therapy with adults, they did not think that online therapy with children and adolescents was possible.

"Well, I've not heard anything before, so I have been hearing something about online therapy from both my environment and my colleagues since March 2020. As I said before, I had such an idea of working with adults at the furthest, but I had neither the idea nor the belief that it is possible to work with children and adolescents online." (P3)

All participants went through a process in which they denied transition to online therapy for a while and felt different emotions ranging from shock to anger. They generally had negative attitudes about online therapy and their capability of doing it.

"We didn't believe in online therapy as child and adolescent therapists." (P1).

"I remember that I was a bit fussy, angry, and a little bit emotional during that transition period." (P8).

They (P3, P5, P8) thought that it would be a temporary situation and they would go back to face-to-face therapy. The way they would conduct online therapy sessions with children and adolescents was a huge hollowness and obscurity for participants. In that sense, both pandemic and online therapy were associated with a sudden and unclear change for participants.

“I found it a very temporary thing. I mean, we do online therapy for a few weeks. Then we continue our way.” (P5).

“All that physical environment came to an end, and of course, there was a very optimistic outlook at first; three weeks later I sincerely believed that we would return to the rooms in the first place, but that never happened.” (P3)

Following the getting out of shock, participants informed parents of the transition to online therapy. One participant (P1) thought that parents would not accept the transition to online therapy.

“*I thought that parents would not accept online therapy.” (P1).*

Some (P2, P7) doubted that clients would drop out. They considered both parents’, children’s, and adolescents’ attitudes toward online therapy along with their appropriateness for attending online therapy.

“I thought that my clients would drop out.” (P2).

“I wondered if the therapy process must end with some clients.” (P7).

Since they (P1, P4, P7) did not have any experience or practice in online therapy with children and adolescents, they were not sure whether they conduct online therapy sessions competently. They felt incompetent about online therapy, and they were confused.

“I also thought that I could not do it, but not much.” (P1).

“Well, I was very confused. I was technically confused about what could be done. I mean, something happened suddenly while I was playing with the child in the room. I mean, how can I say, I was very shocked. It was discussed to continue the play therapy online with the children.” (P4).

They did not know anything about online therapy and most of the participants were new on the job. Also, they added that online therapy with children and adolescents was an unknown field. Thus, they were nervous and believed that it would not be easy.

“Of course, as someone who has just started to experience the therapy process, experiencing online therapy that no one knows about was worrisome

initially." (P7).

Participants did not know any information about how to conduct online sessions with children and adolescents. Also, in psychodynamic play therapy clients' needs differ and the therapist's way of working with clients differs, too. They had to adapt the way they work with clients according to their needs. Initially, they questioned their competency regarding online therapy.

"I remember 10-15 days when I did not do anything, and I had questions in my mind like "Can it be done? Can I do it? Is it suitable for my clients?" (P4).

They thought about how to conduct online therapy sessions with children and adolescents. Uncertainty was compelling for them, and they made themselves ready for online therapy via recreating it in their mind.

"*Uncertainty was worrying about how it will happen, what I will do, and how I will do it. I was a little worried and I remember that I was thinking a lot about what it would be like. Can I do it? Can we do it? Is it possible?" (P7).*

They were playing with children in the room and there were a lot of materials. However, they did not have any materials for therapy with children at home. Not being sure about containing clients from a distance was another concern. All these issues arose questions in their mind that whether they would have professional competence in online therapy or not.

"First, I thought that I wouldn't be able to hold them from afar and they were young…I did not have any materials in my home. I had a lot of questions in my mind such as what I can do for children between 5-7 and what it will be like. I was very worried for a client with a psychotic core because not conducting sessionsface-to- face made me anxious too much." (P2).

One participant (P1) stated that being a graduate student and having training within the scope of the graduate program helped her to believe that she would come through it. Thus, in contrast to other participants, she did not have any bias toward online therapy. She approached it with curiosity rather than negative emotions. In this sense, supervision and being an intern under the umbrella of a graduate program gave her confidence in online therapy.

"I was not very anxious; I was at school because I was in the period of

internship, and I was getting supervision. I had friends. We were in something together and the pandemic was completely new for the whole world, and I just approached it with curiosity. I mean, I did not have any bias because it was something that I had no idea about. Thus, I thought that we would come through it together." (P1).

Online therapy with children and adolescents was an unknown field before the pandemic. Even though there were ethical guidelines about online therapy before the Covid-19 outbreak, the transition to online therapy revealed that there is nothing about the nuances of working with children online. Thus, online therapy with children and adolescents was a new thing for most therapists independent form the duration of experience. All participants had to discover ways of working with children and adolescents on their own.

"Working with children online was a new thing for everyone." (P1).

"Indeed, no one who knew this much in the world, and everybody was trying to create something by guess and by gosh. On the one hand, it did not make me feel like I was trying to learn something everybody knows except me. At that time all the professionals who worked with children and adolescents were really on the same level. That is such a new field for all of us." (P7).

All participants stated that supervision was very critical for them in the transition period. With the transition to online therapy, all things related to therapy were arranged again. Getting supervision facilitated the transition to online therapy and supported therapists who were feeling nervous.

"Group supervision comforted me. Personal supervision comforted me. I would not change to online therapy without them." (P3)

"Getting supervision was supportive for me, as I said getting supervision regularly." (P6)

All participants revised their living space for online therapy. Some (P5, P7, P8) found that having another room for therapy was much better than using a living room for online therapy in determined times. Those who did not have a separate room created a space where materials such as toys and crayons were situated. They defined this preparation as a difficult process.

"I created a working space for myself." (P2)

Those who did not have a separate room created a space where materials such as toys and crayons were situated. They defined this preparation as a difficult process.

"First, I tried to revise the place for therapy. A space, not that whole room of course. I tried to change the room into a therapeutic place for myself, but it was troublesome. I mean, now I remember that it wasn't a very pleasant time because it was all an attempt, too. I mean that I would attempt, and it would happen. It was like I needed to give feedback. It was such a spatial preparation." (P6)

While most of the participants placed their computers on tables in contrast to playing with children on the floor, one participant (P3) stated that she created a space on the floor to make children feel like the therapy setting did not change. Experiencing spatial transition had been a process.

"When I started to conduct sessions at first, I created a space like a playroom. I put a carpet on the floor like a play mat in the playroom. It was like I wanted to frame it again. I mean, here's a white wall and I did not want them to know about my materials, but I wanted a few toys and a carpet-like play mat. I probably wanted to make children feel like nothing changed and I could move into a system in which there was just an armchair, a table, and a screen. I think, even this transition was a process deep inside of me." (P3).

Participants (P3, P4, P5, P6, P7) found ways for conducting sessions with children and adolescents online via searching on the internet and conferring with colleagues about online therapy. Talking with colleagues, in other words, peer supervision helped them relieve and realize that they were also handling both the pandemic and online therapy.

"I was not the only one who changed to online therapy. Since many colleagues of mine switched to online therapy, exchanging views on online therapy relieved me obviously." (P3).

They discovered an online equivalent of materials in the room such as a

sandbox and dollhouse. All these preparations were an attempt for them. They did something and then observed its influence on online therapy.

"...But then we blindly found out what online therapy would be like. I mean, we got each other's opinion, conveying that I found an online doll house, and I discovered an online sandbox and so on." (P4)

"We learned by trying and doing." (P1)

Participants (P2, P3, P4, P6, P7) mentioned that as they discovered ways of conducting online therapy sessions with children and adolescents, they felt more comfortable and more competent during sessions. In the course of time, online therapy has had its own order. As they found the instances of inclusion of therapists in online sessions, they felt relaxed.

"Then, such a new language of therapy started to emerge, a language of online therapy. I mean, learning this language, but being able to focus on clients' experiences with having an anxiety-provoking stance less." (P7)

"Then as I searched, I found things that were done before and ways showing how therapists are included. I saw that inclusion of therapists can be possible. I felt more comfortable about this issue." (P5)

They found an online equivalent of all therapy components such as therapeutic frame, boundaries, and reciprocal play. They learned to contain clients from a distance, and they started to play reciprocally in contrast to their bias about having a passive role. They developed "a new language of therapy" with clients in time.

"I mean, it was like we tried to find online equivalents of everything in the room. For instance, containing the client, we already knew how to do it when we were in the same room. However, containing the client in online therapy was an issue. You were not in the same place... It was certainly the way we played in the room, the client was playing, and we were watching in the room. I mean, we could play together. For instance, at first, I thought that children would play, and we would probably watch. It was like what we could do from afar but, we learned play could be reciprocal. The language of online therapy is composed of a reflection of

everything in the room on online therapy." (P7)

While psychodynamic therapy with children and adolescents was client-centered, therapists (P4, P5, P8) had to be a bit more directive in online therapy. They talked about associations, their play, and how clients spend time at home. It was not like playing at all. It was more like cognitive and directive interventions.

"It was like an exercise more about play related to free associations, creating a story and associations of words. It may not be called a play. I brought these up a bit." (P8)

Surprisingly, one participant (P5) stated that cognitive and directive interventions became his way of working following the two years of the pandemic.

"I don't know how to say that, but I started to use more directive interventions with children and adolescents. I used more cognitive and directive interventions and not my therapeutic framework but the way I work with children and adolescents started to change in time." (P5)

Also, while therapists were working with parents by making them think about the child's or adolescent's mind, in other words mentalization based sessions with parents, they started to be more supportive and give more suggestions due to the compelling conditions of the pandemic.

"I preferred meeting parents more often and getting information about how the client feels and spends time to establish the relationship. I followed a path that was more directive and I had to give directions." (P8)

In that sense, the frequency of sessions with parents increased. They observed that having a supportive approach was good for parents since they were affected by the pandemic, too.

"Well, since I started to be more holding and supportive rather than just making interpretations, I was not as neutral as I was at the beginning. It may seem like it had a positive impact." (P5)

"I was more supportive in meetings with parents. I said that to them, too but I also gave them credit because they all were working, and they did not have a

support system. They were having great difficulty. So, I reminded them that we would do as much as we could. It was like "I don't have very high expectations, but I care if you would do this blah blah." I worked through a supportive approach rather than resolving the problem." (P6).

Three participants (P1, P5, P8) added that having a supportive approach when people focused on struggling with the difficulties of the pandemic increased their investment in therapy.

"But on the other hand, as I said I had a position in which I gave directions, living up to their expectations. I was not like, "How did that make you feel?". I think, having a position in which I heard their concerns and responded to them increased their investment, probably." (P5)

Parents felt thankful for the supportiveness of therapists who witnessed their confusion and continued being a resource for them.

"Both mother and father were surprised at what had happened. Everyone was surprised at what had happened. They felt that we were supportive, and they were thankful." (P1)

Since parents were feeling negative emotions and trying to accompany their children's feelings, their children's therapist had become a resource for them, too. Their children's therapist reminded them of the importance of self-care for their parenting skills.

"Well, adults were also affected by this process, the pandemic. They had difficulty regulating their emotions. They especially stated that they benefited from that counseling part very much. Some of them realized that they forgot to set aside time for themselves. Some parents thought that being alone and leaving the child alone was a bad thing. When we talked about that was a need, too, that made them feel good." (P8)

Being open to new experiences and change was determinant for adapting to online therapy. Those who do not cope with uncertainty and sudden changes easily have difficulty adapting. They were obliged to online therapy, so they had to adapt somehow.

"I'm not someone who can deal with uncertainty or such rapid changes in

my private life, either." (P4)

"I mean, if there is such a process again, I will try to adapt again. I cannot say I have adapted but I adapt again, and I will have difficulty again because it is quite a different thing, there is a process at that moment. You must continue that process. That part happens again in the beginning, but I could not adapt easily. If it happens again, I cannot adapt very quickly but I will continue." (P3)

As they were familiar with conducting sessions with children and adolescents online, they have adapted to online therapy much. Also, working with children required them the capacity to be flexible compared those working with adults.

"Maybe, as a human being, I didn't really like change but on the other hand, as you start working with children, that capacity to be flexible becomes a capacity you must have." (P7).

The capacity to be flexible and being sarcastic when facing compelling situations helped participants to cope with both the pandemic and all the changes in therapy. It can be considered as the importance of humor as a defense mechanism, especially in the case of traumatic events.

"I have a sarcastic side that I love very much. This emerges when working with children or in play. That sarcastic side of me allows me not to take such things very seriously and to deal with the current situation without creating disaster scenarios. This sarcastic side of me also comes from flexibility. Instead of saying "What happened? What are we going to do? Am I a competent therapist?" I said, "This happened to us. Let's try it!". I've tried to approach it from a more flexible, humorous side. Such a capacity has emerged again." (P2).

Resilience has become prominent in that tough situation, too. Being a flexible and resilient person brought patience and calmness.

"In my opinion, I am a resilient person. I don't think that I'm a person with a very low capacity for resilience in general. I don't break down when difficulties emerge. I have an attitude that I can overcome. That capacity supported me." (P7).

Being solution-focused and even tempered helped therapists to think about what could be done. Also, pandemic is not an acute traumatic event like an earthquake, and it gave time to find possible solutions.

“Everybody was in a panic. I approached it like that I would be calm and think about what could be done. Also, the pandemic was not like a traffic accident. Since you don’t need to intervene a bleeding, it gives you some time to do planning.” (P8).

A sense of wonder and determination facilitated participants' adaptation to online therapy. Loving the occupation that they are practicing has affected both their determination and motivation for online therapy.

“I love my job and I am determined, too. I said that I would continue doing online therapy.” (P3)

They wondered what online therapy would be like and continued trying without giving up. Curiosity and persistence helped them to continue due to all the compelling sides of online therapy and the pandemic.

“I am curious, I wonder. Thus, I think that curiosity helped me. I am persistent, also. I don’t mention absolute persistence. I mean, I am determined to do what I want to do, I make effort and I work. I think this had an influence, too. That curiosity, persistence, and effort helped me.” (P6)

One and a half years later following the first case of Covid-19, restrictions were removed, the Covid-19 vaccine became widespread, and life has started to go back to “normal". All participants do not perceive the world as uncanniness as they perceived it at the beginning of the pandemic.

“I constantly hear about someone undergoing Covid-19 but the invention of the vaccine relieved me probably. There have been so many people undergoing Covid-19 around me. They beat the virus and that relieved me.” (P3)

“I don’t perceive the world as uncanny anymore.” (P1)

Anxiety about getting infected has decreased and people have a Covid-19 test without worrying if they have any symptoms.

“*Now, I think that it is a “normal” illness right now and we will go back to our “previous” life normally.” (P8).*

The pandemic was experienced intensely depending on its waves. Even though the vaccine was found, its spread to the whole country, and its implementation for all ages took some time. The perceived intensity of the pandemic decreased in time.

"Now I don't feel the presence of the pandemic. It was very intense in the beginning. I was feeling its intensity, too…That intensity has changed for all of us, and I feel more comfortable right now." (P7)

Participants have returned to face-to-face therapy, and they stated that they felt free. They are feeling like the pandemic is over right now. As life goes back to normal, hearing anything about the pandemic makes them feel bored.

"Restrictions have been removed a bit more and being free makes me feel better. Returning to the office is good for me because I have missed my clients. I have missed working face-to-face, too. I feel freer from its beginning to right now." (P2)

Talking about the pandemic led to boredom. Neither therapists nor clients wanted to hear something about the pandemic in the course of time. It became something related to everyday life.

"Many people don't want to hear anything about the pandemic. Also, I don't want to talk about the pandemic much because I conduct my sessions both online and face-to-face. I see that clients continue their lives with that reality, and this is a kind of adaptation. They don't mention it. They see it as a part of daily life." (P8).

Even though participants (P3, P4, P7) adapted to online therapy, they have a dilemma about it. They doubted whether it is a "real" therapy or not. A lot of questions wandered in their mind.

"There are always questions in my mind. Is that a complete therapy? How much of it do we call online therapy? Where does therapy start and where does it end?" (P3)

As time passed, they realized that they did their best in the compelling circumstances of the pandemic.

"At first, I was like "What are we doing right now? Is that therapy or is that breaking the bond?". I wasn't convinced about that kind of job. I remember that there was a period like that because it took a month." (P4)

In addition to that dilemma, one participant (P6) added that she had thoughts that she deserved the fee in face-to-face therapy, but she didn't deserve it in online therapy. She thought that she didn't make the same effort in online therapy. Thus, it was difficult for her to take the fee for online sessions.

"The payment part of the sessions was a bit emotional. I mean, I have thoughts like we deserve the fee when it is face-to-face, but we did not deserve it when it is online or I shouldn't deserve it…I mean, I was convinced that it was the same effort and it had even more difficult parts." (P6)

3.2.3. Clients' Attitude toward Online Therapy

There were two different attitudes among clients; those who easily adapted to online therapy and those who resisted to adapt. Also, children's attendance in online therapy was dependent on parents' willingness to continue. Children were more flexible than therapists' expectations of them.

"The children were very flexible. When I thought about them, they were content with their situation." (P1).

Therapists did not expect them to adapt to online therapy easily. They adapted to online therapy quickly and therapists were surprised about their adaptation capacity.

"They adapted very quickly. I was surprised. I was really surprised." (P6).

Their adaptation capacity is also related to their familiarity with technology, smartphones, and computers.

"Children didn't have difficulty. Both children and adolescents were good at technology. I mean, being on the phone and doing something via using the phone was not something they didn't know. In that sense, I remember that they found it juicy a bit. Some acted as if they were shooting a YouTube video." (P7)

One participant (P2) added that the ones who wanted to be hold and contained were more flexible.

"Children were more flexible than me by the way. I realized that each child who needed to be held was more flexible." (P2).

One participant (P8) added that those adapted to online therapy because of the need for therapy. Their relationship with the therapist and the level of benefit from therapy were related to the motivation for online therapy.

"Most clients adapted to online therapy due to their need for therapy. They adapted because their relationship with the therapist and the level of benefit from therapy were related to not ending the therapy process." (P8)

Online therapy was also a resource for dealing with the difficulties the pandemic brought about.

"The group we established a therapeutic bond benefitted from therapy to cope with the difficulties of the pandemic." (P8)

Clients' and therapists' attitudes toward therapy seem reciprocal. Clients' adaptation to online therapy facilitated therapists' adaptation and perceived comfort in online therapy.

"Clients were also adapted to that process. If they didn't adapt, online therapy would not come into question. Thus, I think it was reciprocal." (P3).

Children's adaptation to online therapy helped them relive in online sessions. As they became comfortable, they focused on clients better during sessions.

"As I said, the relationship can be established in an online setting as well. The relationship we established in face-to-face therapy continues in online therapy, too. Children adapted to online therapy, too. I remember there was a feeling of relief for a while after this point." (P7)

Therapists who felt close to face-to-face therapy had clients who were comfortable with face-to-face therapy. Also, therapists who preferred online therapy had clients who easily adapted to online therapy.

"I prefer face-to-face therapy much and I observe that therapists who are at ease in online therapy have clients who adapt to online therapy well and they

can continue online therapy. Those who prefer face-to-face therapy much like me have clients who prefer face-to-face therapy, too. It can be about either the message we sent or the setting we're comfortable in." (P8)

Those who had difficulty adapting to online therapy resisted the process. There were two types of resistance: parents' resistance and children's resistance. Since parents made payments and helped children to attend sessions, their resistance emerged initially. They had concerns about what online therapy would be like.

"First parents resisted and then children resisted. I mean, they were like "How will it be? How will we do it? Shouldn't we do it?". Staying at home was good for people. Thus, they told me that there was not an intense need for therapy, we were just at home with children, too." (P4)

Some parents had doubts about the effectiveness of online therapy. They stated that online therapy wasn't helping. They needed to ask questions about the effectiveness of online therapy due to seeking validation from the therapist. Giving frequent feedbacks about the process and the therapist's clarity helped parents to relieve.

"Some families started to call me frequently and said that "We don't know what you are doing during online therapy. It is just online. Does it serve a purpose? Is it efficient? The attitude depended on the family." (P4)

"Some parents said that it isn't helping. I had difficulty, of course…I said that I'll give brief feedback on how it was after the first meeting. I think that if there is something wrong with the process and online therapy doesn't go well, I will end the process anyway…I told all families and I think that clarity was good for them." (P6)

One participant (P8) associated parents' doubts about the effectiveness of online therapy with emotions such as despair and getting bored due to the prolongation of the pandemic. Therapists' open communication and being clear on the effectiveness of online therapy facilitated the process.

"After a while, as the pandemic has prolonged, I started to observe that parents felt emotions like hopelessness, getting bored, and feeling suffocated more.

Sometimes it was toward the pandemic. There was also a feeling that the therapy was not helping, but mostly it was related to the pandemic." (P8)

Some children also resisted after the therapists worked on their parents' resistance. They had questions about how they would play together. Some refused playing for a while. Children's resistance cannot be explained, depending on the child's age. It seems like it is related to symbolization capacity and being comfortable with the distance.

"When I started to work with children online after working on their resistance, children were like "How will we do it? What will we play? How will I play with you?"...Some children said that we couldn't play in online therapy. They refused online therapy, or they didn't want to start the process. It is not something explainable related to age." (P4)

Not being able to share the same room was compelling for children. Even though they seemed like that they adapted to online therapy, they got bored. They could not find the reciprocity they had in face-to-face sessions.

"Children between 6 and 8 years old were playing in the room and they had difficulty adapting to online therapy. Even though they could adapt, they were like that was so boring, at the end of the day...because we're not in the same room. We cannot play hide and seek together or even if we draw pictures together, there is no reciprocity." (P6)

Adapting to online therapy or resisting it depended on the client's pathology, age, temperament, symbolization capacity, and reason for referral. Older ones adapted to online therapy easily compared to their younger peers.

"Some clients-maybe age was really related, and clients' needs take part in that- but I think, older clients adapted easily." (P3)

Those who have a high level of symbolization capacity could play with the therapist in online therapy. To evaluate a child's suitableness for online therapy, considering the child's needs, family dynamics, and temperament can be helpful.

"It depended on the client. I mean, I know a client between 4-5 played as if we were in the same room. He passed the doll forward and I pretended to receive the doll from him. However, their reactions to online therapy depended on

age, temperament, the reason for referral, and lots of things." (P4)

Some personality organization may not be suitable for working online. The probability of drop-out was high for those with borderline personality organization.

"Clients with borderline personality organization dropped out." (P2)

Also, independent of personality organization some clients ended the therapy process earlier because they had difficulty accepting, and thus adapting to online therapy.

"Some processes ended earlier. It was like a drop-out. They dropped out after we talked about the process, but it ended earlier. The therapy process was not over yet." (P4).

"After they heard about the transition to online therapy, one client didn't want to attend online therapy. They broke off. They could not bear the state of not seeing each other face-to-face. There was no such thing before. They had difficulty attending face-to-face therapy before, too." (P2).

3.3. DIFFICULTIES OF ONLINE THERAPY WITH CHILDREN AND ADOLESCENTS

When talking about the online therapy experience, participants talked about how they had difficulty in online therapy. They emphasized that the therapeutic framework and its components such as privacy and fee were affected by the transition to online therapy. Attending therapy from home and being in separate places made keeping the therapeutic framework difficult. In this sense, while keeping the therapeutic framework was very difficult for therapists, in the beginning, they created a therapeutic framework depending on the conditions of online therapy in time. The relationship between client and therapist was impacted related to the therapeutic framework and the client's personality. Both therapists and especially adolescents tried to be sure about privacy during online sessions and that affected their focus on each other and therapeutic relationship. While being in

the same room with various materials was enough for the therapy process, requirements for conducting sessions changed and became varied with the transition to online therapy. Internet connection, a smartphone or a computer, and other equipment became new components of the therapy. Based on participants' reflections, five subthemes were named as "loss of the space: deprivation of containment", "recreating the therapeutic framework", "therapeutic relationship: will it stay the same?", "technical difficulties" and "screen: a third party in therapy".

3.3.1. Loss of The Space: Deprivation of Containment

Since they started to attend sessions from their homes, they could not share the same room and the same moment in the same room. Both therapists and clients were in their own spaces and even though they could share the same moment in online therapy, the room they attended sessions was different.

"All the physical space ended." (P3)

Even though they had the chance to talk about not being in the same room, it did not compensate the presence of being together in the playroom.

"The things in the environment are very different. Now we have an online interview. How is your room and how is mine? How does your room smell and how does my room smell? What is the temperature in your room? I have no idea about that. I don't know to what extent we experience and feel the same things right now. I'm aware that we can talk about it and work on it in therapy, of course. However, I think being in the same room is something very different." (P3).

They felt that they "lost" both their spaces for therapy and being together in the same room suddenly. From their perspectives, there was an obstacle, in other words, a third party in online therapy.

"Loss of space is much…I think it is very important to share, to be in the same place." (P1)

"There is a loss, the loss of being in the same room. I remember that we

talked about that loss with children." (P6)

Loss of space and togetherness brought about mourning. Participants (P2, P3, P6) stated that they felt anger, grief, and longing at the same time.

"*It was a process of grief and loss. I mean, we lost being in the same room with our whole body and companion." (P6).*

They also added that clients felt anger and longing, too. In that sense, therapists and clients mourned "together" in different spaces. They were separate in their rooms, but together in the grief process. They talked about grief and anger with the client while they were feeling the same things.

"One of my clients missed being in the same place much and stated that he missed Bilgi University, the room. He asked, "Does that place still exist?". We looked at the photos of Bilgi University and the psychological counseling center together. Actually, both of us mourned. I heard these kinds of reactions and feedback." (P2).

They related children's anger and mourning to not being able to have access to the therapist. In that sense, children felt inadequate.

"Sometimes I got angry, and I think the client also got angry, too because there was a therapist and she suddenly disappeared. She appears on the screen, but the client never touches or never has access to her. I think that made them angry, too." (P3)

"Children's mourning was related to the feeling of inadequacy and feeling of not being able to reach. I would almost tear up in one session. When we looked at the photo of Bilgi University, the child was like "Do you remember that we met in front of that door, I played in the garden, you saw me, too. I was also mourning during that period. I missed my school; I missed my friends. I felt a lot of emotions at the same time." (P2)

The space was facilitative for therapists to contain the client in face-to-face therapy. However, they were deprived of the containing role of the space in online therapy.

"The space does not have containment and only you are containing everything… I mean, containment was more difficult. The space is also containing.

The space helps." (P1)

Also, not being in the same room prevented them from being attuned to each other. They lost the accuracy of making eye contact.

"Its compelling side is not being in the same room, not being in sync with the client and not being sure about coming eye to eye." (P6)

While having a containing role was difficult on its own, containing clients in online therapy required more effort. Thus, therapists felt more tired in online sessions compared to face-to-face sessions.

"It was like I was making an extra effort to keep the togetherness and to make clients feel containment. I was trying to be there extra, and I was a bit tired." (P7)

Therapists were not able to see the body language of the clients and that also made the containment difficult. Therapists' extra effort in online therapy was related to that mostly.

"The compelling side of it was not being able to see the client's whole body. That is the main thing. I benefit from the trembling of the client's foot, the way the client sits, and the client's position. I can develop a hypothesis and combine it with questions and words. It doesn't happen in online therapy that much." (P8)

Therapists missed the client's look, smile, and other facial gestures. Thus, being in sync became difficult. Also, reading body language and interpreting it were significant parts of the psychodynamic therapy approach.

"That becomes more problematic in sessions with the parents. While parents were sitting in front of me, I was directing the sessions by reading their body language and observing the way they look at each other, their communication with each other, and their communication with me." (P5)

Therapists missed a lot of information about the client's body language in an online setting. In that sense, that was another "loss" online therapy brought along.

"There are things that we missed; gestures, mimics, and the body in the

sessions where we just saw the face." (P4)

Being face-to-face" and playing in the same room was very natural. The therapist and client were playing reciprocally in face-to-face therapy. In online therapy, therapists and clients could not play together and therapy became mechanical and lost its spontaneity.

"Sometimes I said, "You can play. I will watch you." but I think it is unnatural because the child is playing but I am watching the play. It was not like the play in a face-to-face setting." (P8)

Even though they tried to play reciprocally, the screen was a barrier between them. Sharing the same moment and online platforms as a medium were not adequate for a reciprocal play.

"I experienced the difficulty of that. The child had a toy. I had another toy, but there was a screen between us. The child was reaching forth and I was reaching out toward the camera, but we never touched." (P3)

Also, the client's perception of the therapist as mechanical may affect the relationship between them due to the importance of natural interaction. One participant (P2) stated that even though there were equivalents of materials in the room, they were so technical and prevented spontaneity and the flow of the session.

"The *negative side of online therapy -I think that is the thing affecting much, indispensable- not being in the same room. Being face-to-face and in the same room is very natural. There is a good expression one client said. The client told me you were like Siri for me from the beginning of the pandemic. So, he resembled the iPhone Siri in iPhone, more literal, mechanical, and not having a feeling and soul." (P2)*

Since working with children and adolescents requires different materials, being deprived of the containment of the space affected working with these two groups differently.

"I think we had a good therapy process with the adolescent, but we must be in the same room with other clients." (P3)

Therapists had to have materials in their own environment while working with children. However, there was no need for extra materials for online therapy with adolescents since they were using language.

"There is a need for material in working with children. The need for the material in therapy with adolescents is related to using language. That is the distinction. Thus, I think that online therapy with the child was more difficult." (P6).

All participants stated that working with adolescents in online therapy was easier than working with children because they were talking during sessions. Children were playing with the therapist in the room, but they could not keep playing in the same way in online therapy. However, there was no such great change in the way the therapist works with adolescents.

"The different part was about to what extent play is included in therapy. The distinction was between "play therapy" and "talk therapy" while working with children and adolescents. When the medium changed, the flow of the session and being online changed much." (P4)

For some of the participants, all difficulties related to loss of space led to having a dilemma about transference and countertransference. Making a distinction between the therapist's feeling of helplessness and the helplessness online therapy brought over was difficult.

"I was like "Is that my difficulty related to countertransference or is that the difficulty of feeling helplessness online therapy brought along?" I think making a distinction between them has become difficult. I mean, that was very clear in the room; the framework was apparent, and the room was the same. That kind of feeling was interpretable but with the pandemic, our order changed and there was no such thing as the room. The transition to online therapy happened. The framework was upside down. I couldn't know whether all the distress was related to my desperation, or it was countertransference." (P6).

Also, the clients saw the therapist in the office in face-to-face sessions. However, the clients saw the therapist's home environment and that affected the therapist's neutrality negatively. Thus, it was confusing for therapists to consider

the client's curiosity about their private lives as transference in online therapy since the therapist was not a blank space for them anymore. Besides, the therapist saw the client's home environment and that affected the therapist's countertransference, too.

"I can say that transference was intense, but they saw my real life. So, I don't know whether we call it transference, or I was uncovered. It is the same for children, too. I'd say countertransference has increased, but it seems like concepts are something else here. I mean, there are different concepts. It is about being in the home and seeing the child's reality." (P1)

Plus, the screen was an obstacle for both transference and countertransference. While the therapist and the client were sharing the same room, the screen and sometimes the ones in both the client's and the therapist's home environment became the third party.

"I felt that transference and countertransference were not as transparent as it was in the room. There is always an obstacle, a third-party." (P2)

3.3.2. Recreating The Therapeutic Framework

All participants stated that they had to make necessary arrangements for the therapeutic framework with the transition to online therapy. Loss of the space brought along difficulty keeping the therapeutic framework in online therapy. They stated that losing control over the therapeutic framework was the most difficult part.

"The room has boundaries. The child comes in and attends the session with you, but when we're at home, I see the child at his home for the first time. Also, he sees me at my home for the first time, too. Thus, some children leave the room suddenly to show me something in the home. Being alone with the child in the room was the most compelling part of keeping the framework because of those wandering at home, calling their moms, and shutting down the computer." (P4)

Therapists kept accompanying children somehow, but they lost their

physical control over the room, in other words, the therapist's role in the psychodynamic approach.

“I remember that a child threatened me to go up the wardrobe. I couldn’t stop him. The siblings of the child were coming. They were hitting each other. I was just saying “Don’t do it!”. I couldn’t interrupt them because I couldn’t set boundaries much.” (P1)

In a face-to-face setting, children were leaving the room if they needed to go to the restroom. The therapist was reminding the child of the framework if he wanted to leave the room in the middle of the session. However, in online therapy children could leave the room whenever they wanted. Also, security became an issue because the therapist lost control over the space.

“Sometimes the camera was standing there, but the child leaves the room, and I was too uneasy, and I was like “What is the child doing right now? Is the child good? Is there someone watching the child?” because it was very risky that we were in the room, in the session, but mom and dad were outside of the room, but to what extent they were outside of the room and how they were able to hold the child.”(P3)

Also, security became an issue because the therapist lost control over the space. While the therapist could ensure the security of the child in the playroom, concerns about the child’s security emerged in the online setting. Even though the therapist was worried, there was no chance to intervene.

“Sometimes I had security concerns. I mean, for instance, if a very active child fell while he was jumping, I would not be able to intervene.” (P6)

Also, even if the child stayed in the room, he was able to turn off the voice and video. Thus, the dimensions of the control include both the room and the online platform.

“Children had a handle on smartphones, of course. They turned the camera and voice off.” (P3)

“They were getting out of the Zoom suddenly.” (P2)

While some children turned off the voice and video as a part of the play,

some did it to express their anger. Thus, the extent of the contract in the playroom has changed.

"There is a rule in the room; starting and ending the session at the same time, not harming the toys and each other. We are in the room with a basic contract, but in the online setting if the child gets angry, he can turn off the voice and video and I was in a spin thinking where he is, on the other side of the screen." (P3)

Therapists made a new contract with the child and talked about the contract in the session. They collaborated with the parents when needed. In that sense, the need for parents' support increased in online sessions.

"I made a contract with the child. When there was a difficult situation such as disconnection or risky behavior, I called the child's parents to say that I need their support. Once, a child stepped up onto a wardrobe and I called the parents immediately." (P2)

Therapists got parents' support to bring the child back if he leaves the room and to remind him to stay in the room during the session. Even if they made a new contract with the child to stay in the room, that did not work.

"I told the parents that the child might want to leave the room but whenever he left the room, please remind him of the session and send him back to the room." (P6)

Loss of control was the most difficult part of online therapy due to therapists' efforts to keep the therapeutic framework.

"I remember that the child turned off the camera even though you made a contract with the child. The loss of control was one of the compelling sides of online therapy." (P7)

Also, one participant (P6) added that the need for parents' support was a distinctive feature of working with children. While adolescents attended sessions on their own and there was no need for parents' support, the presence of parents was a prerequisite for online sessions with children.

"The different part of working with adolescents is that they can take

responsibility for attending sessions on their own. They don't need their parents. That was more comfortable and made adolescents feel secure. One of the most important differences between working with children and adolescents is the presence of parents. You must have access to parents while working with children at some point. With adolescents, parents aren't accessible and there is no need for access, too." (P6)

Loss of space and staying at home affected both therapists' and clients' confidentiality, a significant component of the therapeutic framework. In face-to-face therapy, the therapist and client were together in the same room, and ensuring confidentiality was the therapist's responsibility. However, in online therapy, it became harder in terms of being unsure about the presence of a third party.

"I had difficulty when someone came in and a sound came from outside. I checked the client's confidentiality, and I told the client "Are you feeling comfortable and safe to talk and to share right now?" If the client didn't feel comfortable, I let him talk about whatever he wanted." (P6)

Parents were waiting in waiting rooms which are generally far from the room for therapy sessions in the therapist's office. However, parents generally were in the next room during the child's or adolescent's online sessions.

"I felt insecure because there was a waiting room in the psychological counseling center and the door of the room was closed. There was a playroom in the office, but there was no playroom in both clients' homes and my home. I heard the voice of the television in the back. I heard the sound of the television and the sound of the arguments at home. Sometimes children attended the sessions in the living room." (P2)

Also, sometimes family members entered the room during online sessions. Ensuring confidentiality was hard and the therapist's concerns about it may affect the quality of the therapeutic alliance.

"Everybody was at home. Mom, dad, and siblings were at home. Thus, confidentiality could not be ensured. There was that kind of difference in the framework. Everybody was entering the room, the sibling entered, and the mother entered." (P1)

In face-to-face therapy with children and adolescents, parents were informed about the themes of the child's play in meetings with parents. However, in online therapy with children, parents' wish to hear children's sessions increased.

"Families generally closed their doors when the child had a session, but I remember that I witnessed that the child opened the door suddenly and the mom was there, listening to the session behind the door." (P7)

Interestingly, even though they accepted the privacy between the therapist and the child in face-to-face sessions, they became paranoid and wanted to know everything about the session. It may be related to their witnesses of online classes and being a close part of the school system at the beginning of the pandemic. The parents had difficulty making a distinction between online classes and online therapy.

"Parents normalized listening to sessions, and they have become more paranoid. They want to listen to the session, and they want to enter the room. They want to know everything. I mean, I am the therapist in the room, but they were like the child, and I can have nothing private. Ensuring confidentiality is very difficult for me right now." (P1)

Thus, most of the participants doubted that parents were listening to the sessions. It might affect the therapist's focus on the session.

"I remember that I had doubts that parents were listening to online sessions because you realize that the door seems to be left open, or there were sounds nearby." (P6)

Therapists reminded the parents of their role in ensuring confidentiality and they asked them not to intervene in the child's session. Interestingly, therapists were asking for support from the parents when the child left the room. However, when it came to confidentiality, therapists collaborated with the child.

"I remember that I reminded them of confidentiality. I told them "It is his space. Please, don't intervene." (P6)

In that sense, they were dependent on their willingness to ensure confidentiality and to conduct online sessions effectively.

"You are mentioning the therapeutic framework by telling them, "Here is

the confidentiality. You were explaining it to the family like "We have to ensure confidentiality here, too." However, you were dependent on them to ensure confidentiality." (P7)

Interestingly, some parents did not mind whether the child or adolescent would hear the therapist's meeting with them. Since therapists and parents were talking about the therapy process, and the client's circumstances at home and school, it would be good for the client not to hear what they talked about him.

"Sometimes the child came in -that was a great risk for clients- shouldn't have heard about what we were talking about, but the pandemic was such a process that everybody had to stay at home. I very nervously tried to arrange the date when the client wasn't at home, but that never made me feel good. Parents' attitudes were like "He never hears. Nothing happens. Let's start the session!". I felt that it was an attack against my framework." (P3)

Parents' unconcern about the confidentiality of therapists' meetings with them worried one of the participants (P3) because if the client heard the meeting, the therapeutic relationship would rupture.

"I didn't like the feeling that the client would hear the meeting, the therapeutic alliance would rupture, and the therapy process would end. It was compelling. I didn't like that feeling." (P3)

In contrast to the parents who did not care about the confidentiality of parent sessions, one participant (P5) stated that his clients' parents were nervous about the possibility of being heard by the child.

"The only problem was that parents were nervous about whether the child would hear the session since the child was at home. I was a bit nervous, too." (P5).

Children were not as attentive as adolescents who cared about confidentiality. They attended the session while the door was open.

"Children don't care about confidentiality. Children aren't concerned about whether their parents would hear the session or not. Few children were concerned about it." (P6)

"Children were like "Oh, let it go!" They left the door open and had an

attitude like "Let them hear!". Young ones were not like "What will happen? They will hear me!" (P7)

Thus, therapists reminded the child of confidentiality at the beginning of the session. They asked the child to close the door and they started the session after checking the confidentiality of the session. In that sense, therapists' emphasis on the therapeutic framework increased in online therapy.

"I felt like I had to remind the child of closing the door and of creating the framework. I remember that if the door was open, I told the children that "We were meeting in the room. Do you remember that we were going far from the waiting room and closing the door? Let's close the door of your room and then we start the session." (P6)

"Normally the child or adolescent attends the session, and the session starts with what they bring to the session. In online sessions, I started the session by saying that "Your door is closed. You are in a safe setting where you can talk, aren't you?". I didn't say "Let's start!" because there were children, and I was anxious about their confidentiality. Thus, I was certainly confirming their confidentiality and expressing it. I was saying "Let's start if everything is okay." (P4)

All participants stated that adolescents were very anxious about ensuring confidentiality. They did not want to attend sessions from their homes at first because they thought that their parents would listen to their online sessions.

"Adolescents had difficulty attending the session at home. They were like "I cannot talk at home. My mom listens to me." (P4)

Even if the parents did not listen the session, the size of the home affected the adolescent's concerns about confidentiality.

"I remember that adolescents were anxious about confidentiality. They were like "They will listen to me. They will hear me." Even if parents don't listen to the session, some homes were small, and the rooms were next to each other. Thus, the voice reaches them at some point." (P7)

If they had any doubt about being heard, they preferred using the chat section of Zoom and texting what they would say instead of talking to ensure their

confidentiality. Texting became a normal way of communication in online therapy.

"I had a 13-year-old client, and he was texting me to ensure their privacy when he said something special to me. I was responding to him by chatting." (P2)

"Adolescents were using the chat part of Zoom. It was not something I suggested, they brought it. It was probably about the negative side of conducting sessions at home. They were like "Will I be heard? Will I be listened to?". When they had thoughts like that, they preferred texting. They wanted to communicate via texting things they couldn't express easily." (P7)

One participant (P4) was working with the ones who were abused. Since family members might not know about abuse, clients with an abuse history didn't want to attend sessions. Thus, working with adolescents online requires sensibility depending on the case.

"I was working with clients who were abused within the scope of an association. More adolescents who didn't want to attend sessions because they were talking about the abuse, and they might not want to talk about it at home or people at home might not know the whole story. It could be more critical because there was a security issue." (P4)

One participant (P5) added that even though some adolescents stated that they would not mind confidentiality, they started not to talk about some themes such as sexuality and related issues due to their concerns about confidentiality.

"When I doubted and asked questions about whether they could talk about everything, they responded "So what? Nothing happens. They don't listen. They aren't at home." but I realized that none of them talked about certain contents. They didn't talk about sexuality, their sexual development, issues about the body, the opposite sex, and sexual orientation." (P5)

Besides adolescents' solutions for confidentiality, therapists found ways for ensuring confidentiality. Putting white noise in front of the door and setting sessions when parents weren't at home were solutions for ensuring confidentiality.

"I was conducting the session when their parents weren't at home or I told them that "You could turn on the vacuum cleaner, and such methods. Thus, I

could ensure confidentiality with adolescents somehow." (P1)

"We put the music in front of the door with some adolescents. When the music paused, they went out of the room and solved it. We reset the date of the session when the parents weren't at home. Some attended the sessions from home." (P4)

The therapists also found solutions to ensure confidentiality in their own environment. They put headphones or attended the sessions in the farthest room of the home.

"I was living with my family during that period. There were 4 people in the home. I was in the farthest room and point of the home and I attended every session with my headphones. I asked clients, especially adolescents and parents to do that." (P6)

There was just an issue of "confidentiality" in face-to-face therapy, with the transition to online therapy confidentiality has become multi-dimensional. The therapist's confidentiality was one of the dimensions of confidentiality. One therapist (P5) was living alone, and others were living with their families. Those living with their families sometimes had difficulty ensuring confidentiality.

"I couldn't ensure confidentiality as a therapist. I had a lot of difficulty. I was living with my family. My room opened into the living room and all I said was heard. There was that kind of difficulty for me." (P1)

Besides, living with the family impacted the therapists' own therapy process. They had to ensure their confidentiality and that made them more empathetic toward the client's difficulty of ensuring confidentiality.

"It was a process in which I went to therapy, too. My own therapy changed to online and one of our greatest question marks was that some of us had space and some of us didn't have a space at home. I was one of those who didn't have a space." (P3)

One participant (P2) stated that one of her family members entered the room and the client saw the family member. Therapist's neutrality was affected negatively, and the client's transferences was affected, too.

"I am living with my family. That was difficult, too, because one of my

family members entered the room suddenly once and one of my parents appeared on the screen and the clients knew one of my parents. No matter how you try to ensure confidentiality, there were times when I had difficulty ensuring confidentiality since you live in a crowded home, and you don't live alone." (P2)

The collaborative approach of their families helped them to ensure confidentiality. However, they were more relaxed when they found additional solutions such as white noise machine for ensuring confidentiality.

"I was living with a family of 4 and the other three people had to respect the job I practiced and follow the path according to that so that I could get involved in that process. They did their best and nobody went out of the room during sessions. There was white noise outside. I think that was a compelling process for them, too." (P3)

"I had that solution, a white noise machine, that kind of thing. I had that at home, too. I put that in front of the door. Nothing in the room can be heard in its presence." (P5)

Even though the family members collaborated with them, they could not stop the flow of everyday life at home. Thus, they felt tense when they heard a noise.

"*I enjoined my family to ensure confidentiality. I mean, I told them "Please, don't listen to me!". However, there were three people outside all in all and there was life in the home. When I heard a noise, I remember that I was tense, but the people I live with respected me generally." (P6)*

One participant (P6) stated that the children had questions about where the therapist connected the session from when they heard the voices from the therapist's home, too. In that sense, concerns about being heard from the other party were mutual.

"When the client asked me "Where are you? What are you doing?", I was in front of the same display -I mean, bookshelf, window, and curtains- I told the client "I am in my working area right now. There is no one in that room. Only I hear you and I see." (P6).

Besides the client's question about confidentiality, seeing therapists' homes

increased clients' curiosity about the therapist's private life. Clients started to ask more questions about therapists.

"They saw my room before anything else. One of my clients asked me "Is that your room?" I created a workspace for myself. The questions were like "What do you have in your room? Show me your bed! Show me your wardrobe!" (P2)

From therapists' point of view, clients' transference accelerated. They wanted to see the therapist's room rather than viewing the same background during sessions. Therapists had difficulty keeping their neutral stance against clients' insistent questions. Therapists thought about the client's curiosity and interpreted it.

"Their curiosity and things related to transference emerged like "Where are you right now? Who's there?". There is a bookshelf behind. One of them asked me, "Did you read all the books?" Slight but meaningful things came from clients." (P6)

"Clients' questions were like "If that is your home, who were the other ones living with you there? How are your home's walls? How is your apartment? Is there any pool in your apartment?" All these questions were too active." (P3)

Two participants (P5, P6) realized that seeing the therapist's home had a positive impact on the client's therapy process. They also worked on the clients' positive emotions toward seeing their private sphere.

"Even they liked it because they saw my home and I also saw their homes. They told me proudly "Look, here is this, here is this!" and they showed me their homes, rooms, and toys. I can even say that it was accelerating in terms of the progress of the therapy process." (P5)

"Being at home and being in the room was good for some clients, but I worked on these, too. I said "It's like I've come to your house, now. How does that make you feel?" We worked on that step by step." (P6)

Clients' questions showed that even though therapists tried to have a neutral background and to stay neutral as much as possible, their effort in keeping neutrality was limited in online therapy at some point.

"No matter how we try to look neutral, the therapist seen in the therapy room connected the session from his room and home. Even if there is nothing in the background, the arrangement of the books behind and their names give an idea of where the therapist is, how far he is, what he does, and what kind of room he has. I think, even something as much as what is seen behind me gives an idea." (P4)

"Since therapy is based on a psychodynamic approach, we have a clear framework like the length of the session and being with our therapist identity in the room. I had to give my personal phone number to the clients." (P6)

All participants also had an idea about the child's home and the parents' status at home with children. While parents were describing the home setting in face-to-face therapy, the therapist had a chance to observe that setting in online therapy. In that sense, that was a significant data source for them.

"I also had been in their private space, children's rooms, beds, and study rooms. Sometimes families were passing behind, with tea in their hands, in pajamas. I saw the mother's or father's status at home." (P2)

"You could observe the child's life at home transparently. The system is important for us while working with the child or adolescent. It doesn't matter a lot while working with an adult. You are working with the individual but on the other hand, you are working with the system. So, you can see much of what happens at home. Also, how is the child's space? What spaces are provided to the child? That provides you with more information." (P7)

One participant (P4) added that she did not know many details about the clients and their families. They were showing their representable appearance in face-to-face therapy. However, the therapist saw their most natural status when they witnessed their home environment.

"I think that is the most wounded part. I mean the state of being neutral changed much even transition to sessions at home. That was the same for us, too. The child or adolescent was talking about the home, but when we saw the client at the home, there were posters and the state of the home behind. They generally were wearing casual clothes. The position where we know and put them changed

much." (P4)

Three participants (P2, P6, P7) stated that they witnessed parents' debates during the session with the child. They had difficulty in those moments, and they felt shocked, helpless, and angry.

"I couldn't hold my emotions at first. For instance, the parents' debates with loud sounds despite my presence made me think about what they can do in my absence even if they did this in my presence because it is heard, of course. I felt furious. I felt the limitlessness of the family." (P2)

One participant (P7) tried to understand the situation and intervene during the session as best as she could. Since the participant just heard the debate, she could not understand whether it was physical or verbal violence. It was compelling for them to understand the child's emotions, decide on whether intervening in the situation is necessary or not, and stay calm.

"While we were in the termination session with the client, voices were coming from inside, it was like yelling. The client seemed fearful. As I knew the violence at home, I was like "Is something happening at home? How would I interfere? I found a solution in a tough moment to hold the child in the room and think about whether the mother was safe or not. I asked the child to call her mom and I said, "I need to talk with your mom." because I had to control it. I invited the mother to the session, but it was not physical violence but verbal violence. They had a verbal fight, but I was very anxious about what I would do if something physical happened." (P7)

The other participant (P6) preferred talking about it in the meeting with parents. The common side of both experiences is that participants were worried and tried to calm themselves down.

"While we were talking in the session, we heard the debate between the father and the mother. I realized that I had difficulty. I had a dilemma about whether I told the child that I heard it or not or whether I should continue the session. I don't remember what I did…Staying calm and soothing myself helped me. I told myself that you cannot control that, that is your data for the home environment, and I talked about that with the parents." (P6)

Confidentiality was not the only component of the therapeutic framework affected by the transition to online therapy. All participants stated that payment and attending the session on time were negatively affected, too. However, forgetting sessions were linked to various reasons. One of them is that sudden changes in daily life and staying at home disrupted routines and people lost track of time. Also, the pandemic led to brain-fag in both therapists and clients.

"People were confused, too. Since I was confused, the sessions were forgotten. I confess I forgot one or two sessions. That was too confusing." (P5)

Thus, clients started to forget sessions. Even though forgetting sessions seemed like it was related to external factors, therapists tried to understand clients' needs behind forgetting sessions.

"One adolescent forgot the session and manipulated it. We talked about all of that, and we talked about that with families. We found a solution last; I was sending him a standard message to remind him of the session 24 hours ago. That was meaningful in his therapy process, receiving my care for him. It did work."(P6)

Four participants (P1, P2, P4, P7) stated that they were working with clients under the scope of a clinical psychology graduate program. They did not take the price of sessions due to the pandemic since they were working with clients with low socioeconomic status. Clients started to forget sessions and parents' investment in therapy decreased obviously.

"It was decided that therapists would not receive payments from clients, but I observed that it wasn't good as the process progressed because they were going to therapy. Paying a charge even if it was symbolic was affecting the clients' investment. I cannot say the same for children because they didn't pay its price, but not paying a charge for online sessions affected parents' investment. They started to forget sessions." (P7)

Thus, they had to remind the clients of sessions. From the participants' point of view, the absence of payment affected the therapeutic framework negatively.

"Since they didn't pay the charge, they started to forget sessions and I was

reminding them of sessions." (P1)

When clients came to therapists' offices, they had a preparation process. They were wearing clothes except for the clothes they wore at home. They might think about the session before attending it. They were preparing themselves both physically and mentally. Four participants (P2, P4, P7, P8) stated that with attending sessions from home, the preparation process disappeared.

"The clients were doing something else, and they attended the session suddenly. They were not aware of attending the session. There was no preparation for the session either mentally or emotionally because they were maybe washing the dishes. It was like a sudden transition from the kitchen to the session." (P7)

In that sense, it affected the client's investment in the therapy process. They lost the transitional space between the home and the office in which the sessions took place. That transitional space provided them to think about the sessions before and after it.

"Online therapy can affect a client's investment in therapy. The client focused on therapy while coming to the office. I mean, he was taking a ferry, getting on the bus or car and he was thinking for three minutes, five minutes, or an hour that I would go to therapy and do something special for myself. Most of my clients tell me "I have a coffee when I get out of the office. That doesn't happen in online therapy." (P8)

Thus, their investment in therapy decreased and they started to forget sessions. Also, one of the participants (P2) had difficulty preparing for the session at home.

"They were more accessible. It was easy to arrange a session in the home setting, but the sessions were forgotten quickly because it is not something we met after we went out of the home." (P4)

When all participants thought about the therapeutic framework, they realized that the framework has become flexible due to both pandemic and online therapy. They tolerated the clients' forgetting sessions depending on the clients'

collaboration and intent since that was a tough time for everyone.

"When the time for starting the session came, they needed to be on the screen. I was starting the session and waiting but there was no one. Then I called them after 5-10 minutes passed. I remember that I had to be flexible at the beginning of the process. Cancellations, the charge, time, and forgetting sessions were more complicated." (P4)

They had to arrange the length of the session according to the client's needs. For instance, a 45-minute-long session has become very long for younger children since they had difficulty sitting in front of the screen. Thus, a 30-minute-long session was ideal for younger children.

"Even though there were young clients, if the child could stand in the room, we could have sessions for about 45 minutes in face-to-face therapy. I remember that I shortened the time for some clients such as conducting sessions for 30 minutes, including the parent in the session, or using the remaining time with parents. It was about changing the framework related to the time according to the client's need." (P7)

One participant (P5) realized that having a flexible therapeutic framework was good for both the clients and the therapist. Also, instead of working with the child for 45 minutes, therapists worked with some children for less than 45 minutes if the child had difficulty attending the session. They included one of the parents for the remaining time.

"It made me and my therapeutic framework so flexible. Also, even though I started to continue face-to-face sessions, I work with a flexible framework…I realized later that the clients benefited from it. I also realized that I feel comfortable with such a flexible framework." (P5)

3.3.3. Therapeutic Relationship: Will It Stay the Same?

Attending the session at home affected therapeutic relationships with clients as well as it affected the therapeutic framework. Since the therapist and client were not in the same room, keeping the therapeutic relationship, especially with children

became difficult.

"Talking with the child and following him at the same time was another trouble, the angle of the camera was another trouble, and establishing a relationship or keeping it was another trouble." (P8)

Children were wandering in the room and sometimes they were leaving the room suddenly. Continuing the session without any interruption and thus keeping the relationship the same became difficult while it was relatively easy for therapists in face-to-face therapy. In that sense, that theme was related to other themes like loss of space and recreating the therapeutic framework. These three themes are interconnected.

"Conditions of the home were making it difficult. One was coming in and another one was going constantly. The child was losing his attention." (P1)

The psychological maturity of clients was also effective in keeping the relationship. Children were not able to attend the sessions, arrange the place for therapy, and keep the framework in mind. Those with a high level of psychological maturity could keep the therapy process and therapeutic relationship without much change which originated from the pandemic.

"How it reflected on the apparent side of the session was that starting the session on time can become an issue. Since the client was disorganized, he can ask for the link again. Those who have impulsive behavior can play with the screen, and their image can disappear suddenly, they are attending the session and leaving again." (P8)

Since children tended to get bored during the session and continuing the session was difficult, that affected the therapists' feelings during the session.

"But the children were like "I got bored, I got bored, I was too bored." Hearing all this, standing there, and trying to interpret it…actually, I was feeling bored at that moment." (P3)

Clients with introverted personalities had difficulty in keeping the relationship in online therapy as opposed to their relationship with the therapist in face-to-face therapy.

"For some clients, I had a good relationship in the room, I could contain

and hold the client, but I may say for withdrawn children that they froze up because of distance. I felt that there was a screen between us. No matter how much we tried to pretend like we were together, it wasn't. I felt that the client didn't benefit, either." (P7)

Also, some clients behaved like the therapist was not there and the therapist felt left off. Thus, the therapy process was terminated when the client did not include the therapist in the session. Reciprocity, a significant component of the therapeutic relationship, disappeared.

"A child was only sharing the screen and playing like I wasn't there in all sessions. I was just watching the screen. I terminated the process after a while. I couldn't do it with that child. Thus, mostly I share the screen. It was a very difficult part for me to work with children who play the game by themselves and want me to watch it." (P1)

Disorganized families who had difficulty attending face-to-face sessions regularly dropped following the transition to online therapy. Establishing a therapeutic relationship became harder.

"They had difficulty attending face-to-face therapy before. They were attending one week, and they were not attending the other week. In online therapy, both therapeutic framework and therapeutic relationship were annihilated." (P2)

3.3.4. Technical Difficulties

Technical difficulties affected the flow of the session. Even though children and adolescents were familiar with technology, online platforms like Zoom or Skype were new and unknown to them.

"Using technical equipment was difficult for children. Everybody I worked with knew how to use a computer, but they didn't know how to use it in that way." (P5)

Also, clients' technological possibilities were determinative for the therapy process in online therapy. Some clients didn't have a computer or internet access in their homes. Thus, therapists had to continue their sessions by calling

them.

"I was working with children aged 7-13 but working with children between 7-8 years old was a very, very compelling experience for me because we were conducting sessions with them via Zoom. Sometimes there was no access to Zoom because the online therapy experience was limited by the clients' technological opportunities. They couldn't install Zoom, or their mobile phones or computers were not suitable for that technology." (P3)

The sessions were interrupted due to connection problems and phone calls in the middle of the session. Some children were using their parents' phones during the session.

"The child was connecting the session with a mobile phone. A telephone message was coming, or the phone was calling, but the child couldn't ignore it. He took the call inattentively and said, "one minute". That kind of difficulty happened." (P8)

Since when someone called the parent, the session was interrupted. Thus, they were connecting the session, again. Therapists found that difficult in terms of not continuing the session without any interruption.

"When the client attended the session with his father's phone, the session was interrupted unavoidably, and attending the session again was compelling. That part put question marks in my mind. The framework is 45 minutes, on the same day and at the same time, but when you were starting the session, it was interrupted by phone calls." (P3)

Also, the client's or therapist's image or sound was freezing sometimes due to connection problems. Therapists were asking clients to repeat what they said.

"There were problems with the internet above all. There were connection problems because the internet was disconnected. You were calling the child's family, but when they reconnected how you would continue the session. That was compelling." (P2)

When the internet was disconnected, the client's expression of an important thing was disrupted, too. The clients could not be seen and heard fully and that might lead to frustration of clients.

"My internet connection became a problem, so it froze sometimes. The client's internet connection became a problem. For instance, the client was saying a very important thing and I couldn't understand him. It was compelling to say "Could you repeat, please? I couldn't understand that. Could you say it again?" initially." (P3)

Besides, they were missing the client's gestures and facial expressions when the image was frozen. Connection problems were a barrier between the therapist and the client in addition to the limit of the screen.

"Compelling sides, it decreased a little glimpse and smile because it was freezing. I was like "I didn't hear, please say it again." I mean, there was something between us at that moment." (P4)

3.3.5. Screen: A Third Party

The therapist and the client were meeting in the room without any medium in face-to-face therapy. In online therapy, the screen, online platforms, computers, mobile phones, or even parents when working with children were mediums that brought the therapist and client together.

"Once a third party intervened such as Zoom or a computer." (P2)

While the therapist and client were having sessions one-on-one in face-to-face therapy, the screen intervened as a third party, which is a matter for a participant in terms of countertransference. One participant (P2) stated that a third party in the session annoyed her, and she had difficulty adapting to the presence of the screen.

"I questioned myself in terms of countertransference. I mean, to what extent I could make room for a third party in dyadic relationships. That was something about me because I felt that I had such a bond with some children and the intervening role of Zoom, or another object annoyed me." (P2)

One participant (P1) felt anxious in the presence of the screen while she was comfortable in face-to-face therapy. That might affect the therapeutic

relationship between the client and the therapist.

"When I sat on the armchair in the presence of a person, I felt more confident. I am feeling anxious in front of the screen. I am still anxious, but I don't feel anxious in face-to-face therapy." (P1)

The screen limited the complete appearance of the client. In that sense, it has decreased effective communication since therapists missed information about the client's body. Fathers generally did not want to be involved in the therapy process. With the transition to online therapy, involving them in the process became difficult. In that sense, online sessions with parents led to the missing of their gestures and body language.

"In online therapy, two screens are generally like the mother was like that and the father was like that (shows how they appear on the screen). Half of the father's head appears, and the father is like "I wish it would end so I could go.", he looks at his phone. I don't understand them and what they're doing much. It is compelling to communicate with them in this respect. Thus, it prevents me from working with them comprehensively." (P5)

Besides, the clients could not see the whole body of the therapist. One participant (P2) added that a child with a psychotic core imagined the therapist's body in parts. Thus, the therapist had to stand up to show her whole body. In this context, this theme was related to expressions such as reading the body language, playing together, and the extra effort for containing the client under the theme "loss of the space: deprivation of containment".

"As my supervisor said that since he saw just the upper part of my body, he started to imagine my body in pieces. Thus, I had to stand up and I told him "Look, my arms are here! My legs are here." I had to show my whole body." (P2)

Working in the presence of a screen made participants feel tired since it requires more attention due to connection problems. They had a headache at the end of the session, in other words, Zoom fatigue.

"It was something about Zoom. I was feeling tired. I am more familiar with it now, but I was feeling tired during that period. I mean, I had a headache because of looking at the screen. I remember that." (P1)

They stated that they felt less tired in online therapy contrary to face-to-face therapy which provided a setting they were familiar with. Loss of the containing role of space and the therapist's extra emotional effort to keep the therapeutic framework impacted the therapist's feeling tired, too.

"Online therapy is tiring. I don't know why it is tiring. It was probably because of paying attention to a lot of things at the same time. It is difficult because it isn't automatic, it is a setting I'm not familiar with. It is necessary to pay attention to the connection. I went out of the room without feeling tired in face-to-face therapy. Also, I felt very energetic but at the end of the online sessions, I felt tired." (P5)

3.4. FACILITIES OF WORKING WITH CHILDREN AND ADOLESCENTS

According to the participants, online therapy provided advantages besides its difficulties. Participants were able to continue the therapy process with their clients due to the toughest times of the pandemic. They kept being a constant object while the clients were facing the pandemic, in other words, the uncanny (*das Unheimliche*) side of life. Online platforms provided a basis for creating togetherness via screen sharing and whiteboard. Being there no matter what affected the therapeutic relationship with most of the clients positively. Therapy has become accessible for those who do not have any chance for physical access to therapy. Participants stated that online therapy led to saving of time and people's preference for online therapy has increased. Thus, online therapy has become a new alternative while there was no such alternative before the pandemic. Based on the experiences of the participants, five subthemes were formed "creating togetherness in online therapy", "keeping the relationship with clients", "saving of time", "accessibility", and "a new alternative".

3.4.1 Creating Togetherness in Online Therapy

Zoom was a new alternative for everyone while Skype was used by therapists for a long time. At the beginning of the pandemic, there were security issues with Zoom since someone else could attend the session without the host's permission. After a while, most people started to use Zoom for attending meetings, classes, supervision, and therapy sessions. Children mentioned classes and school often since Zoom had different meanings for them. Also, they found the sessions boring due to the increased length of time they spent on Zoom.

"Zoom affected children and they were talking about the things related to school in the sessions." (P1)

"They found online therapy boring because the sessions were like online classes because they had their classes on Zoom." (P3)

Online platforms, especially Zoom, enabled therapists and clients to create an "online therapy room" utilizing screen sharing, chat, and whiteboard. These options helped therapists to relax.

"I discovered the whiteboard on Zoom. That made me comfortable. I mean, it was a common space for us. We had a space like a playroom to work together." (P2)

Seven participants (P1, P2, P3, P4, P5, P6, P7) stated that whiteboard and screen sharing provided a "common space" for them. They used the whiteboard for drawing a picture together, playing hangman, and Squiggle game. Interestingly, only one participant who was more experienced than others did not use whiteboard. Young and less experienced therapists were willing to explore online equivalents of the materials in playroom such as sandbox or doll house.

"I think it creates a very nice common space. We can draw pictures or write something." (P1)

"I used the whiteboard for a Squiggle game. We made a lot of things depending on Squiggle Game." (P5)

Children were discovering the playroom on their own in face-to-face therapy, the therapists had to introduce various options of the online platforms.

"I used the whiteboard those days. I was not directive, but I told the client "Do you know that there is a whiteboard here, too. We have a space to write and draw something. If you want, we can draw together." I presented the whiteboard to the clients who may need it to create a sense of togetherness, and generally, we used it for drawing pictures, playing hangman, and playing together." (P3)

Six participants (P1, P2, P4, P5, P6, P7) used screen sharing for computer games. Adolescents were talking about online computer games in face-to-face therapy and with online therapy, they found an opportunity for showing the games they were playing at home.

"Clients were telling me "Let's play Minecraft! There is a world like that." to explain the computer games they played during the sessions in face-to-face therapy. We had a chance to say "Let's open the virtual world you talked about in the session" in online therapy. I remember that we got inside virtual reality, and the children were talking a lot while playing the game." (P4)

Therapists made interpretations of these games and talked about them. They found it an effective way of online therapy provided.

"It was common among male clients. They were playing computer games a lot. They shared the online game and we interpreted it and talked about it together. It became an effective way of online therapy." (P5)

Also, the adolescents suggested screen sharing to show the games they played. Thus, the therapists did not need to be directive in the online sessions.

"They were playing online games and they wanted to show it in the session. They were showing the computer game via screen sharing and I witnessed the moment they played the game. They suggested screen sharing and showing the game they played." (P7)

Besides the options of Zoom like screen sharing and the whiteboard, therapists also played with the child reciprocally using paper, pencils, and toys. Therapists and children need to do something concrete at some point.

"I kept it in mind, and I took the papers and crayons. In the next session, if the client wanted to draw a picture again, I told him that "I told you last week that I would take my crayons and papers, too." I guess I wanted to do something

reciprocal." (P3)

Trying to play reciprocally from afar emerged the therapist's creative identity. The therapist used her finger as a toy in the online session.

"I didn't have a toy in my hand, but I drew a face and mouth on my finger and pretended like it was a toy. There were certain toys in my room, too. There were some toys in my place, too. I mean, there were clays, crayons, papers, pencils, and board games. I remember that we played UNO with a child for a long time." (P6)

Children's leading role in psychodynamic play therapy helped therapists to attune to their play.

"Children directed the play. I think that is the facility of psychodynamic therapy. They were leading and making everything into play." (P1)

3.4.2. Keeping The Relationship with Clients

All participants stated that they kept the therapeutic relationship with most of their clients even though some of them thought that it wouldn't be possible to establish a therapeutic relationship in online therapy. Also, they evaluated the role of the client's openness in establishing a relationship with the therapist. The clients' adaptation to online therapy facilitated keeping the therapeutic relationship.

"If the alliance is established and a bond is created between the therapist and the client, it will occur in any case. I mean, if the client you worked with in face-to-face therapy is not open to establishing a relationship and has difficulty, even if you worked with him three times a week, the bond will not be formed. But if the bond is established, even though the client attends the session from even the USA, Sweden, or the other end of the world, you can form the bond in any case." (P2).

Establishing the therapeutic relationship in face-to-face therapy helped therapists to keep it in online therapy. They did not have to terminate the therapy process and separate from their clients. They had a chance to keep the therapeutic

relationship thanks to the presence of online therapy.

"The positive side of it was not ending the relationship and transforming it. If we must do online therapy, the most positive side of it is not ending the relationship. I mean, saying I'm here, you're here, and it is still space." (P6)

Also, forming a therapeutic alliance in online therapy helped the clients to adapt to online therapy and that made the therapists feel relaxed.

"I was nervous in the beginning. The children's adaptation and establishment of the relationship in face-to-face therapy -I worked with all clients in face-to-face therapy for at least two months- made me relax. With the strength of the established relationship, I started to relax." (P7)

Continuing the therapy process and supporting both parents and children had a positive impact on the therapeutic relationship. The clients experienced the therapist as a constant object, especially in the most difficult times of the pandemic.

"I am continuing with the clients I worked with in online therapy in those periods. Not dropping, being there, and continuing despite these conditions held us and the alliance between us." (P2)

Clients' trust in the therapist and therapy process increased. While the child was in the center of the therapy in a face-to-face setting, therapists were a source for both children, adolescents, and parents.

"Not disappearing provided child trust. I mean, the pandemic happened, everything happened, but I was there as a therapist. Great trust was established there. Thus, I continued with a great progression with the clients I worked with in face-to-face therapy." (P1)

Although being a resource was tiring for the clients, they did their best to remain a constant object in children's lives. Experiencing a global pandemic may lead to a sense of togetherness between the therapist and the client, too.

"Even though I couldn't be there, those people would continue their lives. I mean, if you start doing something, not disappearing is important. I mean, I was like "There is a pandemic by any means, I know it's a very difficult process, but look, I'm here! You're continuing with this process, too." I think both therapist's and client's belief in "This process will be overcome." was very important. In my

opinion, our clients helped us very much in this process." (P3)

The therapists felt desperate sometimes but continuing online therapy with children helped them to find something meaningful in the middle of the chaos of the whole world.

"I was like "Okay, it has been two months, but it's like nothing will change. People say it takes years. At least, something stable remains in the children's lives. Everything is going away from their lives right now. I will be there; I will be there in front of the screen. If necessary, we play together in a relationship even though it's not therapeutic. We spend time together and they see I didn't disappear. It was a need to maintain the object." (P4)

Physical distance and attending the session from home accelerated the process for some clients surprisingly. Children who had difficulty separating from their mothers were comfortable in the home.

"It was accelerating for some clients and some adolescents. It was probably due to the absence of direct contact. They started to be more comfortable, and they started to express themselves easily. They felt less uneasy in the sessions. Some clients -no matter our relationship is positive- were feeling uneasy during the sessions and that uneasiness was not something I could explain- It was about being in the same room and saying something to someone they were in the same room with. Thus, the distance made them comfortable." (P5)

Five participants (P4, P5, P6, P7, P8) stated that physical distance was good for some adolescents who had an introverted personality, social anxiety, issues about physical appearance, and difficulty establishing rapport. They started to express themselves easily, felt less uneasy, and their free associations increased.

"Online therapy was good for some adolescents. I mean, the ones with an introverted personality, had issues with physical appearance, and social anxiety. They also were successful in the classes and focused on therapy. I can say that was an advantage." (P8)

Clients with a history of abuse preferred turning off the camera to decrease eye contact. One participant (P1) added that children who had difficulty trusting

their parents wanted to come to the office. Physical distance made them feel safe, especially in the presence of a home environment which they were familiar with.

"The distance was good for some adolescents. I mean, it happens a lot in cases with a history of abuse. They turned the camera off and explained something. They chose distance since it decreased eye contact. I observed that communication increased." (P4)

Two participants (P1, P4) added that children with introverted personalities or separation issues benefitted from being at home and online therapy. Their relationship with the therapist strengthened and the therapy process gained speed.

"We worked with the mother. I mean, we worked with the mother-child dyad. I was always there. I guess that continued for a long time. Being at home and working with the child at home developed trust in the child barely." (P1)

"Sometimes if the client is shy, online therapy provides a secure base for therapy." (P4)

3.4.3. Saving of Time

All participants stated that online therapy ended the need for preparing the sessions for hours. Both clients and therapists did not have to spend hours in traffic jams. Clients who come from afar liked attending the session quickly. Following the adaptation to online therapy, parents' want for online therapy has increased.

"The positive side of it is that it could be difficult for families to attend face-to-face therapy. Families with two or three children had difficulty coming to the office. For instance, I had a client coming from Göktürk. They had difficulty. Online therapy was very good for them. They also said "Do we always attend online therapy? We are connecting fast." It was good for both my and my family's convenience in terms of time and transportation." (P2)

In that sense, online sessions led to saving time and not getting tired during transportation to the session.

"It was very easy in terms of time. I mean, the child starts the session as soon as he comes home, and he doesn't cover a distance." (P5)

Some therapists are using a hybrid style, both utilizing face-to-face and online therapy. For instance, if they or their clients have Covid-19, they attend the sessions at home even though they started to work face-to-face with the transition to a "new normal".

"Using the time well and reaching the client are the advantages of online therapy. Thus, they provide practical advantages. For instance, when it was difficult to attend face-to-face sessions for some clients, having an alternative like online therapy was good. I mean, attending the session and finding the time was very difficult. I was like "Okay, we can do it online this week. Changing to hybrid was an advantage for accessibility." (P8)

Four participants (P2, P4, P5, P7) stated that setting sessions, making an appointment, and arranging their programs were facilities of online therapy. Being at home enabled them to do other tasks and conduct online sessions together.

"Arranging both online therapy sessions and your daily program becomes very easy. I mean, you don't spend one or two hours in traffic. It can be fast in the home." (P7)

"They (clients)become very accessible and arranging and organizing something in the home is easier." (P4)

"The greatest advantage of online therapy is that you can set sessions in sequence. I mean, you leave one session and have a 10–15-minute rest and you can connect to the other session easily." (P2)

3.4.4. Accessibility

Six participants (P1, P2, P4, P5, P6, P8) stated that online therapy allowed reaching clients around the world. Those who live in rural areas didn't have access to therapy mostly. Also, those living abroad didn't have physical access to therapists who could speak their native language.

"It is a very positive thing for the ones who live abroad or in remote

places. It is completely positive; I cannot mention anything about its negativeness. They have an online therapy option rather than not going to therapy." (P1)

Also, those living abroad didn't have physical access to therapists who could speak their native language. All the obstacles were removed, and therapy became accessible. Also, one participant (P5) added that talking about an increase in the fee was easier with clients living abroad.

"We see a very important thing depending on people's announcements. They are living in different countries, but they need a therapist speaking Turkish. They don't have an opportunity like that in the place they live in. I think online sessions with a therapist speaking Turkish is a very important opportunity." (P3)

Two participants (P3, P5) considered having access to clients around the world as a different experience. They found the possibility of online therapy with those living in different cities and countries exciting at the beginning of the pandemic.

"I like it. It is pleasing to work with people from different countries and different cities." (P5)

"I found the idea of working with people around the world exciting in the beginning. I was thinking that "I'm in İstanbul but I can work with others in different cities and countries. Such a great field and a good opportunity that is." (3)

Five participants (P1, P2, P3, P4, P5) stated that online therapy will become widespread in terms of saving time and accessibility.

"I wish wholeheartedly that online therapy would become widespread and especially those who live in small cities and villages benefit from that." (P1)

Online therapy was associated with the pandemic in the beginning and people must do it. However, people discovered and realized that there was an easy and comfortable option like online therapy. People prefer online therapy currently independent of the pandemic.

"I think it will increase and become widespread because it has already been discovered that there is an opportunity like online therapy. I'm not sure

whether online therapy will continue with children, but I'm sure that it will continue with adolescents and adults." (P3)

People also preferred online therapy depending on others' references and positive comments about the therapist.

"It doesn't seem like it started with Covid, and it ends with Covid because as I said the effect of Covid lessened up. Families realized that everything is accessible and when they heard someone who said that he has online therapy sessions and it is helping, it doesn't matter whether it's online or not." (P4)

One participant (P5) added that online therapy platforms were created with the emergence of the pandemic and these platforms bring therapists and clients together. Thus, therapists do not pay a commission to an office and clients can have access to therapy at an affordable fee. In that sense, online platforms provided therapists a system to have access to clients and business opportunities.

"There are a lot of online therapy platforms. There were these kinds of platforms before, but they have become popular such as HelpMe in America and Hiwell in Turkey. The benefits of these platforms are having access to clients for therapists newly graduated. Most of the people around me get help from these platforms and they are very pleased...Paying affordable prices for online therapy is a good alternative for those who cannot afford 600-700 liras in face-to-face therapy. I think that makes our job more accessible." (P5)

3.4.2. A New Alternative

Four participants (P1, P4, P5, P8) stated that online therapy is a new alternative following the normalization of the therapy on online platforms.

"I think online therapy is valuable in terms of creating an alternative." (P8)

Online therapy increased the possibility of some clients' benefitting from it. Those with social phobia and children who have difficulty separating from their mothers had access to therapy. There are different fields of specialization in therapy service. Those who cannot find an expert in a special field may benefit

from online therapy, too.

"Thus, online therapy has practical advantages. For instance, online therapy is an alternative for clients who have difficulty attending face-to-face sessions."(P8)

Some therapists were comfortable with online therapy, and they included online therapy as a new alternative to their way of work. They offered online therapy options after evaluating the client's pathology and psychological maturity.
"It is good for me to keep online therapy as an option." (P4)

"Online therapy will be kept as an option for children and adolescents as well as adults." (P7)

Also, online therapy provides a stable basis that is not affected by changes, holidays, and illnesses.

"Cancellations decrease in online therapy. I mean, it becomes stable. It isn't affected by snow holidays and other things. It's not just about Covid. That part is good. It has a stable order." (P4)

3.5. CONTRIBUTIONS OF ONLINE THERAPY WITH CHILDREN AND ADOLESCENTS

Participants thought about the pandemic and their online therapy experiences. They stated that that was compelling for them at first. However, they realized that online therapy contributed to their professional development. They stated that even though they didn't feel close to online therapy, and they had doubts about their competence for it, following two years of online therapy experience their professional assurance has increased. Adaptation to online therapy enhanced their capacity to be flexible both personally and professionally. Based on their accounts, two sub-themes emerged as "increase in professional assurance" and "flexibility".

3.5.1. Increase in Professional Assurance

All participants thought about their experiences with online therapy and the pandemic. While some of them were comfortable during the interview, some experienced remembering those times as compelling. Interestingly, those who were comfortable during the interview were also comfortable with online therapy and those who had difficulty had doubts about online therapy.

"I confess that it didn't make me feel good at first. I was like "One minute, I got through these. Will I remember these?" but it was good to remember that there were good things, there were things I established." (P6)

All participants stated that they had a chance to think about their experiences of online therapy retrospectively. They thought about the change in their experiences of online therapy following the first two years of the pandemic.

"I felt like I've gone over one or two years and now I remember what I've experienced retrospectively." (P8)

In that sense, the interview was like a "time machine" for the participants. One participant (P5) added that he didn't realize that he was practicing online therapy automatically till he participated in the interview.

"I felt like I was in a time machine. I remember the times I had difficulty. I recalled how online therapy transformed my experience over time. I was inexperienced in the beginning. Now two or three years have passed since the first time I started to conduct face-to-face therapy with my clients. When I look back, we experienced this process with the pandemic and even in a new context." (P2)

Three participants (P2, P6, P7) realized that they could conduct sessions in online therapy despite their doubts about it. They were proud of themselves since they tried to do their best and they were a resource for others during the pandemic.

"When I think about it, I feel proud. I mean, despite the tough conditions, continuing the therapy process makes me feel strong. It makes me feel good." (P2)

They stated that they can practice their jobs no matter what the conditions are. As time passes, their experiences of online therapy have deepened. An increase in professional assurance may affect their relationship with the clients

and the therapy process, too.

"Its biggest contribution is "You can practice that job.". I mean, you can do that in every circumstance. You don't need a room, a space. You don't need a room for the session, and you can work in times of crisis. I mean, it gave me professional reassurance about doing that job… and of course, it was an area for new experiences. I was unconfident while accepting a client for online therapy, even a year ago. Now I told myself "It's okay." because I know that experience. I mean, that experience deepens." (P6)

"Some questions were difficult. I mean, we literally practiced that job." (P7)

3.5.2. Flexibility

Five participants (P2, P3, P4, P6, P7) stated that their capacity to adapt and be flexible has increased. The pandemic and transition to online therapy forced them to be flexible and adaptive.

"That happened in the progress of time. That's exactly what happened. My capacity to change has increased in time." (P3)

Also, their therapist identity has become creative. They realized that their capacity to be flexible was more than they thought. They have been open to giving online therapy a try. In that sense, they overcame the prejudice that online therapy cannot be practiced.

"I felt that my capacity to adapt had increased. I realized that I have had a more creative therapist identity and everything in the home became material. For instance, we used a jar and filled it with water, and made a storm in the jar while working with a child." (P2)

They (P3, P4, P7) realized that therapeutic space is open to change and flexibility. It was surprising for them since psychodynamic play therapy has a strict framework in face-to-face therapy. They realized that flexibility has also been better for them and their clients, also rather than holding on to a strict framework of psychodynamic therapy.

"How did it contribute to me? For me, it helped me learn to be flexible."

(P3)

"I've never been a therapist who had such a strict framework or boundaries. Being able to be flexible and doing something in online therapy made me feel good." (P4)

They experienced that "Everything is possible." in the therapy process. Therapy could exceed a shared space and there was no need for a physical space. They added that flexibility made them feel good about their professions.

"Dividing the session into two parts and conducting the session with the child while the mother was in the room made me flexible, too…I experienced that everything was possible, and the therapy was space out of that room, dollhouse, animals, and board games. In that sense, the experience was tough, but at the same time, it was a process that was good for me professionally." (P6)

Even though they were biased toward online therapy, especially with children, the therapist's capacity to be flexible and adapt to changes easily impacted their job satisfaction and perceived professional assurance.

"Its greatest contribution is that I thought that it could not be done, it was impossible. I believed online therapy could not be practiced with children, it was impossible. I shouldn't have said anything like this was impossible. I guess it is about being flexible and adapting to what the period brought over. The greatest contribution was that. I mean, it is about trusting in the client's experience in any way." (P7)

3.6. SUGGESTIONS FOR THERAPISTS

All participants made suggestions for effective online therapy to facilitate their colleagues' practice while working with children and adolescents online. First, they evaluated their preference for online or face-to-face therapy and the effectiveness of each modality depending on their own experiences. They considered the client's pathology and their perceived comfort in each modality.

They found the evaluation of the client's personality organization, age, and reason for referral necessary before accepting them for online sessions. As they stated the difficulty of keeping the therapeutic framework, they emphasized the importance of having a clear stance about online therapy. They considered flexibility and openness to change as significant for the basis of online therapy. They realized that their professional needs have changed, and supervision has become more important than ever. Considering professional needs would be better for being ethical and keeping the therapy process as effective as possible. Based on their reflections, three subthemes were formed as "face-to-face vs. online therapy", "preparation and evaluation", "establishing therapeutic framework", "being flexible", and "change in professional needs".

3.6.1. Face-to-face vs. Online Therapy

All participants stated that they would prefer face-to-face therapy due to being in the same room, keeping the therapeutic framework, confidentiality, and an effective therapy process, especially with children. They considered face-to-face therapy dynamic and efficient.

"Meeting face-to-face is more dynamic and I prefer it much." (P6)

They had to conduct their sessions online, but with the "new normal" that was not obligatory. Six participants (P1, P2, P3, P6, P7, P8) stated that they do not prefer online therapy, especially apart from the situations like the demand of clients who live abroad or in rural areas but they found it less efficient.

"I don't think of working online in terms of a therapy process, but I had to conduct the sessions online with my clients. That is a quite different issue. Maybe, online platforms can be used for parent counseling, but I don't think about it for therapy." (P3)

They stated that they do not prefer working with especially young children online and they feel close to working with adolescents.

"I have clients I've started to work with during the pandemic. I plan to terminate the sessions with them, and I don't think of working with children online.

It may be possible only if there is no professional where they live. When someone calls me for online therapy, I want them to search for a professional in the place they live. There are professionals everywhere on the other hand. Thus, I say yes to working with adolescents online because they talk and if they do not have the opportunity, but I say no to working with children online except in rare cases." (P7)

Three participants (P4, P7, P8) stated that online therapy was less efficient than face-to-face therapy.

"I think it was very different at the beginning of the pandemic and right now. If I must evaluate it completely, it was not very very efficient initially." (P4)

"Online therapy can be possible if it is obliged, but I think it is less efficient." (P7)

Also, one participant (P8) added that online therapy decreased clients' investment in therapy.

"I think it is less efficient compared to face-to-face therapy. I mean I cannot assess it in terms of observing its effectiveness and attendance in online therapy. I think it is less effective in terms of their investment." (P8)

They emphasized the importance of considering the client's pathology and circumstances to evaluate his appropriateness for online therapy. One participant (P5) underlined that its effectiveness changes from child to child. The client's age, symbolization capacity, attention difficulties, ability to use language and express himself, personality organization, and collaboration are significant factors while working with a child.

"Online therapy is more difficult with the child who cannot play, I mean with the child whose capacity to play doesn't develop." (P7)

If the client has difficulty expressing himself easily, focusing on the session, and sitting for a while, that kind of client is not suitable for online therapy from the participants' perspective.

"I think online therapy is more tiring for a child who has difficulty using language and words. I mean, online therapy is not easy for a child who cannot

talk during the session and has difficulty using language. For instance, the child has attention difficulties. He focuses on everything other than the screen. It is more difficult for these children." (P6)

Thus, therapists' preference for online therapy changed depending on the factors related to the client such as being organized and following sessions.

"Those who cannot follow up on the sessions and have a distracted mind. They are forgetting constantly. I must chase them and remind them saying "You didn't attend the session." I don't prefer clients who cannot collaborate completely in online therapy." (P5)

Three participants (P1, P4, P5) consider online therapy effective. Interestingly, those who are comfortable with online therapy find online therapy as effective as face-to-face therapy. The perceived effectiveness of online therapy affected participants' preference for online therapy.

"I think it is effective. I mean as I said it was effective in the pandemic. It provided trust and supported them so much. When I think about online therapy with clients who live abroad or in other cities, I find it effective, too." (P1)

The purpose of online therapy is to find a quick and possible solution and keep the bond at the beginning of the pandemic. Following the two years of the pandemic, they found that there is no big difference between online therapy and face-to-face therapy.

"Online therapy was about to keep the bond, but right now I think that there is no big difference between face-to-face therapy and online therapy." (P4)

"I think it is not much different from face-to-face therapy. I consider it like face-to-face therapy as a therapist." (P5)

Two participants linked its effectiveness to certain requirements such as keeping a therapeutic framework and confidentiality, a space for online therapy, and parents' awareness about online therapy. They stated that in the absence of those requirements, online therapy would not be effective.

"It may be good if everybody becomes conscious of online therapy. I mean, if everybody has space for therapy and they are aware that therapy shouldn't be heard, the therapeutic space should be respected, and it may work

out. I don't know whether it works out without that awareness." (P3)

Also, building a rapport with the client was linked to ensuring confidentiality as well as its effectiveness.

"If confidentiality and regularity are provided in online therapy, the client feels safe in his room, and there is a rapport between the therapist and the client, online therapy is possible…I don't believe that there is any difference between the effectiveness of online therapy and face-to-face therapy." (P5)

Six participants (P1, P2, P4, P5, P6, P7) stated that they evaluate working especially with adolescents via online therapy but do not prefer it in particular.

"I say yes to online sessions with adolescents, but if they are in another city. I don't give them a chance if they are in the same city." (P7)

They feel close to online therapy if they or their clients move to another city or if a client from another city refers. Establishing a therapeutic alliance in face-to-face therapy and then conducting sessions online was preferable for the therapist.

"Let's suppose that the client moves to another city, or you move, and you must continue the sessions. I have been conducting this client for 3 years because the alliance was established between us. Thus, I continue online sessions under these circumstances or in case of a referral from a different city." (P2)

Only two participants (P4, P5) stated that they prefer both online therapy and face-to-face therapy and offer online therapy as an option. However, even though they offer it as an option, they consider the client's age, pathology, and family dynamics. Also, they prefer working with adolescents.

"I work with adolescents and parents online intensively. I work with children face-to-face. Thus, I can accept online applications fast, but I work with young children face-to-face. It is like a little online, a little face-to-face. I mean I prefer online therapy." (P4)

"I conduct sessions online not because of the pandemic. I'm doing it because it's an online session. Most of the sessions I do are online." (P5)

3.6.2. Preparation and Evaluation

Seven participants (P1, P2, P4, P5, P6, P7, P8) stated that preliminary consideration is important for online therapy. They suggested to their colleagues that they should keep in mind that every client is not appropriate for online therapy.

"I think deciding to do it after a comprehensive evaluation is important. I mean there is only one option; the client needs therapy and there is no professional where he lives. However, we should evaluate whether the child or adolescent is appropriate for online therapy." (P7)

Evaluating the client's appropriateness for online therapy following the referral and thinking about the child and family specifically are significant steps of online therapy.

"My most important suggestion is not to do it for the sake of doing it. When you decide to do it, it can be done in any way. Thinking about the child and family is important." (P6)

Taking into consideration that each client requires a different treatment approach and considering the client's needs is significant in online therapy, too.

"I think therapists should decide whether they would work with a client after an evaluation. I do evaluate, too. I observe the child's appropriateness for online therapy in two or three sessions till the feedback session. In the feedback session, I told parents "This child or adolescent seems like that, you can do that, he needs therapy, or he doesn't need therapy, but if he has difficulty in online therapy or he is very appropriate for it." (P4)

Three participants (P2, P3, P8) stated that the therapist's preparation for the session is as important as the evaluation. Unlike online therapy with adults, working with children and adolescents online requires materials, board games, and adapting therapeutic techniques to online therapy.

"I recommend that if you work with children and adolescents, you can have some of the materials you use at home." (P2)

"There are board games I use with children in therapy. I think their online version can be developed easily." (P8)

It was easy to read the client's body language and mirror it in face-to-face therapy. Even though it is not the exact equivalent of reciprocity in face-to-face therapy, the therapist's adaptation to the child's movement made them interested in the session.

"Adapting young children's movements was like mirroring. First, it attracted the children's attention, he tried to understand, and then he liked it. Maybe it could be the compensation for reciprocity and closeness that were lost." (P3)

Since the therapist and the client cannot share the same room, materials can facilitate the therapist's practice in online therapy. Online platforms such as Zoom provided a lot of opportunities for therapists, too.

"I highly recommend Zoom. Zoom and screen sharing is very helpful in this respect." (P2)

3.6.3. Establishing Therapeutic Framework

All participants stated that they had difficulty keeping a therapeutic framework. Thus, they highly recommend establishing a therapeutic framework and holding onto it regarding the conditions of online therapy since establishing the therapeutic alliance and framework were easy in face-to-face therapy.

"They should think about the framework twice because establishing an alliance in face-to-face therapy is easier. You can establish a therapeutic framework easily. Maybe an online consent form can be sent, and the therapist can look at the online consent form with families. They can hold on to the therapeutic framework." (P2)

Confidentiality, therapeutic relationship, transference, and countertransference should be considered. Two participants (P2, P3) suggested an online consent form for emphasizing the therapeutic framework. Therapists should also determine a date for therapy according to the routine of the home. Also, the

session can be divided into two depending on the child’s distractibility.

“Okay, we don’t have a strict framework, but this is a therapy, and it needs to have a consent form no matter what happens. The framework needs to be held on to initially…Therapy is therapy within a framework. Thus, I recommend that the framework should be valid, and the other party must know it.” (P3)

Also, the session can be divided into two depending on the child’s distractibility since 45-minutes-long therapy can be boring for younger children and negatively impact the effectiveness of the process.

“The child and the therapist can have a little break every twenty minutes because the child would sit there. I mean, he can be distracted and get bored even though we play therapeutically. He can have difficulty concentrating especially while talking. I cannot recommend that the length of the session should not be longer than 45 minutes or 1 hour because it decreases the efficiency of the session.” (P8)

Three participants (P2, P3, P7) recommended that therapists working online should have a space for therapy so that their voices shouldn’t be heard if they live with others.

“You can create a separate space for yourself with insulation.” (P2)

They stated that rather than creating a space in the room where the therapist's personal space takes place, having a separate room for therapy is important.

“It is good for me to have a separate room for working. That wasn’t like that initially. I was using the living room and I remember that the work I have made me more tired. Now the space for online sessions is separate. Having a separate space and a separate room made me feel good and I recommend that.” (P7)

Also, one participant (P3) added that keeping neutrality against the client’s insistent questions is significant since seeing the therapist’s home environment increased the client’s questions. Interpretation of the client’s questions and understanding the client’s needs are valuable.

"When we are at home, we tend to answer clients' questions about our private life because we were like "I attend the session from home and isn't that question logical?" but I think not responding to the questions can be important. Being at home made those questions active." (P3)

3.6.4. Flexibility

Four participants (P2, P6, P7, P8) emphasized the importance of being flexible and accepting that online therapy can be flexible, too. They all were biased about online therapy at the beginning of the pandemic.

"I don't want them not to be open to online therapy as I was in the beginning. It can be done, and it can be tried" (P2)

Since psychodynamic therapy has strict rules, they felt weird when they had to be flexible. As a result of two years of experience in online therapy, their bias was eliminated. They realized the dispensableness of being flexible and adapting conditions in online therapy. Participants did not have an idea of being flexible in the therapy process since they had education and training in psychodynamic play therapy. Playing a digital game with the client was weird for them and they had a bit guilty about it in the beginning. However, when they heard that their colleagues also were playing online games with their clients, they felt comfortable.

"That is so cliche, but it is about being open to novelties. I mean there are strict rules in our occupation. If I say to others "I played a digital game with a child." you can be excommunicated like "Oh, what did you do?" but it was good for the child. Being both innovative and flexible is important around these parts." (P6)

In this regard, the therapists realized that they were open to being flexible and they did not have to hold on to the belief that they had to be strict for efficient therapy. Also, flexibility emerged as a prerequisite for the progress of the therapy in online therapy.

"I recommend a flexible base to make progress in an online setting. I mean, my experience shows that. It doesn't seem possible for me to sit and talk with a child for 45 minutes." (P8)

One participant (P7) added that trusting in the client's experience and not trying to be controlling is significant to focus on the session.

"When you relinquish control, you can focus better, you can see and hear some things. That means trusting in the client. I think it is trusting the client's experience." (P7)

3.6.5. Change in Professional Needs

Three participants (P4, P5, P6) stated that online therapy takes place in their professional lives. Thus, they see online therapy as an area that should be researched and explained to others. They shared their experiences with their colleagues and that helped them during the pandemic.

"If there is a flow of information about online therapy, especially with children and adolescents, it can be very efficient because I think there are a lot of things to say about every topic like "The framework can be like that." but it's a personal experience. I have a guideline like "These games can be played, that can be done with the child who brings his own game." in my way." (P4)

Their want to listen to others' experiences has increased and they wanted to know how others kept the therapeutic framework and what they did during the sessions. In that sense, supervision has become more important.

"Having supervision of an open-minded supervisor -my supervisor was very open-minded, and she was working online- is important. However, if you have the supervision of someone who says, "Don't do online therapy.", the supervisor objects to online therapy." (P5)

Besides supervision, they recommended their colleagues benefitting from every source that can enhance their online therapy experiences. Having an internal chorus consisting of supervisors, colleagues, and one's own therapist became

significant in online therapy.

"That is too cliche, but I think they should have supervision. I don't think it's a process that can be progressed on its own. Being a therapist has a side like being alone in the room and being crowded outside." (P6)

CHAPTER FOUR
DISCUSSION

The present study aimed to investigate the online therapy experiences of child and adolescent therapists with a psychodynamic perspective during the COVID-19 pandemic in Turkey. The goal of the interviews was to examine how child and adolescent therapists have been experiencing the pandemic while they have continued online therapy, how their experience of online therapy has changed over time, and their ideas about the effectiveness of online therapy. Based on the reflections of the participants, six themes were identified, namely an outlook on online therapy with children and adolescents before Covid-19, transition to online therapy with children and adolescents, difficulties of online therapy with children and adolescents, facilities of online therapy with children and adolescents, contributions of online therapy with children and adolescents and suggestions for therapists. Under these six themes, there were also two to five subthemes. Under an outlook on online therapy with children and adolescents before Covid-19, two subthemes indicated that participants either feel close to online therapy or they were strictly against online therapy with children and adolescents. These subthemes are named as being open to online therapy and have a strict stance about online therapy. The second theme which highlighted child-adolescent therapists' experiences of transition to online therapy at the beginning of the pandemic as well as clients' adaptation to online therapy includes three subthemes, named as a huge hollowness and obscurity: a state of freezing and shock, transition to online therapy: what will online therapy be like? and clients' attitudes toward online therapy. As for the third theme related to difficulties of online therapy with children and adolescents, significant aspects of online therapy and therapists' difficulties in providing a base for effective online therapy were captured. The four subthemes are defined as recreating the therapeutic framework, difficulties in keeping the therapeutic relationship, technical difficulties, and screen: a third party in therapy. The fourth theme emphasized the facilities of online therapy with children and adolescents including five subthemes that indicated that participants

discovered advantages of online therapy brought over. These subthemes are named as creating togetherness in online therapy, keeping the relationship with clients, saving of time, accessibility, and a new alternative. The fifth theme related to the contributions of online therapy with children and adolescents, participants' reflections on the positive impacts of online therapy on them were investigated. The two subthemes are defined as an increase in professional assurance and flexibility. The last theme was about participants' suggestions for online therapy for their colleagues. They talked about their suggestions for effective online therapy with children and adolescents depending on their experiences. Five subthemes are named as face-to-face versus online therapy, preparation and evaluation, establishing therapeutic framework, being flexible, and change in professional needs.

In the next section, six themes are examined in the existing literature about online therapy with children and adolescents during the Covid-19 pandemic. Then, based on previous studies and the results of the present study, some clinical implications will be presented. Thirdly, some limitations and strengths of the present study will be discussed. Lastly, suggestions for further studies will be made.

4.1. Discussion of Themes

An outlook on online therapy with children and adolescents reported by participants was mostly based on their observations of others' therapy processes and graduate courses related to therapy. I also heard about online therapy with adults during my graduate education. Some of my colleagues working with adults were talking about their experiences of online therapy in the breaks between sessions. Even though all participants had a strict stance toward online therapy with children and adolescents, some participants were curious about discovering online therapy. I was worried about online therapy with children in transition to online therapy and I felt that I could not contain children when we were in different rooms. The most frequently mentioned side of their attitude toward

online therapy has been their firm position that online therapy could not be conducted with children. From the participants' views, the therapy should be conducted in the same room since the therapist and child play together. Thus, they felt close to online therapy with adolescents because they were mostly talking like an adult. Materials of therapy with children and adolescents differed from each other. While one's expression of himself and the capacity to use language were important in therapy with adolescents, play is an indispensable part of therapy with children. Thus, online therapy with children was quite different from online therapy with adolescents. Consistent with this, online therapy experiences with children and adolescents were represented in the literature. In a study that aims to assess the effectiveness of tele-mental health with children, therapists stated that tele-mental health with children is preferred less than tele-mental health with adults. One participant in that study stated that tele-mental health was experienced as a good process with adolescents while it was a struggle with children (Hoffnung, et al., 2021). Articles about online therapy with children and adolescents during Covid- 19 did not focus on therapists' opinions before the transition to online therapy with children and adolescents. The articles mainly focused on therapists' opinions about the effectiveness of online therapy following their experiences with online therapy during the pandemic (Frye, Gardner, & Mateus, 2021; Hoffnung, et. al, 2021).

Before the World Health Organization's announcement of the global pandemic, there was news about an unknown virus affecting people's health in different parts of the world. Some followed the news anxiously while others did not believe the possibility of the spread of the virus globally. While I and my colleagues discussed it between sessions, one of my adolescent clients asked my opinion about the source of the virus in the session. I was a graduate student and I had 5 clients at the beginning of the pandemic. The government announced a 3-weeks gap to decide on the necessary cautions. Thus, I told my clients that we could not conduct the sessions for three weeks. I did not know that it was our last face-to-face sessions with most of them. They also did not know that, too. I did not have a chance to work on separation with the clients due to its suddenness.

When the graduate program decided to conduct sessions online, I was shocked, and I hesitated that my clients did not want to join online sessions. In the transition to online therapy with children and adolescents, all participants stated that it was like a grief process including various emotions such as anger, sadness, confusion, and being shocked. The virus was a very new thing for the whole world and how long the pandemic would take was unknown. It was a huge hollowness and obscurity for the whole world. Participants experienced the pandemic intensely at the beginning of it. Some participants had fears about getting infected and infecting others. One participant (P5) followed the news before the announcement of the first Covid-19 case in Turkey and felt fear, others got anxious about the confusion of uncertainty after lockdowns. The sudden change of life was unexpected for all of them.

Their reaction to Covid-19 and all the sudden changes were like the reactions of a person who was in a grief process. Some participants denied the virus, while the most experienced participant (P8) blamed others, such as the government and their management of the process. Captari (2020) observed the same reactions of the clients. Therapists and clients experienced the collective trauma the virus brought. Unlike other traumatic events such as a sudden loss of a loved one, the collective trauma was real and affected the whole world at the same time. Walsh (2020) highlighted that therapists also experienced loss and suffering while accompanying the clients' grief in the clinical encounter. It also evoked both therapist's and client's past traumatic histories. I also realized that my fear of losing beloved ones evoked and my capacity to handle uncertainty was low.

Therapists tried to be a resource for clients, but also that was tiring for them since they were experiencing the pandemic and uncertainty. Conducting sessions during the pandemic can intensify the empathic stance of therapists, but it also can increase therapists' vulnerability to compassion fatigue, secondary traumatization, and burnout (Captari, 2020; Joshi & Sharma, 2020). I felt smothered and I perceived the parents' needs too demanding. Therapists lost their peer networks in the office and that increased their self-doubts and stress besides the negative change in work-life balance as Captari (2020) supported in the article.

During the first months of the pandemic, I was attending online classes, and online therapy sessions and worked as a research assistant. Interestingly, I was feeling more tired in online sessions compared to face-to-face sessions. Participants stated that both sessions and their other works merged in Zoom, and they felt overwhelmed. Meeting peers via technological opportunities could help clinicians overcome the feeling lonely in their clinical work. Participants paid attention to meeting colleagues via Zoom and that provided them to discover different ways, such as an online sandbox while working with children.

Self-care became more important for therapists more than ever, but as one participant (P8) stated he could not move freely in the city or meet friends. I was talking with my colleagues between sessions, and it was relaxing for me. With transition to online therapy, I lost the physical connection with them. Galea, Merchant, and Lurie (2020) pointed out that people interpreted physical distancing as social distancing and it was difficult for them to be physically distant from their friends. In this context, Zoom meetings with friends reminded me that I was not alone. Thus, therapists had to try to be alerted to manage their exposure to risk factors (Captari, 2020). Participants stated the importance of supervision for adapting to online therapy and not feeling lonely in their online therapy practice. Buechler (2020) also highlighted the importance of having an *internal chorus,* which consists of the voices of supervisors, colleagues, and one's therapist. While therapists could contain the clients in such tough times, the perceived presence of that internal chorus' containing role could help therapists deal with the struggles of clinical work. Having personal and group supervision within the scope of the graduate program became my internal chorus in the online sessions. Experiencing the same things with clients and being a resource for them passing through it might enact therapists' healing fantasy in which they did not abandon their clients, but they accompanied them in the middle of chaos and traumatic events instead (Captari, 2020). In consistent with Captari's (2020) finding, most of the participants stated that they did not want to terminate their sessions. Even it was not therapeutic, they wanted to keep the relationship with the clients. They did not want to disappear suddenly.

Therapists experienced the sudden transition to online therapy at the same time. They tried to keep the effectiveness of psychotherapy while understanding their clients' needs and making necessary adaptations for that (Callahan, 2020). Therapists were evaluating their technique depending on the client's needs in face-to-face therapy, but constant adaptation became indispensable in this new medium (Captari, 2020). I remember that I met one of my 5-years old client in online setting. While I was working with 5-years old children alone in playroom, I revised the way I work and included the mother in the process. First, it was weird to include them in online therapy and I felt comfortable over time. Participants also did not feel comfortable with this transition. Participants emphasized that online therapy with children was a new thing for everybody. Even experienced psychotherapists might feel confused in terms of professional competency while adapting to this new territory (Captari, 2020). In contrast to therapists' confusion in the present study, Békés and Aafjes- van Doorn (2020) found that therapists who experienced online therapy before had positive attitudes toward online therapy and they prepared their clients before the transition to online therapy. In that sense, one of our instructors in the graduate program shared her experiences with online therapy.

Therapists adapted their way of working via online platforms over time. Therapists felt less competent in online therapy as supported in the literature (Aajes-van Doorn, Békés, Prout, & Hoffman, 2020). Since psychodynamic therapy has a traditional way of working with children and a strict therapeutic framework, therapists found creative ways of working with children in online therapy flexibly. Even though participants adapted to online therapy, they had doubts about whether it was therapy or not. I also felt like I was just playing with children in the first time of transition to online therapy. While I was feeling incompetent in face-to-face therapy, my feeling of inadequacy increased in online therapy. Wampold (2015) opened a new window into what psychotherapy exactly is and mentioned that even though meeting with a client for 45 minutes in the office provided stability, the framework was an extension of the convention and history. Research in therapeutic relationships consistently shows the importance of

establishing a real relationship, including empathy and collaboration which are important factors of change. Holding onto a certain therapeutic approach or protocol has less effect on change compared to the therapeutic alliance. Towards the termination sessions with clients, I realized that my 5-years-old client's need is the inclusion of his mother in the process and being flexible brought along the change. Thus, being authentic in clinical work during tough times of the pandemic may be helpful rather than sticking to the conventional ways of conducting sessions (Captari, 2020).

Clients' attitudes were also important for the transition to online therapy. Since families bring a child or adolescent over to therapy, therapists informed them about that change first. While some families were accepting it, some families had doubts. Hoffnung et. al (2021) found that families were more accepting compared to clinicians. I was conducting face-to-face sessions with 5 children and adolescents and their families. They all accepted the online therapy option. Participants stated that children were familiar with the technology and the screen. Thus, they liked seeing themselves on the screen. Fonagy, Campbell, Truscott, and Fuggle (2020) found that young participants preferred online therapy and wanted to attend sessions in the familiar environment of the home. One of my clients was a child whose family was referred to therapy due to the separation issues of the child. She was very anxious in the beginning and wanted to check the presence of her mother in the middle of sessions in face-to-face therapy. She was playing Monopoly generally. In online therapy sessions, she started to play with various materials, and her spontaneity and creativity improved. I attributed her change to the feeling of safety in the home environment. Also, my 12-years old adolescent client started to attend sessions on his own without the need for his parents' presence. The clients' and the therapist's adaptation to online therapy was reciprocal. Participants stated that they adapted to online therapy depending on their client's adaptation capacity.

Online therapy led to difficulties differently from face-to-face therapy. In a study comparing therapists' attitudes toward online therapy, difficulty with emotionally connecting with patients was mentioned (Békés, Aafjes-van Doorn,

Luo, Prout, & Hoffman, 2021). Participants lost the playroom, the space where they were together with the child. They felt that they were deprived of containing role of the space. While therapists were greeting the clients in the waiting room, that transitional space was lost, and therapists started to admit clients by clicking "Admit from Waiting Room" on Zoom (Captari, 2020). One participant (P1) stated that she talked much in online sessions to make clients feel contained. Fonagy, Campbell, Truscott, and Fuggle (2020) mentioned that therapists can be overly active by giving advice or using psychological jargon such as intellectualizing due to lapses in mentalization. They added that in those moments therapists can be more rigid rather than being authentic in sessions. Also, working with children online became difficult because the therapist and the client could not share the same room. Hoffnung and colleagues (2020) stated that since psychotherapy depends on communication and relationship, online psychotherapy with children may be more difficult in contrast to psychiatry and support services. Participants felt less emotionally connected with clients, which was supported by the study of Aafjes-van Doorn et. al (2020).

Recreating a therapeutic framework was the most difficult part according to the participants. Online therapy changed the home environment into a clinical setting and that was a tough experience for both the therapist and the client. Therapists had difficulty keeping the therapeutic framework, especially the client's private space for ensuring confidentiality as supported by the study of Békés et. al (2021). Fonagy et. al (2020) mentioned that some children had concerns about their privacy to talk with the therapist. Children showed the boundaries of privacy and their feelings of wounded privacy or their capacity to preserve privacy. In online sessions, I saw that there was not a door in my client's room. I was working on separation-individuation with the child, and I realized that the mother also did not let the child have a personal space. Also, parents were included in the school system through online classes, and as participants mentioned their want to listen to the sessions increased. Thus, some parents became intrusive. They "attacked" the framework and that might affect the therapeutic alliance. Also, children's free association related to school increased

since they used the same platform, Zoom for both online classes and therapy sessions. One participant (P1) associated children's boredom in the sessions with their screen use of the educational system. Frye, Gardner, and Mateus (2021) observed the same situation in their study conducted with pediatric patients receiving psychological services via videoconferencing.

Adolescents may need to know that their sessions will not be recorded or shown to parents. Also, they may need to know that no one will listen to the session on the therapist's side (American Academy of Child and Adolescent Psychiatry 2008; American Telemedicine Association 2009b, 2013). In the present study, especially adolescents had concerns about their confidentiality, and they chose to use chat to share information about themselves. While the boundaries of the room were certain in online therapy, it was difficult to keep the framework in the online setting. My adolescent client interrupted the session due to his food delivery. Since domestic violence increased during the pandemic (Bradburry-Jones & Isham, 2020), three participants (P2, P6, P7) witnessed verbal violence at home. Those voices were data sources about the home environment of the child (Potash, Kalmanowitz, Fung, Anand, & Miller, 2020).

Clients also witnessed the home environment of the therapist somehow. Especially children's questions about the therapist's private life increased. Captari (2020) pointed out that clients become interested in the clinician's health. My 7 years-old client who had fears of losing her mother started to ask questions about my health and my mother's health. She was also curious about my room, and she was making a guess about the remaining part of the room I attended the sessions against my neutral stance toward her insistent questions. That can be considered a chance to improve the therapeutic relationship rather than the client's being intrusive. Therapist's authentic responses to the client's questions while keeping a neutral therapeutic stance can be an opportunity to calm the client and deepen trust and therapeutic engagement.

Participants stated that clients started to forget sessions and they associated that with the brain-fag the pandemic led to, being at home and decreased investment in therapy due to lack of physical and mental preparation for the

session. Frye, Gardner, and Mateus (2021) realized that especially adolescents forgot sessions since they were dependent on their parents in face-to-face therapy. Also, parents forgot sessions because they did not have to spend time traveling. All my clients forgot sessions sometimes due to the absence of mental and physical preparation and a decrease in their investment. I also remembered some of my sessions at the last moment at the beginning of the pandemic and I had difficulty adapting.

Participants' experiences of the payment part of the framework were divided into two; those who continued to receive payment and those who did not get paid within the scope of the clinical psychology graduate program. The clinical psychology graduate program I studied in decided to not receive payment from clients because of possible financial difficulties regarding the low socioeconomic status of the clients. That changed the therapeutic framework completely. Interestingly, even though they made payments to the psychological counseling center, and transition to face-to-face therapy following the first year of the pandemic they did not want to make payment. One participant (P7) mentioned that families acted like therapy is a service they were not supposed to make payment. However, those who kept receiving payments mentioned that some families made payments at the end of the sessions while some made monthly payments. They also made payments via bank transfer. Transferring the money rendered following the payment difficult for participants. When a participant controlled his bank account, he realized that some families made more payments while some did not pay the full amount. It was interesting that some families continued making payments via bank transfer while it was not an option in face-to-face therapy.

Keeping a therapeutic relationship was compelling, too. Therapists had difficulty keeping the therapeutic relationship, especially with children since reciprocity in the relationship became difficult. They tried to create a space where they shared something reciprocally via online platforms. Therapists' satisfaction with online therapy depends on their flexibility, openness to change, and comfort with technology (Goldstein & Glueck, 2016). In the present study, all participants

integrated technology into their work except one participant who was the oldest and the most experienced. While other participants who were younger found various ways of creating a common space and online equivalents of the materials in the playroom such as sandbox and dollhouse, the oldest participant suggested developing therapeutic board games for the online playroom. He did not hear about various materials other participants found for a therapeutic space. Other participants' contributions to the therapeutic space in an online setting might affect the therapeutic relationship between the therapist and the client. That participant (P8) stated that keeping the therapeutic relationship was difficult in online sessions.

Missed communication cues, disruptions in conversation, and lack of warmth can be evaluated as the decrease in the perceived satisfaction in online therapy (Frye, Gardner, Campbell, & Katzenstein, 2021). Fonagy et. al (2020) emphasized that therapists' ability to establish the therapeutic alliance in online therapy is limited. The computer took place as a third party between the therapist and the client, and it prevented the therapist from observing the client's body language (Potash et. al, 2020). Participants stated that since they were not in the same room, they had difficulty reading the client's body language and it was difficult, especially working with parents. I had difficulty following the child's play and over time the child felt alone due to not being able to play in the same room. Also, one participant (P2) stated that the client perceived the therapist as mechanical as Siri on the iPhone. My 5-years old client said that when I did not use my gestures, she thought that my image froze. She requested me of using my gestures. Goldstein and Glueck (2016) suggested that using gestures, an affective tone, and ensuring the accurate interpretation of communication can develop rapport between the therapist and client in online therapy. One participant (P4) added that she was not sure whether they could maintain eye contact, an essential component of building rapport. Goldstein and Glueck (2016) warned therapists to determine whether poor eye contact is related to a technical issue or the child's difficulty in interpersonal relationships.

Technical difficulties made the flow of online sessions and developing

rapport harder. To minimize technical difficulties, adequate bandwidth is very important. Participants mentioned difficulties related to the unstable internet connection which may arouse feelings of helplessness and frustration when the screen freezes during the client’s sharing something important. Captari (2020) recommended therapists explore the client’s experiences and emotions like frustration and the client’s experience of the therapist as someone who has limited knowledge of technology brings significant reflections. Connectivity issues were not under the control of either the therapist or the client. In the present study, one participant (P4) added that the therapist's difficulty while sharing a screen and inability to control the internet connection might affect the client’s transference, and the therapist’s so-called “omnipotency” was affected.

Screen as a third party affected the flow of the session and the client’s engagement in the session, also. Participants stated that they had fatigue at the end of the session. Two participants (P1, P7) associated that fatigue with making an extra effort for containing the client. Captari (2020) explains this situation as Zoom fatigue, which results from excessive effort to stay emotionally present. Therapists must process a lot of information such as speech, body language, and facial expressions in online therapy. Loss of all the things like mutual gaze, joint attention, eye contact, and implicit communication in the physical presence of both therapist and client explains the reason for fatigue. I also felt tired in online sessions even though I was more active in face-to-face sessions.

Besides the difficulties of online therapy with children, online therapy brought along facilities, too. Participants stated that online platforms enabled them to create togetherness in online therapy. Therapists used the materials, and the children also showed their toys. The toys or materials the child chose in his environment had a meaning for psychodynamic play therapy, too (Potash, et. al, 2020). Fonagy and colleagues (2020) stated that therapists respond to implicit and explicit communication in face-to-face therapy with children. Online therapy reveals children’s primitive sensory expressions which revive their experiences of regression. One of my clients started to use water in a bowl for weeks while she was only playing Monopoly in face-to-face therapy. Her play became more

regressive, and its interpretation progressed the process. The transition from sensory-somatic play to symbolic play is related to primary developmental processes between the mother and the child. That provides a detailed explanation for why some children cannot play in online therapy. Two participants (P1, P3) stated that sensory play and mirroring helped them to create attunement with younger children. Fonagy and colleagues (2020) recommended therapists work on body awareness, synchronization, and mirroring as a central way of creating a sense of closeness in online therapy. One participant (P1) stated that some children turned on and off the camera to play with the therapist. Goldstein and Glueck (2016) recommended playing "hide and seek" with younger children using the camera. Also, oppositional children can turn off the camera to challenge the therapist. All those plays and interpreting them can be clinically useful.

All those plays contributed to creating togetherness and keeping the therapeutic alliance in online therapy. Participants explored screen sharing and whiteboard with children, which facilitated establishing a therapeutic alliance with them (Goldstein & Glueck, 2016). Screen sharing creates a base for joint attention to make therapeutic change possible (Fonagy et. al, 2020; Tomasello, 2016; Tuomela, 2007). Epistemic trust is important for therapeutic alliance and therapeutic change (Fonagy, Luyten, & Allison, 2015). While it was easy for therapists to show the client they can see the world from their point of view, in online therapy it is required for therapists to have clear communication about their interest and engagement in the client's experience (Fonagy, et. al, 2020). In the present study, one participant (P3) stated that while she doubted whether she told the client that she couldn't hear what the client said due to the unstable connection, she decided to tell it to show her engagement in the client's experience.

Participants stated that there was not a great difference between online therapy and face-to-face therapy in terms of establishing a therapeutic relationship. Simpson and Reid's (2014) systematic review on establishing the therapeutic alliance in online therapy showed that therapeutic alliance can be developed at an equal or stronger level than face-to-face therapy depending on the ratings of both therapists and clients. Also, if therapists perceived the therapeutic relationship as

sufficiently genuine early in the pandemic, that also affects their perception of problems regarding emotional connection (Békés, et. al, 2021). However, therapists may spend more time building therapeutic alliance online rather than accomplishing tasks (Williams, Bambling, King, & Abbott, 2009). Besides, establishing rapport depends on both the client's and the therapist's technological skills and the technical problems they encountered (Hanley, 2012). In times of crisis like COVID-19, parents have difficulty supporting their children. During the Covid-19 crisis, parents must regulate their emotions first (Cohen & Shulman, 2019). The therapist's supportive attitude toward parents helped them to regulate their children's emotions. Also, therapists' being accessible to parents, and parents' holding the therapists in mind as caring, supportive, and stable other made object constancy strong and fostered mentalization (Captari, 2020). Keeping online sessions helped families to cope with the pandemic and therapists remained a constant object in their lives. A study conducted with children, families, and therapists showed that families found online therapy helpful for them and their children to cope with fear and anxiety (Hoffnung et. al, 2021). In times of crisis like COVID-19, parents have difficulty supporting their children. Also, attending sessions from home strengthened the therapeutic relationship for some clients. One participant (P4) stated that she was working with abused children under the scope of an association and attending the session at home relieved them. Captari (2020) stated that a patient who experienced abuse was comfortable being at home in the absence of the therapist's body and the therapeutic relationship strengthened.

Participants stated that online therapy saved both their and clients' time. They did not have to spend time in traffic jams and the financial costs of transportation decreased as consistent with the literature (Hoffnung et. al, 2021). Also, they could connect with clients around the world. Online therapy increased the accessibility of tele-mental health services and parents preferred it much after the pandemic. In the study of Hoffnung and colleagues (2021), participants asked whether online therapy could continue due to its ease of use. Online therapy became a new alternative for the clients. Goldstein and Glueck's (2016) study

showed that knowing online therapy as an alternative affected patients' preference. The parents of a client whom I started to conduct sessions in the playroom suggested conducting their sessions with me online. Holding on to the framework and reminding the importance of body language was helpful. However, the flexibility of the framework depends on the client's physical conditions. For instance, a client's father lives in a different country due to his occupation and we arrange the meeting with parents mostly online. If the father is in Istanbul, we arrange face-to-face meetings with the parents. That flexibility facilitates the process but in our first online session with parents, the father attended with his undershirt smoking his cigarette. However, he was well-dressed in the face-to-face meeting. Participants stated that they learned to be flexible and that made them feel good. A qualitative study to determine the difficulties therapists faced showed that they learned to use telehealth platforms flexibly (Jurcik, Jarvis, Doric, Krasavtseva, Yaltonskaya, & Ogiwara, 2020). Thus, being flexible increased the professional assurance of participants. Being flexible and having professional assurance it brought along may affect the therapeutic alliance positively. Also, those who were flexible might perceive online therapy as more effective. Those who had limited resources for therapy can have access to therapy via tele-mental health services. I realize the increase in the demand for online therapy for especially adult clients. However, there is more demand for online therapy with adolescents if the client could not have a professional in the city he lives. Besides, the clients did not have to spend their time traveling and the financial costs of transportation (Hoffnung et. al, 2021).

Depending on all the difficulties, facilities, and contributions of online therapy, most of the participants found face-to-face therapy more effective than online therapy since the therapist and client share the same space, and keeping the therapeutic framework is easy. Also, they did not have all the materials they had in the playroom. Only two participants (P4, P5) found online therapy effective, and they offered online therapy as an option. As Hoffnung et. al (2021) mentioned in their study, clinicians were less excited about tele-mental health. Clinicians stated that they felt discomfort and the inadequacy of tele-mental health

services. Participants stated that they felt more tired in online sessions. Feeling more tired at the end of online therapy sessions may be linked to distractibility. Self-view, seeing both party's appearances may be related to the distraction of online therapy. In the same vein, Békés and Aafjes-van Doorn (2020) found that therapists had negative attitudes toward online therapy. It was found that therapists' attitudes toward online therapy and their ideas related to its effectiveness were linked to the quality of emotional connections such as expressing and feeling empathy, feeling connected, and reading patients' emotions (Békés, et. al, 2021). Besides, the clients did not have to spend their time traveling and the financial costs of transportation (Hoffnung et. al, 2021). I also do not especially prefer online therapy. I feel close to online therapy with adolescents if confidentiality is ensured. A study conducted in Sweden showed that participants found online therapy effective (Benoit & Kramer, 2020). Online therapy is an effective option for those who have difficulty attending face-to-face sessions. Engagement and collaboration are critical elements of online therapy with children (Hoffnung, et. al, 2021). Participants stated that they prefer online therapy with adolescents because they are open to collaboration.

Having a separate space for online therapy and informing parents about children's and adolescents' confidentiality was important for an effective online therapy process. The most difficult part of online therapy was keeping the framework. Participants stated that establishing a therapeutic framework was important. Confidentiality and attending the session on time were important components of the framework. Each client brought along different difficulties regarding the various components of the framework. My 7 years-old client who was referred to therapy for separation-individuation had difficulty not including others, especially her mother during the session. I was like in the middle of the home. I heard her parents', aunt's, and grandfather's voices during the session. They forgot that she attended the session and wanted to come in the room. The child reminded them of the session. Also, my 5-years old client was very active during the sessions, and I was concerned about his security. Participants stated that children did not concern about confidentiality whereas confidentiality was

very important for adolescents. Therapists should inform adolescents the session will not be recorded. Providing them with trust helps therapists establish a therapeutic alliance (Goldstein & Glueck, 2016). One participant (P1) stated that the client shared his screen, and the client was playing a digital game on an online play platform. A third party wrote something in the chat section of the play. The therapist stated that that was a compelling experience for both. Thus, in online therapy confidentiality is not about the physical presence of others. The digital presence of others prevented from ensuring confidentiality, too. Discussing confidentiality in face-to-face therapy and online therapy can be clinically meaningful. One participant (P3) added that keeping neutrality was critical for therapists in online therapy. The client may wonder about the therapist's home or privacy but being genuine and authentic without giving unnecessary details is a therapeutic stance (Captari, 2020). The clients may hear voices from the therapist's space and working on the client's association, thoughts and feelings can be effective in the therapy process.

The child's room should be large enough so that the therapist can observe the child's behavior (Goldstein & Glueck, 2016). In the present study, participants observed dyadic play between the mother and the child. Thus, a large enough room was required for them to play comfortably. Participants stated that therapists should also have a separate room for online therapy. Even though I had a separate space for online therapy, I could not attend the session in that space due to the unstable Internet connection and I had difficulty ensuring my confidentiality. Evaluation of the nature of the case was significant before the first session of online therapy. Participants stated that online therapy was effective with children who had the symbolization capacity as Fonagy et. al (2020) stated. My 7-years old participant could play in online setting while my 5-years old client had difficulty playing and only my presence affected the process positively. Symbolization capacity impacted the establishment of therapeutic alliance and the effectiveness of online therapy, which was also dependent on being flexible. Flexibility became prominent as an indispensable part of both therapist's characteristics and the therapy process. While some tried to hold onto manualized treatment Captari

(2020) emphasized the importance of adaptation and flexibility according to each patient's need. Participants stated that they learned to be flexible and being flexible in the therapy process influenced the effectiveness of the process. In the study, Jurick et. al (2020) showed that therapists from Canada, Russia, Australia, and Japan learned to utilize online platforms flexibly. In this sense, the therapist's flexibility, comfort with technology, and being open to new ideas affected professional satisfaction in online therapy (Hoffnung et. al, 2021). In the present study, the oldest and the most experienced therapist was not comfortable with technology, and he did not feel close to online therapy. Also, he did not find online therapy as effective as face-to-face therapy. When questions about the difficulties of online therapy were asked, he mentioned the government's inadequacy of managing the crisis. He externalized his difficulties and could not focus on his internal experiences. Online therapy revealed the therapist's technological skills, and he might feel incompetent even though he was more experienced than his younger colleagues. It was an outlier in the data regarding his age and the duration of experience, but it was significant for seeing the difference between the younger participants' and the oldest participant's experiences.

Their professional needs were changed. Participants stated that supervision has become more of an issue with online therapy. Supervision made therapists feel secure and they did not feel isolated in their first online therapy experiences with children and adolescents. Participants met their colleagues and attended peer supervision to share their experiences with online therapy. Jurick et. al (2020) found that therapists benefited from peer supervision to find solutions for difficulties encountered. More training and supervision are required for any approach to improve therapeutic alliance and increase professional assurance and satisfaction (Hoffnung et. al, 2021; Ertelt, Crosby, Marino, & Mitchell, 2010). Supervision helps the therapist not feel overwhelmed and strengthens the sense of competence (Buechler, 2012). I also benefitted from personal and group supervisions much. I heard about online equivalents of playroom in the interviews with participants. In the fast-changing world which becomes more digital-based

each day, therapy which is expected to be the last digitalized part has become an option pops-up in people's mind. I do not think that therapists will prefer online therapy with younger children but developing therapeutic board games would be helpful. Therapists had an extensive practice of online therapy and in case of another crisis, they can conduct sessions more effectively. All in all, their holding on to strict rules of psychodynamic approach has transformed. They realized that the balance between keeping the framework and flexibility is the golden rule.

4.2. Clinical Implications

One aim of the present study is to present the clinical implications of online therapy with children and adolescents from a psychodynamic play therapy approach. Creating togetherness in online therapy, keeping a therapeutic framework, being flexible and preparing for the session, and evaluating the nature of the case before accepting online therapy can become beneficial for clinicians working with children and adolescents in online therapy.

First, it becomes useful for therapists to take each client's needs into account to create togetherness. In their article, Fonagy, Campbell, Truscott, and Fuggle (2020) discuss that being at home affects children differently and their play can change. Their play may change into sensory play, which evokes the early developmental processes. In this sense, it is significant for therapists to consider each child's needs in online sessions. In the case of the present study, therapists try to understand the home environment of the child and family dynamic to understand the child's needs better. Even though online platforms provide various options to create a virtual playroom together, keeping in mind that some children prefer physical materials such as drawing a picture separately becomes helpful for clients not to insist on the same medium to create togetherness.

Besides creating togetherness in online therapy, therapists need to be aware of keeping the therapeutic framework when working with children and adolescents via online therapy (Goldstein & Glueck, 2016). The authors emphasize that adolescents want therapists to ensure confidentiality. They want to know there is

no one watching or hearing their sessions. Therapists should have a separate room for online therapy if possible. Putting on headphones, a white noise machine, and establishing collaboration with family members can be ideal to keep confidentiality. Also, Captari (2020) points out that clients' questions about therapists' privacy can increase in online therapy. Rather than answering these questions in detail, responding authentically to their questions is significant. The present study also demonstrates that especially children's questions about the therapist's private life increased and therapists might tend to answer these questions because they were at home. Keeping neutrality became more important in online therapy.

Therapists should also consider their openness to change and flexibility while working with children in online therapy. Captari (2020) points out therapists' flexibility according to the client's need. Therapists learned to be flexible while dealing with the difficulties of online therapy (Jurick et. al, 2020). In the present study, participants stated that they learned to be flexible in time, even though they did not think that they are not open to change in the beginning. They realized the importance of being flexible following their two years of experience in online therapy. A therapist's flexibility and openness to ideas increase professional satisfaction (Hoffnung et. al, 2021). Therapists who found creative ways while working with children stated that they found online therapy effective.

The last clinical implication is about the evaluation of clients before conducting the first session with them. Participants stated that online therapy is not appropriate for each client. Evaluating the nature of the case, the client's age, symbolization capacity, the reason for referral, and the parents' openness to collaboration is critical. Participants emphasized that those with pathological behavioral patterns and low levels of symbolization capacity are not suitable for online therapy. Adequate bandwidth for a stable internet connection is technical preparation for the session (Goldstein & Glueck, 2016). Therapists should have materials to create togetherness in online therapy (Fonagy, et. al, 2020). Also, the clients, especially children should have a large enough room to let therapists observe their play effectively (Goldstein & Glueck, 2016). In the present study, participants stated that an online consent form, psychoeducation for parents to

increase their awareness about online therapy and confidentiality, and precautions such as putting on headphones, white noise machine are required for effective preparation. Plus, therapists should take a long look at whether they are comfortable and willing to work with children and adolescents in online therapy.

To sum up, while working with children and adolescents, it is important to be sensitive about the therapeutic relationship and therapeutic framework. In addition, being aware of the transference and countertransference becomes highly important in online therapy because both parties see each other's privacy somewhat. Therapists working in Turkey need to keep in mind that family structure is intertwined in Turkey. Thus, keeping confidentiality can be more difficult than expected. Being patient and consistent about reminding confidentiality could be beneficial in the therapeutic process. Lastly, it seems significant for therapists to comprehend the strengths of the family's effort and collaboration since they provide the setting for the child to attend online sessions.

4.3. Limitations and Suggestions for Further Research

The present study contributes to the literature and clinical considerations about online therapy with children and adolescents from the psychodynamic play therapy approach by examining how child and adolescent therapists experienced online therapy, how their experience has changed, and their opinions about the effectiveness of online therapy. Even though the studies about online therapy with children date back to the 2010s, there is no detailed qualitative research on establishing a therapeutic alliance with children via online therapy in Turkey. In this sense, examining online therapy experiences of therapists who work with children and adolescents through psychodynamic play therapy can become influential both in the area of psychotherapy and research. Moreover, most studies have been conducted from an empirical view by means of quantitative methods. In this study, utilizing a qualitative design gave more chance and opportunity to understand the unique experiences of child and adolescent therapists in a deeper

way.

Besides these strengths, there are also some limitations of the present study. First, it was difficult to reach the child and adolescent therapists who conducted their sessions via online therapy utilizing the psychodynamic approach as participants. However, after collecting applications, it was seen that there were a few numbers of applications from male participants. Generally, there were more females working with children and adolescents and that affected the distribution of the participant's gender. For further studies, considering the homogenous distribution of gender can be beneficial. Since the present study focused on the experiences of child and adolescent therapists who utilize psychodynamic play therapy, the experiences of child and adolescent therapists who utilize different modalities can be helpful to understand the effect of the modality on therapists' experiences of online therapy.

Another limitation of the present study is about child and adolescent therapists who have different durations of experience from two and half years to fifteen years (M = 5 years). The variations on that issue could influence participants' experiences of online therapy. For instance, participants with two and half years of experience mentioned that they had difficulty in keeping the therapeutic framework while more experienced participants mentioned it was not a compelling experience for them. However, while young therapists easily adapted to technology use during the sessions, the most experienced therapist had difficulty integrating new things such as whiteboard or online sandbox into the therapeutic setting. In this sense, not setting the upper limit on the duration of experiences could be a limitation of the present study. Therefore, it can be suggested to set an upper limit to the duration of experiences or increase the duration of experience as a lower limit in future research.

Besides the duration of experiences, the demographics of child and adolescent therapists utilizing the psychodynamic approach seemed to be homogenous. They all have master's degrees and live in İstanbul. Due to the nature of the qualitative studies, findings are not applicable and generalizable to other contexts. Thus, evaluating the results of the study regarding the nature of the

qualitative design would be helpful. Related to limitations, further studies can include more heterogeneous participants from different backgrounds (e.g., working in the eastern part of Turkey). This kind of approach can lead to seeing the difference among therapists who live and witness different cultures in Turkey. In this sense, it becomes interesting and beneficial to conduct a study that includes therapists in different parts of Turkey and focuses on their experiences. In the present study, questions related to the therapeutic alliance with parents were limited. For further studies, including questions related to families would be beneficial for the impact of the third party on therapists' experiences.

Also, a qualitative study about the experiences of participants who live in different countries and thus in different cultures helps to observe the effect of culture on preserving confidentiality. For instance, in the present study preserving confidentiality was compelling since there are more intertwined family structures in Turkey. However, the results of the study may differ in other countries with individualistic cultures. Besides, a qualitative study that aims to understand the clients including adolescents and parents provides a 360-degree perspective on the online therapy experiences.

CONCLUSION

The aim of the present study is to the explore experiences of child and adolescent therapists who utilize psychodynamic play therapy. More specifically, it tries to understand how child and adolescent therapists experienced the pandemic and the transition to online therapy, how they established therapeutic relationship with clients, and the effectiveness of online therapy depending on participants' experiences. The present study includes eight participants who work with children and adolescents online utilizing psychodynamic play therapy. The interviews were done with each participant through online channels. The literature about online therapy is extensive, but the focus seems to be on adults rather than children and adolescents. On the other hand, the subject of online therapy with children and adolescents seems to be newly emerging in the literature following the pandemic. In this sense, the present study can contribute both to research about online therapy with children and research about the experiences of therapists who work with children and adolescents online utilizing the psychodynamic play therapy approach in the Turkish context.

The findings demonstrate that child and adolescent therapists had different opinions about online therapy with children and adolescents. They appreciate online therapy since they have created togetherness in online therapy and kept the therapeutic relationship with children and adolescents. Also, online therapy provides accessibility and emerges as a new alternative both for therapists and clients. On the other hand, they perceive negative aspects of online therapy such as technical difficulties and difficulties ensuring confidentiality and keeping the therapeutic framework. Since they do not share the same room with children and adolescents, containing them becomes more compelling and they make an excessive effort to contain them. Technical difficulties and the screen make it difficult to read the body language of the clients. Besides the difficulties of online therapy, therapists learn to be flexible during online therapy and their flexibility leads to an increase in professional assurance.

Lastly, they find face-to-face therapy more effective compared to online

therapy, especially with children. They recommend their colleagues who work with children and adolescents via online therapy to prepare for online sessions such as creating a space for therapy and preventions for keeping confidentiality such as headphones or a white noise machine. They also emphasize the evaluation of participants in terms of appropriateness for online therapy. According to them, some clients with borderline personality organization or self-harm behavior are not suitable for online therapy. They see being flexible and supervision as indispensable parts of online therapy with children and adolescents.

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APPENDICES

Appendix A: Interview Questions

A. Giriş

1. Kendinizi tanıtır mısınız ?

B. Pandemi ile Birlikte Çevrimiçi Seansa Geçiş

2. COVID-19 salgınından önce çevrimiçi terapiye dair nasıl bir yaklaşımınız vardı? Çocuklar ve ergenlerle çevrimiçi terapi yapmaya dair düşünceleriniz nasıldı?
3. Çevrimiçi seanslara geçmeden önce nasıl hissediyordunuz?
4. "Gerçek bir terapi odasından" sanal bir terapi ortamına geçmeyi nasıl deneyimlediniz?
5. Çevrimiçi seanslara geçiş terapötik çerçevenizi nasıl etkiledi ve buna nasıl uyum sağladınız?
6. Zoom gibi çevrimiçi görüşme uygulamaları ekran paylaşımı, beyaz tahta, mesajlaşma gibi farklı seçenekler sunabiliyor. Bunları çevrimiçi seanslarda nasıl kullandınız?
7. Danışanlarınız çevrimiçi seanslara geçişi nasıl deneyimledi? Hisleri nasıldı? Yüz yüze devam ettiğiniz danışanlarınızla çevrimiçi seanslara geçmek terapi sürecini ve aranızdaki terapötik ilişkiyi nasıl etkiledi?
8. Çevrimiçi seanslar danışanların aileleriyle kurduğunuz terapötik ilişkiyi nasıl etkiledi?
9. Çevrimiçi seanslarla birlikte danışanlar seanslara genelde evden katılmaya başladı. Normalde danışmanlık merkezlerinde seans odalarında görüşme yapılıyorken gizliliği sağlamak daha kolay olabiliyordu. Bir terapist olarak sizin açınızdan ve danışanlarınızın açısından gizliliği sağlamak nasıldı?

C. Pandemi Sırasında Terapist Olmak

10. COVID-19 salgınını salgının başında bir terapist olarak nasıl deneyimlediniz ve şu anda nasıl deneyimlemektesiniz?

11. Bir terapist olarak değişiklikleri karşılama ve uyum sağlama kapasiteniz hakkında ne düşünüyorsunuz? Salgın bunu nasıl etkilemiş olabilir?

12. Hangi özellikleriniz bu süreçle baş etmenize yardımcı oldu?

13. Çevrimiçi çalışmanın zorlayıcı yanları ve kolay yanları neler?

14. Seans sırasında danışanlarınızla yaşadığınız zor bir an olduysa ne oldu? Bu durumla nasıl baş ettiniz?

15. Çocuk ve ergenlerle çevrimiçi seans yapmanın olumlu ve olumsuz yanları sizce neler?

16. Çocuklarla ve ergenlerle seans yapmanın benzer ve farklı yönleri neler?

17. Çevrimiçi seansların etkililiği hakkında ne düşünüyorsunuz?

D. Kapanış

18. Çevrimiçi seanslara devam etmeyi düşünüyor musunuz?

19. Sizce çocuk ve ergenlerle çevrimiçi terapinin geleceği nasıl olacak?

20. Kendi deneyimlerinize dayanarak meslektaşlarınıza çevrimiçi seans yapmaya ve danışanlarla terapötik ilişki kurmaya dair önerileriniz nelerdir?

21. Genel olarak düşündüğünüzde, çevrimiçi seanslarla ilgili deneyimlerinizden neler öğrendiniz, size nasıl bir katkısı oldu?

22. Bu konu hakkında konuşmak size nasıl geldi?

23. Sizin eklemek istediğiniz bir şey var mı?

24. Bana sormak istediğiniz herhangi bir şey var mı?

Appendix B: Informed Consent Form

Araştırmanın Yürütüldüğü Kurum:	İstanbul Bilgi Üniversitesi
Araştırmanın Adı:	Psikodinamik Yaklaşımla Çalışan Çocuk ve Ergen Terapistlerinin COVID-19 Salgını ile Çevrimiçi Seanslarda Danışanlarıyla Kurduğu Terapötik İttifak Üzerine Niteliksel Bir Çalışma
Araştırmacının Adı:	Büşra Baştürk
Araştırmacının E-mail Adresi ve Telefonu:	
Araştırmanın Danışmanı:	Dr. Öğr. Üyesi Zeynep Maçkalı
Danışmanın E-mail Adresi ve Telefonu:	

Değerli Katılımcı,

Sizi İstanbul Bilgi Üniversitesi Klinik Psikoloji Yüksek Lisans Programı öğrencisi Büşra Baştürk'ün Dr. Öğr. Üyesi Zeynep Maçkalı danışmanlığında yürütmekte olduğu araştırmaya davet ediyoruz. Bu araştırmada psikodinamik oyun terapisi yaklaşımı ile çalışan çocuk ve ergen terapistlerinin COVID-19 salgını ile başlayan çevrimiçi seans deneyimlerinde terapötik ittifakı nasıl kurduklarının ve sürdürdüklerinin incelenmesi amaçlanmıştır. Araştırmanın çocuk ve ergenlerle yapılan çevrimiçi görüşmelerde kurulan terapötik ilişkinin geliştirilmesine katkıda bulunması beklenmektedir.

Araştırmaya klinik psikoloji yüksek lisans programından mezun olmuş, çocuk ve ergenlerle süpervizyon alarak seans yapma deneyimleri olan ve pandemi öncesi yüz yüze yaptığı seansları pandemi ile birlikte çevrimiçi platforma taşımış, psikodinamik yaklaşımla çalışan çocuk ve ergen terapistleri katılabilmektedir.

Katılımcılardan bilgilendirilmiş onam formunu doldurduktan sonra demografik bilgi formunu doldurmaları istenecektir. Demografik bilgi formunda verilen bilgilere göre araştırmaya katılma şartını sağlayan katılımcılarla görüşmelere devam edilecektir.

Araştırma kapsamında katılımcılarla yaklaşık bir saat sürmesi beklenen çevrimiçi görüşmeler yapılacaktır. Katılımcılardan izin alındıktan sonra görüşmelerin ses kaydı alınacak, araştırmacının bilgisayarındaki şifreli bir dosyada muhafaza edilecek ve araştırma sona erdiğinde silinecektir. Araştırmacıdan ve tez danışmanından başka kimsenin kayıtlara erişimi olmayacaktır. Görüşme sırasında verdiğiniz bilgiler isminiz kullanılmadan değerlendirilecek, araştırmanın raporlanması ve sunulması sırasında görüşmede verdiğiniz bilgiler kimliğiniz ile eşleştirilmeden anonim bir şekilde kullanılacaktır.

Bu araştırmaya katılmak gönüllülük esasına dayalıdır. Araştırma sürecinin katılımcılara herhangi bir zarar vermesi beklenmemektedir. Görüşme öncesinde, sırasında ve sonrasında sormak istediğiniz bir soru varsa sorabilirsiniz Görüşme sırasında sorulan soruların sizin için psikolojik veya fiziksel olarak zorlayıcı olduğunu hissederseniz araştırmadan istediğiniz zaman çekilebilirsiniz. Araştırmadan çekildiğiniz durumda verdiğiniz bilgiler değerlendirilmeye alınmayacaktır.

Katılımcıların araştırma sorularına detaylı ve uzun cevaplar vermesi beklenmektedir. Görüşme sırasında sorulara vereceğiniz cevaplar çocuk ve ergen danışanlarla pandemi ile yapılmaya başlanan çevrimiçi seansların danışan ve terapist arasındaki terapötik ilişkiye dair etkisini anlamak amacıyla tez araştırması kapsamında değerlendirilecek ve katılımcıların cevaplarına dair ortak temalar araştırılacaktır. Deneyimlerinizin doğru bir şekilde anlaşılması adına görüşmenizin sonuçları araştırma sonlandırılmadan önce sizinle mail yoluyla paylaşılacak ve sonuçlara dair geribildirim vermeniz istenecektir.

Eğer araştırmanın amacı ile ilgili verilen bu bilgiler dışında şimdi veya sonra daha fazla bilgiye ihtiyaç duyarsanız, araştırma yürütücüsü Büşra Baştürk'e e-posta adresi ile ulaşabilirsiniz. Bu araştırmaya katkıda bulunduğunuz için şimdiden teşekkür ederim.

Bu çalışmaya tamamen gönüllü olarak katılıyorum. Yukarıdaki bilgileri okudum, anladım. Bu çalışmaya katılmayı ve vereceğim bilgilerin bilimsel amaçlı yayınlarda kullanılmasını;

Kabul ediyorum   Kabul etmiyorum

Appendix C: Demographic Information Form

1. Cinsiyetiniz:

2. Yaşınız:

3. Yaşadığınız şehir:

4. Eğitim Durumunuz:

a. Yüksek Lisans

b. Doktora

5. Yüksek lisans programından ne zaman mezun oldunuz?

6. Yüksek lisans eğitiminizin içeriği psikodinamik oyun terapisi yaklaşımı üzerine miydi?

a. Evet

b. Hayır

7. Bir önceki soruya cevabınız hayır ise psikodinamik oyun terapisine dair nasıl bir eğitim aldınız?

a. Yüksek lisanstan sonra katıldığınız eğitimler

b. Süpervizyon

8. Kaç yıldır çocuk ve ergen psikoterapisti olarak deneyiminiz var?

9. Pandemiden önce çevrimiçi seans yapmaya dair bir eğitim aldınız mı?

a. Evet

b. Hayır

10. Pandemiden önce çevrimiçi seans deneyiminiz oldu mu?

a. Evet

b. Hayır

11. Kendinizi çevrimiçi terapiye geçişe nasıl hazırladınız?

a. Meslektaşlarımla konuştum

b. Süpervizörüme danıştım

c. Makale okudum

d. Diğer ise belirtiniz:___

12. Danışanlarınızı çevrimiçi terapiye hazırladınız mı?

a. Evet

b. Hayır

13. Bir önceki soruya cevabınız evet ise danışanlarınızı çevrimiçi terapiye nasıl hazırladınız?

a. Çevrimiçi seansa geçişten önce konuşarak

b. İlk çevrimiçi seansta konuşarak

c. Teknik destek sağlayarak (Zoom ya da Skype'I nasıl kullanacaklarına dair bilgilendirici videolar)

d. Çevrimiçi terapiye dair bilgilendirilmiş onam formu göndererek

e. Diğer:

14. Çevrimiçi seansları nerede yaptınız?

a. Ev

b. Ofis

15. Çevrimiçi seanslar için hangi platformu kullandınız?

a. Zoom

b. Skype

c. Diğer:

16. Çevrimiçi terapi ile gördüğünüz danışanların profili nasıldı?

a. Pandemiden önce yüz yüze seans yaptığınız danışanlar

b. Yüz yüze seans yaptığınız danışanlar ve direkt çevrimiçi terapide görmeye başladığınız danışanlar

ETHICS BOARD APPROVAL

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