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INTERACTION STRUCTURES IN PSYCHODYNAMIC CHILD TELETHERAPY SESSIONS DURING THE COVID-19 PANDEMIC: RELATIONS WITH MOTHER-CHILD EMOTIONAL DIALOGUES

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Interaction Structures in Psychodynamic Child Teletherapy Sessions During the COVID-19 Pandemic: Relations with Mother-Child Emotional Dialogues

COVID-19 Sürecinde Psikodinamik Çocuk Çevrimiçi Seanslarındaki Etkileşim Yapıları: Anne-Çocuk Duygusal Diyaloglar ile İlişkiler

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ABSTRACT

Mentalization, defined as the capacity to interpret behaviors based on mental states such as desires, feelings, and beliefs and, emotional dialogues of child-mother, defined as a base in which child create narratives have both been found to be protective factors in the times of trauma. Although previous studies found a relationship between different capacities of children and their therapy process, there are no studies about the how different protective capacities of child-mother are related to children's therapy process during the pandemic. Therefore, the first aim of the study is to investigate interaction structures, defined as repetitive patterns mutually created by therapist and patient, in child teletherapy sessions. The second aim is to examine the relationship between interaction structures and the mentalization and emotional dialogue capacity of child-mother dyad. Participants were a clinical sample of 21 mother-child dyads who applied to the Istanbul Bilgi University Psychological Counseling Center. Session data was obtained from the 76 psychodynamic child teletherapy sessions. Interaction structures were determined by using Children Psychotherapy Instrument (CPQ). Dyad's mentalization capacity was evaluated with the Coding System for Mental State Talk in Narratives (CS-MST) and the emotional dialogue capacity was assessed with Autobiographical Emotional Events Dialogue (AEED) task. Principal component factor analysis and Spearman correlation were used as analysis method. The results revealed five interaction structures in children's teletherapy sessions. Child-mother less use of causal emotional mental state talk is associated with the dependent, introverted child and exploratory therapist in the sessions while child-mother less use of total/self/other/unique cognitive mental state talk is related to distant child and unaccepting, directive therapist in the sessions. Lastly, child-mother's emotionally less coherent stories are associated with more fearful children in the sessions. Results indicated the importance of different protective capacities which have relations with children's psychotherapy process during pandemic.

Keywords: Covid-19 Pandemic, Process Research, Interaction Structures, Emotional Dialogues, Mental State Talk

ÖZET

Davranışları arzular, duygular, inançlar gibi farklı zihin durumlarına dayalı olarak yorumlama kapasitesi olarak tanımlanan zihinselleştirmenin ve çocukların anlatılar oluşturdukları bir alan olarak tanımlanan çocuk-anne arasındaki duygusal diyalogların her ikisinin de travma zamanlarında koruyucu faktörler olduğu bulunmuştur. Daha önce yapılan çalışmalarda çocukların farklı kapasiteleri ile terapi süreçleri arasında bir ilişki bulunsa da, pandemi döneminde çocuk-annenin farklı koruyucu kapasitelerinin çocukların terapi süreciyle ne kadar ilişkili olduğuna dair bir çalışma yoktur. Bu nedenle, bu çalışmanın ilk amacı pandemi döneminde, çocuk çevrim içi seanslarında, terapist ve hasta tarafından karşılıklı olarak oluşturulan tekrarlayıcı örüntüler olarak tanımlanan etkileşim yapılarını incelemektir. İkinci amacı ise etkileşim yapıları ile çocuk-anne ikilisinin zihinselleştirme ve duygusal diyalog kapasiteleri arasındaki ilişkiyi incelemektir. Katılımcılar, İstanbul Bilgi Üniversitesi Psikolojik Danışmanlık Merkezi'ne başvuran 21 anne-çocuk ikilisinden oluşan klinik bir örneklemdir. Seans datası, 76 psikodinamik çocuk çevrim içi terapi seansından oluşmaktadır. Etkileşim yapıları Çocuk Psikoterapi Q-Seti (CPQ) kullanılarak belirlenmiştir. İkilinin zihinselleştirme kapasitesi Anlatılardaki Zihin Durumlarını Kodlama Sistemi (CS-MST) ile, duygusal diyalog kapasitesi ise Otobiyografik Olaylar üzerine Duygusal Diyaloglar (AEED) aracı ile değerlendirilmiştir. Analiz yöntemi olarak temel bileşen faktör analizi ve Sperman korelasyonu kullanılmıştır. Sonuçlar, COVID-19 salgını sırasında çocukların çevrim içi terapi seanslarında beş etkileşim yapısını ortaya çıkarmıştır. Çocukların ve annelerin nedensel duygusal zihin durum konuşmasını daha az kullanması seanslarda bağımlı, içe dönük çocuk ve keşfedici terapistle ilişkiliyken, çocukların ve annelerin toplam/kendine yönelik/diğerlerine yönelik/özgün bilişsel zihin durum konuşmalarını daha az kullanması, seanslarda mesafeli çocuk ve kabul etmeyen, yönlendirici terapistle ilişkili bulunmuştur. Son olarak, çocuklar ve annelerin duygusal açıdan daha az tutarlı hikayeleri, seanslarda daha korkan çocuklarla ilişkili bulunmuştur. Sonuçlar, pandemi sırasında

çocukların psikoterapi süreci ile ilişkisi olan farklı koruyucu kapasitelerin önemi göstermiştir.

Anahtar Kelimeler: Covid-19 Pandemisi, Süreç Araştırması, Etkileşim Yapısı, Duygusal Diyaloglar, Zihin Durumu Konuşmaları

CHAPTER 1

INTRODUCTION

Covid-19, a new disease, suddenly entered the lives of people all over the world at the end of 2019. Different precautions were taken to prevent the spread of the virus, and this caused a change in people's routines. Different studies proposed that this time has a variety of stressors for people, and that this period can be a traumatic period (Gruber et al., 2020). Additionally, studies conducted with adults suggested that people's mental health problems have been increasing during this period (Pérez-Fuentes et al., 2020; Kumar & Nayar, 2020; Canet-Juric et al., 2020; Tso & Park, 2020). Children are also one of the vulnerable groups during the pandemic. Children's lives have had to change completely due to preventions taken (Dalton et al., 2020). Studies claimed that this period also reveals different stress factor for children, and this brings along mental health problems (Jiao et al., 2020; Marques de Miranda et al., 2020; Bignardi et al.,2020). On the other hand, they suggested that protective factors should be emphasized during this stressful period (Bruinig et al., 2020). Considering this recommendation, mentalization/mother-child mental state talk can be an important protective factor in these stressful times. Previous studies have shown that mentalization capacity of the one can be harmed in high stress situations and it is important to develop this capacity (Fonagy et al., 1994; Luyten & Fonagy, 2019). Another protective factor may be child-mother emotional dialogues. It has been proposed that emotional dialogues between mother and child help children understand their emotions, their inner worlds, and regulate emotions. Previous studies suggested that emotional dialogues are associated with better coping mechanisms in times of high stress (Fivush, 2006; Fivush & Sales, 2006).

In addition to protective factors, another question is how mental health services are provided to children during the pandemic. Teletherapy is known to have become popular during the pandemic (Pfender, 2020). Research on child teletherapy focused on the benefits and limitations, and what changes have occurred regarding the transition to teletherapy (Burgoyne & Cohn, 2020; Shulman & Saroff,

2020). However, there is no study about the nature of therapy sessions and what techniques therapists use with children during the pandemic. On the other hand, previous studies suggested that trauma focused cognitive behavioral therapy, which focuses on creating narratives, mentalization-based therapy, and psychodynamic therapy are effective while working with traumatized children (Cohen et al., 2016; Lieberman et al., 2009; Ramires et al., 2012). Besides the effectiveness of the therapies with traumatized children, it is also important to understand the nature of the therapy sessions. Process research helps us to understand the nature of therapy sessions and how the different capacities of children relate to therapy processes. Previous research has shown that different pathologies of children and their mentalization capacities are related to their therapy process (Goodman & Athey-Lyold, 2011; Goodman, 2015; Ramires et al., 2017). On the other hand, there is no research about the nature of child teletherapy sessions during the pandemic, and how the different child-mother capacities relate to child teletherapy sessions. Therefore, the first aim of this study is to investigate the nature of child teletherapy sessions during the pandemic. The second aim is to examine how the mentalization and emotional dialogue capacity of child-mother is related to children's teletherapy session process.

In the following pages, the effects of the pandemic on family environment, parents and children will be discussed. Then, two important protective factors for children in the traumatic times will be given: first mentalization and the secondly emotional dialogues. The development of these protective factors, their relationship to trauma, and how they aid children cope with trauma will be discussed in depth. After that, child teletherapy during the pandemic as well as previous research about therapies during traumatic times will be reviewed. Lastly, because this study is based on therapy process research, the literature about psychodynamic process research will be reviewed in depth.

1.1 COVID-19, QUARENTINEE AND MENTAL HEALTH

1.1.1 COVID-19 and Quarantine's Effects on Family Environment, Parents and Children in the World

COVID-19, a new virus, first appeared in Wuhan, China, at the end of 2019 and quickly has spread throughout the world. In March 2020, the World Health Organization declared this phenomenon as a global pandemic. There are currently 164, 285, 632 million cases announced by the World Health Organization (WHO) around the world. (WHO, 2021). To avoid the spread of Coronavirus, most countries agreed to implement quarantine procedures starting from March 2020. Schools and workplaces were closed down, and people began to remain at home. Even though Covid-19 poses a physical danger to people's health, people's routines were disrupted by the quarantine and social isolation phase, resulting in a great deal of psychological stress and difficulty for people (Brooks et al., 2020). As a result, this raises the question of mental health during COVID-19. Gruber and colleagues (2020) discussed three dimensions of COVID-19 that affect mental health. The first is that the virus has no end date and will continue to exist in our lives for a long time. Second, it is a stressor with several dimensions. This means that it affects both individual and family lives, as well as economic and educational systems. Finally, they emphasized the lack of protective factors for mental health such as social interactions and behavioral activation, because of the quarantine process. All in all, studies conducted at the beginning of the pandemic with adult population revealed that rate of mental disorders has been rising, and people have been exhibiting symptoms of depression, anxiety, and post-traumatic stress disorder (Pérez-Fuentes., 2020; Kumar & Nayar, 2020; Canet-Juric et al., 2020; Tso & Park, 2020). Besides the adult population, children are also one of the vulnerable groups during the pandemic. They have had to deal with a variety of stressors such as school closures, disruption in daily routines, and lack of face-to-face interaction with classmates, teachers, and loved ones (Dalton et al., 2020). Therefore, the effects of COVID-19 on children will be explored in-depth in the following sections.

Quarantine has kept all family members at home and parents have become more important figures for children in these stressful times. After a month of quarantine, an Italian study was conducted with 854 parents to determine what the risk and protective factors were for children. It was proposed that quarantine's influence on children's wellbeing is intervened by the stress level of parents and parent-child dyads. In other words, as the parent's perceived individual and dyad's stress level increase, children's emotional and behavioral problems increase (Spinelli et al., 2020). Therefore, it is crucial to observe how the family environment and parents have been influenced by Covid-19 to deeply comprehend the children's experiences during the pandemic.

Since schools were closed, parents had to take on different roles at home, such as helping their children's home-schooling process like a teacher, caregivers, domestic workers, as well as working remotely. Aside from these various roles, parents also had economic concerns, such as the fear of losing their jobs or having their income reduced (Wang et al., 2020b; Cluver et al., 2020). Although parents spent more time with their children, different roles and concerns mentioned above caused an increase in parent's stress level and reduced their well-being (Daks et al., 2020; Gassman-Pines et al., 2020).

Moreover, even if the quarantine motto was "stay safe at home", not all homes were safe environments (Bradbury-Jones & Isham, 2020). Due to lockdowns, victims and offenders had to stay at home, posing a risk to family violence (domestic, children, spouse, animal) (Campbell, 2020; van Gelder et al., 2020). It was found that increased unemployment rates, alcohol consumption at home, and being at home all the time without social interaction were common risks for domestic violence during the Covid-19 period (Xue et al., 2020). Reports from all over the world have also shown that the rates of domestic and partner violence have increased significantly during times of quarantine due to these risk factors (Usher et al., 2020, Peterman & O'Donnell, 2020).

As a result of the above, it can be inferred that some children were not safe in these violent family environments during the pandemic. Pereda and Díaz-Faes (2020) addressed the risk factors of family violence against children during the

pandemic. At the microsystem level, they suggested that increased parental distress, uncertainty about the future and loss of income, alcohol consumption at home, partner violence among parents could cause child abuse and neglect. At the social level, they drew attention to the decline in the number of child abuse reports because of children's inability to access to schools and social services, and fewer chances of detecting child abuse cases. At the cultural level, they pointed out children's rights were neglected during the pandemic, arguing that pandemic preventions were centered on adult rights. According to Roje Dapic et al. (2020), despite of a raise in a global scale in child abuse during the quarantine, rates of reporting cases have decreased due to school closures.

Although not all family environments were risky for children as mentioned above, the daily routine of all children has suddenly changed as a result of school closures. The way children learn and the atmosphere in which they learn have changed. Peer interactions were severely restricted (Wang et al., 2020). School closures have become another risk factor for children's psychological well-being during the pandemic. Lee (2020) proposed that schools are protective places for children's mental health by providing children with routines and emotional coping mechanisms and closing schools to reduce the spread of pandemic may cause long-term mental health difficulties. The longitudinal study with primary school children in China supported this idea. Longitudinal research of 1333 primary school children was conducted by Zhang and colleagues (2020). They collected the data at two time points: the first point on November 19th and the second point after three months of quarantine in May 2020. They found an increase in the prevalence of mental health problems such as depression, non-suicidal self-injury, a suicide plan, and attempts.

To summarize, while quarantine procedures have aided in the reduction of virus transmission, they have also posed numerous challenges for families, parents, and children. Children faced direct risk factors such as school closures, social isolation, and indirect risk factors such as parent's distress, family violence, abusive home environment for their mental health (Courtney et al., 2020). So, all

these changes have had an impact on children's mental health, as shown by research conducted with children during the pandemic, some of which will be addressed later.

Research conducted at the beginning of the pandemic in China showed that lockdown and quarantine processes caused children to feel uncertain, anxious, and emotional, and behavioral problems occurred. While younger children became more dependent on parents, older children struggled with attention and anger problems. (Jiao et al., 2020). Moreover, Duan and colleagues (2020) made a cross-sectional study with 359 children and 3254 adolescents during quarantine, and they found that 23.87% of children had anxiety symptoms. In addition, a study was conducted in Spain with 228 children to understand children's representations and emotions about coronavirus. It has been found that children perceive coronavirus as a bad enemy that must be defeated, and they expressed emotions of anger, boredom, sadness, guilt, and loneliness. (Idoiaga et al.,2020). Even though the degree of symptoms varied by risk and protective factors, high rates of depression, anxiety, and post-traumatic stress symptoms were found among children according to a review article that included 52 studies on children's mental health during the pandemic. (Marques de Miranda et al., 2020). Moreover, in a longitudinal study conducted in the UK, researchers assessed the mental health of 168 children before the pandemic and during the pandemic. They found a significant raise in depressive symptoms (Bignardi et al., 2020). Lastly, Leeb and colleagues (2020) compared the rates of mental health applications of children to emergency departments between the years 2019-2020. They found that applications to mental health services have increased more from April to October in 2020 compared to the same period in 2019.

In contrast to these results, Bruining et al. (2020) highlighted another side of the pandemic's effects on children's mental health. Based on clinical observations, they proposed that increased family interaction and lower levels of daily stress related to school, work, etc. may have caused a reduce on some of the children's mental health problems. Moreover, Dvorsky et al. (2020) also addressed the pandemic as an opportunity for children to develop some resilience

skills. They stressed that while the pandemic brought new challenges to our lives, it also provided us with new ways of interacting with each other and new opportunities for our lives. They noted that this quarantine time provided a space in which children and youth explore new talents and hobbies, and this may contribute to children's wellbeing.

1.1.2 Covid 19: The Situation of Turkish Families and Children

In Turkey, restrictions such as school closures, social distance, transportation restrictions, and quarantine procedures were used to prevent the spread of the Covid-19 (Ministry of the Interior, 2020a). Children began homeschooling, and the majority of parents began working from home.

In Turkey, as in the rest of the world, research has tried to understand how COVID-19 and the quarantine process have an impact on family and parental life. Başaran and Aksoy (2020) conducted a qualitative research with 27 parents to deeply understand the Turkish families' experiences during quarantine, and they found out two themes that are positive and negative experiences of families. Parents who had positive experiences said that they had more time for their children to play, read, and draw. Moreover, they stated that fathers were more involved in children's lives. On the other hand, parents who had negative experiences mentioned some problems such as increasing level of stress, children's increased use of technology, problems related to home-schooling, and children's behavioral problems. Furthermore, in a study involving 154 Turkish parents, parent's positive and negative emotions and their effects on children's stress levels were investigated. It was discovered that parents' negative emotions such as unhappiness, guilt, anxiety, anger have increased, and thus, these negative emotions have affected children's stress level in a negative way during quarantine time (Yalçın et al.,2020). Another study with preschool children and their mothers proposed that children had negative emotions about coronavirus, and they were the most affected by quarantine. In addition, mothers stated that they also had negative emotions such as anxiety, nervousness (Yüksek Usta &Gökcan, 2020).

Domestic abuse during quarantine was also a major problem in Turkey, in addition to increasing children's and parents' stress levels. While the Turkish Ministry of the Interior (2020b) claimed that domestic violence had decreased during the quarantine period, various non-governmental organizations claimed that domestic violence rates had increased in Turkey, as they had in other countries. Socio-Political Field Research Center (2020) published a report about domestic violence in Turkey, which found that violence against women has risen by 27.8 % during the pandemic, and 45.9 % of the participants stated that quarantine caused an increase in violence against children and women. Additionally, it was declared that whereas there were 1,804 domestic violence cases in March 2019, the number of cases was 2,493 in March 2020 in Istanbul (Erem,2020). In conclusion, not all home environments were safe in Turkey during quarantine.

Apart from domestic violence, the Istanbul Medical Chamber (2020) warned about child abuse and neglect during the pandemic in Turkey. They stated that parents' increasing stress level and children's inability to benefit from social services can cause child abuse and neglect. Moreover, Akkan (2020) discussed Covid-19's effects on children's lives from a social-political perspective, arguing that quarantine procedures would further increase inequality in children's lives, making it more difficult to identify child abuse and neglect during the pandemic. This view was supported by a study that examined the child sexual abuse reports to Antalya Child Monitoring Center in both 2019 and 2020. It was found that while there were 211 child sexual abuse cases in April-May 2019, there were 98 child sexual abuse cases in April-May 2020. It was discussed that while the risk factors for child abuse have increased during the pandemic, reports about abuses have rapidly decreased because of quarantine (Aslan et al., 2020).

All mentioned above posed a risk to mental health problems. However, at the beginning of the pandemic, research about Covid-19's effects on individuals' mental health in Turkey was primarily concentrated on the young and adult population. Doğan and Düzel (2020) examined the fear and anxiety levels of 1500 Turkish adults from seven different regions of Turkey during the pandemic. 96%

of the participants stated that they were afraid of getting infected, and 60% of them expressed that their mental health has been affected negatively as a result of this fear. It was found that fear and anxiety levels varied according to gender, education level, and employment status. In another research conducted with 1026 people aged 18-65 years old, it was found that approximately 26% of the participants showed moderate to high levels of anxiety symptoms, and 29% of the participants had moderate to high levels of hopelessness symptoms (Erdoğdu et al., 2020). Furthermore, to have a better understanding of the impact of different quarantine procedures on young people's psychological status, researchers compared Turkish and Australian young people's psychological wellbeing and mental health during pandemic since Turkey had more strict rules for young people than Australia had. They found that Turkish teenagers reported more anxiety and depressive symptoms as well as lower mental health functioning, than Australian teenagers did. (Akkaya-Kalaycı et al., 2020).

Even though there has been research on Covid-19's and quarantine's effects on the mental wellbeing of Turkey's adult population, research on the effects of Covid-19's on children's mental health is limited and still developing. The studies that assessed pandemic's influence on children's lives will be presented by the following. Şahin (2020) conducted a research with 746 students aged 7 to 18 years old to understand better how students spent their time during the quarantine. He found differences in time management skills based on gender and age. Boys spent more time online, while girls spent more time watching TV, according to the findings. In terms of age, both children and adolescents chose watching videos and playing online games over studying lessons. Another study conducted by Gençdoğan and Gülbahçe (2020) investigated sleep habits of children and adolescents during the pandemic. They found that children and adolescents had sleeping difficulties such as delayed falling asleep, prolonged sleep time, increased sleeplessness during the day. In addition to this, they reported that 99.7% of participants had sleep problems at the clinical level during the pandemic. Moreover, Evirgen et al. (2020) conducted a study to understand emotional and behavioral responses of pre-school children based on four areas, namely

regressive behaviors, opposing behaviors, play habits, and psychological well-being. They made interviews with 54 mothers who have children aged between 36-77 months. They observed that children behaved differently in all four areas during the pandemic. As reported by mothers, children had sleep problems such as sleeping late and sleeping with parents, wanting to eat more, showing oppositional-defiant behaviors, separation anxiety, a burst of anger and irritability. Additionally, children played more regressive plays and online games. Another study conducted by Çıkrıkçı (2020) examined the cognitive, emotional, and behavioral changes of first graders by interviewing 54 mothers. According to the mothers, children had attention problems and needed more parental support during lessons. Secondly, mothers reported that their children were afraid of getting infected and staying alone. Thirdly, mothers said that their children had spent more time using technology. Finally, İlbasmıs and colleagues (2021) made a research with 424 parents to determine the children's mental health status based on the parent's observation. They found an increasing level of anxiety, anger, and somatic symptoms in children.

Despite these negative impacts of the pandemic on children's mental health, Soylu (2020) emphasized on the concept of resilience during the pandemic and addressed the protective and risk factors for children. It was discussed that COVID-19 is a traumatic life event and it brings many risk factors for children's mental health such as increasing stress level of parents and decreasing amount of time spent in schools. However, it was proposed that it is essential to focus on protective factors for children's mental health such as secure attachment with caregivers, self-regulation, and cognitive capacities.

In summary, Covid-19 and quarantine procedures had affected family context, parents', and children's daily routines, and created different risk factors, as evidenced by the studies above. Adults and children were stressed by the pandemic and quarantine procedures. This affected the mental health of the children. Children had symptoms of anxiety, depression, regressive behaviors, sleep and eating disorders as a result of this stressful period, according to the studies conducted worldwide and in Turkey. Therefore, it is important, as

indicated by Soylu (2020), to concentrate on protective factors for children during these challenging times.

1.2 TWO IMPORTANT PROTECTIVE FACTORS: MENTALIZATION AND EMOTIONAL DIALOGUES DURING TRAUMATIC PERIODS

1.2.1 Mentalization: As a Protective Factor During Traumatic Times

As the studies above demonstrated, Covid-19 and the quarantine process had various effects on children and parent's mental health. So, it is crucial to pay attention to the protective factors in this process while examining how it affects mental health. Fonagy et al. (1994) addressed the importance of resilience during periods of high stress and claiming that one's mental representations about him/herself and others, and relationships have a crucial role in terms of resilience. In other words, they stressed upon both mentalization and secure attachment as a protective factor that helps people cope with stress. In addition to this, according to Fonagy et al. (2019), the ability to mentalize facilitates self-regulation, which is an important factor in times of stress and trauma, and the absence of mentalization capacity makes adaptation more difficult in stressful situations. Furthermore, Luyten and Fonagy (2019) emphasized the importance of having a secure base attachment figure who can provide marked mirroring about what is traumatic and overwhelming for the person during stressful times. This allows the person to make sense of what happened and begin to mentalize. So, the secure base attachment figure who reflects the child's experiences becomes protective for the child during traumatic times.

In brief, mentalization and secure attachment can be considered as important protective factors for children's mental health during pandemic. So, the definition and development of mentalization capacity in normal development will be discussed in the following sections. Then, what happens to mentalization capacity during stressful times will be addressed.

1.2.1.1 Definition of Mentalization

Mentalization is described by Fonagy and Target (1997) as people's ability to see behaviors of others and self, considering mental states such as desires, feelings, beliefs, purposes, and reasons. Allen (2003) emphasizes on imagining, intentionality, and representation in this process. He proposed that mentalizing is an imaginary process in which mental representations are created based on the intentions of others and self. For humans, this provides a flexible and playful area. Moreover, it was suggested that mentalization enables making sense of behaviors of others and self, and that is linked to the acquisition of emotion regulation, control of impulses, and monitoring of the self (Fonagy &Target, 1997).

Mentalization is a new term that is generally confused with terms like the theory of mind, metacognition, and empathy. Mentalization differs from these concepts as following: a) the theory of mind focuses on cognitive parts of mentalization, b) metacognition is associated with cognition of the self, and c) empathy is related to other's emotional states. Mentalization, on the other hand, is a much broader and umbrella term that encompasses all these concepts (Alen et al., 2008). It has multidimensional aspects. Firstly, it can be implicit which is unconscious and non-verbal, or explicit which is a conscious, verbal, and attentional process. Secondly, mentalization can be made based on internal features such as feelings, intentions, beliefs, as well as external features such as actions. Thirdly, it is not only a cognitive but also an affective activity. Finally, mentalization can be self-oriented or other-oriented. (Fonagy et al., 2012).

1.2.1.2 Development of Mentalization

It has been suggested that mentalization is acquired in stages during normal development. Infants first experience the world physically. They learn to differentiate the self and not-self based on the physical world and they realize that their bodily self can influence the physical environment in which they are (Fonagy

et al., 2002). Furthermore, Beebe et al. (1997) discovered that babies and mothers have an impact on each other from moment to moment. As a result, babies begin to experience themselves as social beings whose communicative behavior can affect the emotions and reactions of the caregivers in the early months (Allen et al.,2008). When infants reach the age of half a year, they begin to see themselves as teleological agents which refers to that they see their own and others' behaviors as purposeful and logical. In other words, behaviors of self and others are interpreted based on actual physical realities, with no mention of mental states at this stage. However, by the age of two, toddlers begin to explain their own and others' behaviors based on prior mental states, and they start to see themselves as intentional agents, realizing that their actions have also impact on others' mind but the distinction between external and internal, or phantasy and reality is still mixed up (Allen,2006, Fonagy & Target, 1996). Around the age of four or five, children begin to perceive themselves as representational agents in which they can make attribution to different mental states and differentiate their and others' mind, inner and outer world, phantasy, and reality (Verheugt-Pleiter et al., 2008).

Although these are typical developmental sequences for acquiring mentalization, it was suggested that moving from the teleological stage to the intentional and representational stage is related to children's early relationships with caregivers, especially attachment relationships (Fonagy & Target 1997; Fonagy, 1989). It was proposed that secure attachment plays a vital role in the development of mentalization (Allen et al.,2008). Healthy mentalization capacity of the child can develop with the help of a caregiver who can observe the child's inner world and mental states, and this requires sensitive caregiving (Fonagy et al., 2002). A sensitive caregiver is the one who can understand the infant's needs, as well as the intentionality of his/her inner world, and adjusts herself according to this (Bowlby, 1969). As the caregiver approaches the child as an intentional being and organizes the child's experience by reflecting and mirroring, representations and symbolization of these experiences arise for the child. It was stated that mirroring or reflecting should not be too similar or too different from a child's experiences (Fonagy et al., 2002). In addition to sensitive parenting, Meins

(2013) identified a new construct called a "mind-mindedness" which is the mother's ability to see her infant as an intentional and mental agent and use mental states to refer to the infant's internal experiences. It was found that the mind-mindedness of the mother predicted secure attachment in infants (Meins et al.,2001).

To summarize, a child can be aware of his/her internal world through the caregiver's representations about him/herself and this is possible in secure child-mother interactions. This secure bond between child and mother enables the development of mentalization and then regulation capacities of the child (Schmeets, 2008).

1.2.1.3 Trauma, Stress, and Mentalization

As previously stated, one's mentalization capacity developed in early secure relationships and contributed to one's resilience and regulation capacities. On the other hand, according to Luyten and Fonagy (2019) traumatic and stressful life events can impair the attachment and mentalization capacities of people. Fonagy and Bateman (2019) suggested that the mentalization ability of people can be influenced by certain situations. In other words, when the stress is heightened, people regress to non-mentalization modes. These modes are called: psychic equivalence, teleological and pretend. Firstly, people in the psychic mode believe that whatever they think, feel, or believe must be indeed true. Secondly, in the teleological mode, people need observable external physical realities so that they can consider the internal state of self or others as real. Thirdly, in the pretend mode, internal realities of the one is detached from the reality (Fonagy& Bateman, 2019)

When it comes to children, it can be said that high stress and difficult life conditions also harm the mentalization capacity of children. Studies suggested that maltreatment and neglect events affect children's emotional development. In other words, these children have difficulties in understanding emotions and emotion regulation (Edwards et al., 2005; Shipman et al., 2005). The effects of

childhood trauma are not only restricted to childhood. One study found that adults with experience of childhood trauma showed insecure attachment patterns and lower mentalization capabilities in adulthood. Both insecure attachment and disrupted mentalization have a role between PTSD symptoms and childhood trauma (Huang et al., 2020). In compliance with this, there are lots of studies demonstrated that how the mentalization capacity of the child can be harmed in the context of trauma. Ensink and colleagues conducted studies with sexually abused middle-aged children. Their studies' findings demonstrated that children who had experienced sexual abuse had lower mentalization abilities than control groups. It has been found that sexual abuse is the only predictor of impairments in children's other-focused reflective functioning. When compared to non-sexually abused children, they discovered that sexually abused children had more psychopathologic symptoms. In the sexually abused children group, they found that as the children and mother's capacity to mentalize increased, dissociation and pathology decreased. Considering depression and externalizing behavior symptoms, they found that there is a negative relationship between children's mentalization capacity and depression, and externalizing behavior symptoms. Also, there is a negative relationship between a mother's mentalization capacity and children's externalizing behavior problems (Ensink et al., 2014; Ensink, Begin, Normadin, Godbout, et al., 2016; Ensink, Begin, Normadin, Fonagy, 2016, Ensink et al., 2017). Moreover, Tessier et al. (2016) revealed that sexual abuse history caused difficulties in children's play capacity which is also negatively affected by their reflective function three years later. They argued that sexual abuse has a negative influence on children's mentalization ability because of the decreased capacity of play in which mental states are explored.

As a result of these findings, it is clear that traumatic and stressful life experiences have an effect on children's mentalization ability and lead to mentalization deficits. Moreover, these studies showed that these mentalization deficits have a crucial role in the existence of the pathology.

1.2.1.4 Mentalization, Attachment, Covid

The studies discussed above mostly examined the mentalization capacity of children in circumstances of sexual abuse and found that traumatic experiences harmed mentalization capacity, resulting in pathology. COVID-19, on the other hand, is now thought to be a multidimensional stressor and traumatic life event. Therefore, it will be important to address what is happening in mentalization and attachment in the context of COVID-19 stress.

Steele (2020) suggested that the basic fear of human life is the fear of death, the fear of losing loved ones. He argued that COVID-19 also triggers fears of extinction among people. He thought that with this triggered fear, people could act irrationally, impulsively, and aggressively. Therefore, he stressed the importance of secure attachment in people's lives as well as healthy mentalization capacity. He suggested that secure attachment and mentalization would help people in thinking carefully and regulating intense emotions.

Similar to Steele (2020), Lassri and Desantik (2020) discussed the mentalization capacity of people during Covid-19. They mentioned that the quarantine process and social isolation, as well as the economic problems and other stressors, generate a highly stressful environment for people. In addition to these, the quarantine process has caused to loss of old habits such as socializing with loved ones, engaging in sports, and traveling, and it has become more difficult to regulate emotions. As a result of these, they observed a group of patients who, in normal times, have a higher and more balanced mentalizing capacity, but struggle to do so during the pandemic. Based on clinical observations, they proposed that the increased stress caused by coronavirus caused breakdowns in the mentalization capacity of people, and these impairments in mentalization capacity caused to increase the rates of domestic and family violence and psychopathology. They concluded this discussion with stressing the mentalization-based approaches to help people regain mentalization capacities during this stressful process.

In compliance with this view, Bate, and Malberg (2020) also addressed the mentalization capacity during COVID-19 from the view of children, families, and clinicians. They stated closure of schools and staying at home caused stress for children while increasing the burden on parents. In addition to these, mental health clinicians have been exposed to the same stress factors as the parents and children have been. Therefore, they suggested that not only children and families, but also clinicians, exhibited non-mentalization modes as a result of pandemic-related fear, stress, and anxiety. They emphasized the importance of having a mentalizing stance, especially during the pandemic to help people to recover their mentalization capacity. Specifically, they recommended that clinicians make use of mentalization-based techniques in their treatment models while working with children and families. They believed that mentalization-based techniques would provide a space in which emotions could be contained. These techniques would help people for emotion regulation and regaining mentalization.

Lastly, Ventura Wurman et al. (2020) addressed the situation of people with a borderline personality disorder to show examples of mentalization-based treatment during the pandemic. They suggested that people with BPD experienced increasing feelings of helplessness, abandonment, and relationship problems. The authors gave clinical vignettes from sessions with BPD patients, demonstrating how mentalization was impaired and how different non-mentalization modes such as teleological, physic equivalence were observed in these patients. As the importance of mentalization-based techniques in high-stress times was previously mentioned above, the authors also suggested that clinicians should implement these techniques, that help emotion regulation and help to reestablish mentalizing, in their treatment.

1.2.2 Emotional Dialogues

As mentioned earlier, mentalization and regulation of intense emotions are believed to be important and protective factors in the sense of trauma. Different researchers emphasized the importance of regaining mentalization capacity during

COVID-19. In addition, Prout et al. (2020) discovered that people who have more adaptive emotion regulation capacities are less likely to have psychiatric symptoms related to pandemic distress. Emotion regulation is a process of organizing emotions in a more adaptive way (Gross, 1999). It is known that children improve emotion regulation capacities in early attachment relationships (Bowlby,1973). Moreover, children-caregiver dialogues aid in the constitution of emotional representations in children, as well as their ability to regulate their emotions (Thompson & Meyer,2007). As a result, children-mother emotional dialogues can be an important protective factor in the times of COVID-19 through helping children in emotion regulation. In the following parts, emotional dialogues between the child and the mother will be addressed in detail.

Fivush et al. (2006) suggested that mother-child dialogues are important in terms of contributing to the development of acquiring the mind, mental states, emotions, and self in children. Fivush (2006) also examined the mother's style of talking about memories and how it affects children's self-understanding and regulation. She offered that autobiographical memory of children and understanding of the self were constituted through mother-child dialogues. She claimed that those mothers who engage in elaborated, and emotionally focused dialogues have children who can regulate themselves better. She also stressed high stressful life events and addressed how children are lack of the ability to create coherent narratives of stressful life events and thus, children need the help of their parents. Mothers may be able to assist children in dealing with traumatic experiences by assisting them in creating coherent stories about those experiences (Fivush 2006).

Moreover, emotional dialogues cannot be considered separate from the attachment relationship between child and mother. Researchers discovered a relationship between emotional dialogues and the attachment styles of children. It was found that there are differences in the stories of securely and insecurely attached children in terms of elaboration, coherence, positive and negative emotions. It was suggested that while securely attached children can create more elaborated, coherent stories in which both positive and negative emotions can be

talked, insecurely attached children can create less elaborated and incoherent stories (Etzion-Carasso & Oppenheim, 2000; Fivush & Vasudeva, 2002). In line with these studies, Oppenheim et al. (2007) also investigated the relationship between the attachment security of one-year-old children and the emotional dialogues of the child-mother at the age of 4.5 and 7. In this study, attachment security was assessed with the Strange Situation procedure. Emotional dialogues were evaluated with Autobiographical Emotional Event Dialogues in which emotional dialogues can be categorized as emotionally matched and unmatched. Emotionally matched dialogues refer to dialogues that are elaborated, coherent, and include positive and negative emotions whereas emotionally unmatched dialogues refer to dialogues that are incoherent, less elaborated and include less emotions. As expected, they found that securely attached children tend to have emotionally matched dialogues at the age of 4.5 and 7, on the other hand insecurely attached children tend to have unmatched dialogues with their mothers.

Moreover, Oppenheim and Koren-Karie (2009) discussed how emotional dialogues can be a secure base for children. They proposed that while non-verbal emotional cues are more important for attachment security in infancy, verbal communication becomes important as children learn to speak. They asserted that as the children grow up, mother-child dialogues would provide a safe environment for children to explore their inner experiences and emotions. They claimed that children can feel safe and easily discover their inner world with a mother who structures, assists, and helps elaboration in verbal communication.

1.2.2.1 Emotional Dialogues and Trauma

As previously stated, mother-child dialogues are important for understanding emotions, self-development, and emotion regulation in children. Traumatic life experiences, on the other hand, are thought to influence mother-child conversations. Overbeek et al. (2019) examined the emotional dialogues of traumatized dyads and non-traumatized dyads in terms of content, quality of interaction, and coherence of the stories. The mean of the mother and child

subscales in AEED was used to calculate "mother responsive guidance" and "child cooperation and exploration" scores in this study. They found that mothers were less sensitive, and children were less cooperative in traumatized dyads than non-traumatized dyads were. Also, traumatized child-mother dyads generated less coherent stories. Furthermore, Visser et al., (2016) researched for the differences between emotional dialogues of child-mother dyads who were exposed to intrafamilial violence and those who were not exposed, in terms of emotionally matched and unmatched dialogues and quality. They found that intrafamilial violence made mother-child dialogues less qualified, similar to unmatched dialogues. In compliance with this, another study examined the quality of emotional dialogues of sexually abused children. This study also showed that sexually abused children and their mothers created more emotionally unmatched dialogues, specifically flat and excessive dialogues, than the control group did. As the previous studies have revealed that mothers of sexually abused children scored less on “maternal sensitivity and guidance” and sexually abused children scored lower on “child cooperation and exploration” than the control group did. (van Delft et al., 2018). These studies highlighted the impact of trauma on emotional dialogues.

1.2.2.2 Emotional Dialogues and Coping Mechanisms

As mentioned above, traumatic experiences negatively affect emotional dialogues. On the other hand, emotional dialogues are very important in terms of emotions and self-development as well as emotion regulation. Therefore, emotional dialogues can help children cope with strong emotions during stressful events. Different studies have shown that emotional dialogues can contribute to the children’s coping mechanisms. These studies will be reviewed.

Firstly, Sales et al. (2003) examined how mothers differ in talking about positive and negative events with children. They found that while mothers asked more close-ended questions and focused more on emotions in talking about positive events, mothers asked more open-ended questions and focused on causal

interpretations in talking negative events. It has also been suggested that different contexts such as structured (storytelling) versus unstructured (free play) also have an impact on mothers' dialogues with their children (Beeghly et al., 1986; Kuersten-Hogan & McHale, 2000). It has been proposed that maternal language changes with the demands of different contexts. So, Sales et al. (2003) concluded that parent could have different purposes in different contexts and mothers and children's dialogues about stressful life events may help children to create coherent stories. In compliance with this suggestion of Sales et al. (2003), studies have shown that emotional dialogues can aid children's well-being during stressful life events. To begin, Sales and Fivush (2005) conducted a study with 27 child-mother pairs in which mothers and children were asked to discuss every day and life-threatening memories related to their children's asthma. Researchers sought to understand how variations in discourse contributed to children's mental health and how these dialogues differed between two cases. They looked at factual, emotional, exploratory, and coping elements in mother-child dialogues and coded them according to content. They found that mother-child dialogues differed in terms of the chronic stressor and life-threatening events. It was found that there was a negative relationship between mothers' elaborated and emotionally focused dialogues about chronic stressors and children's behavioral problems. Secondly, Fivush and Sales (2006) conducted another research with 27 child-mother dyads, in which mothers and children were asked to tell two stories about asthma; one about emergency and the other about the conflict of dyad related to asthma. They investigated the relationship among mothers' attachment, coping styles, and emotional dialogues, as well as children's coping strategies. They found that when mothers had effective coping mechanisms, they were able to create more elaborated and emotionally focused dialogues, and their children showed better coping strategies. Another study conducted by Gentzler et al., (2005) investigated the relationship between parent-child emotional communication and children's coping strategies in middle childhood. Parent-child emotional communication was assessed using parent and child reports and their conversation about children's negative emotion, and children's coping strategies was acquired through parent

reports. The study's results revealed that children used effective coping strategies when their parents engaged in positive and helpful conversations with them. Moreover, Ellis and Alisic (2013) found that maternal emotional coaching, which refers to a mother's ability to accept a child's emotions and provide new ways of coping with negative emotions, was positively associated with emotion regulation of maltreated preschool children.

In summary, studies have shown that emotional dialogues can help children cope with adversity. As a result, mother-child dialogues could be beneficial to children during stressful life events such as a global pandemic although this has yet to be studied.

1.2.2.3 Mental State Talk in Emotional Dialogues

Emotional dialogues between mother and child help us to understand the dyad's capacity of discussing various emotions. Moreover, it provides an opportunity to evaluate the mental state talk capacity of the dyad. Mental state talk is one of the strategies for evaluating mentalization capacity. Although it is not same as the mentalization, it is a good indicator of explicit mentalization capacity (Fonagy et al., 1998). Mental state talk aids in the examination of different mental state words such as emotion (e.g., happy, angry), cognition (e.g., think), perception (e.g., see), physiological (e.g., hungry), and action-based (e.g., play) based on narratives (Bekar et al., 2014).

As previously mentioned, mothers' mentalization stance toward their children is one of the important protective factors for children's mental health. Different studies have demonstrated that a mother's mentalization capacity is related to attachment security, mentalization ability and self-regulation capacity of the child. (Sharp & Fonagy, 2008; Arnott & Meins, 2007; Meins et al., 2001; Fonagy et al., 1991). Some studies explore the significance and protective role of maternal mental state talk in children's mental health. Firstly, mothers' mental state talk is positively correlated with children's theory of mind understanding in various studies (Ruffman et al., 2002; Adrian et al., 2005). Moreover, Brophy-

Herb et al. (2015) suggested that maternal emotional talk can be a protective factor for toddlers with behavioral problems in high-risk conditions. In their research with 89 toddlers and mothers from low-income families, they asked mothers to talk to their children about non-verbal pictures, and then they coded narratives based on emotion, cognition, and desire words. In this study, they focused on the emotional mental talk of mothers which is described as their ability to name emotions and relate emotions to toddlers' experiences. It has been found that toddlers were mostly helped by their mother's emotional mental state talks. While the previous study only focused on emotional mental state talk, Bekar et al. (2018) examined the relationship between maternal mental state talk and children's social-behavioral development in the high-risk pre-school population. In their study, they coded the mother's mental state talk about wordless pictures based on types (emotion, cognition, perception., etc), direction (self-character-other), and causality. They found that mothers of children in the clinic group used less emotion and especially negative emotion words than the non-clinic group did. As for the different aspects of mental state words, they revealed that there is a positive relationship between the use of cognitive mental state words about children and causality in mental states, and social competence of the children. On the other hand, there is a negative association between the use of perception mental state words about children and the social competence of the children. Lastly, the mother's use of self-oriented mental state words is positively related to children's play interaction. In addition to these findings, Carr et al. (2018) proposed that the mental state talk of mother, specifically cognitive mental state words at age of three is associated with less externalizing problems when children are 10 years old. Moreover, mothers' emotional mental state talk is positively linked with children's prosocial behavior when they are 10 years old.

Besides maternal mental state talk and its protective role in children's mental health, it is also crucial to examine the mental state talk of children. It is suggested that mental state talk is important because children learn self and other understanding in the contexts of mental state talk used (Symons, 2004). In addition to self and other understanding, the use of mental state talk in dyadic play with

friends was positively linked to success on theory mind and emotion comprehension tasks (Hughes & Dunn, 1998). Furthermore, Pinto and friends (2017) have made cluster analysis of children's mental states. They found that children's mental state talk was divided into two clusters. One of them is perceptual mental state talk which emerges in action-based narratives and includes mental state words that define the relationship between characters and the world. Another cluster is affective mental state talk which occurs in emotion-centered narratives and encompasses mental state words that describe a character's internal states and their relationship with behaviors. They argued that the second cluster of mental state talk could be seen as superior because behavior is linked to internal states such as emotions and cognitions at this level (Pinto et al., 2017). Moreover, mental state talk of children is protective against behavioral problems. Children's externalizing behaviors begin to decrease, as their total use of mental state talk increases (Carr et al., 2018). On the other hand, behavioral problems of children are associated with mentalization deficits of children. Halfon et al. (2020) examined the mental state talk of children with internalizing and externalizing problems. It has been found that children with internalizing problems have mentalization imbalances in which they focus more on others than themselves and use less emotion mental state words. However, children with externalizing problems and adverse experiences have impaired mentalization capacities in which they make hostile and bizarre attributions to others.

1.3 PSYCHOTHERAPY WITH CHILDREN

1.3.1 Child Tele mental Health During Covid-19

So far, it has been shown by the research that COVID reveals different stress factors for both children and parents, and this period is traumatic. The mental health needs of people have increased. At this point, it will be important to discuss how therapies are done with children during COVID-19.

Covid-19 pandemic has been affecting mental health services, and online psychotherapy/teletherapy has been widely used during pandemic (Prefender, 2020). This situation poses different challenges for psychotherapy. Ronen-Setter and Cohen (2020) shared their tele-mental health observations during Covid-19 and proposed that Covid-19 could affect clients, therapists, and their relationship with each other. They argued that sudden change in the normal life and therapy setting revealed issues of losing control and coping with unknown situations for clients. On the other hand, they mentioned that therapists experienced the same traumatic life situations as their clients, and this was a difficult situation for therapists as well. They described this situation "shared traumatic reality" (Ronen-Setter &Cohen, 2020, p. 266). It was discussed that this "shared traumatic reality" could influence therapists in two ways. On one hand, therapists may have felt satisfied by assisting patients during this challenging period. On the other hand, since therapists were in the same position, they may have felt frustrated and avoided the material that patients brought to the sessions. In terms of the therapeutic relationship, they mentioned that the therapy relationship has turned into a more symmetric relationship in which both the therapist and the client share the same experience. Finally, they mentioned that because of Covid-19, therapists were required to alter clinical settings quickly, which may have made the therapist feel unsettled.

Despite of the difficulties mentioned above, previous studies on tele-mental health services claimed to be as effective as traditional treatments in all age groups (Hilty et al., 2013; Gloff et al.,2015). However, there is no evidence-based research about tele-mental health services with children during Covid-19, but articles are based on the authors' experiences.

Burgoyne and Cohn (2020) discussed their experiences with teletherapy in the Family Institute at Northwestern University during Covid-19. They argued that teletherapy required changes in the therapy framework. One change was the place of the therapy. Both therapists and patients had to attend the session from their homes. This has led to the therapist's privacy problem. Moreover, it was proposed that this change has made it difficult for both therapists and patients to

mentally prepare for therapy sessions. Another change in the therapy framework was time. This modification had to be implemented more in children's sessions. They noted that despite their concerns about providing children with teletherapy services, the children showed great adaptability skills in this new context. However, they stated that more adjustments should be made when working with children during teletherapy sessions. It was mentioned that parent's support was needed to provide an appropriate online therapy environment for children. Moreover, they claimed that it was difficult for children to maintain their attention in online therapy. Therefore, they observed that therapists had to come up with new strategies to involve children in sessions. Because of attention difficulties, therapists had to shorten the session times and include the parents in the sessions more than before. Furthermore, they mentioned that while working with younger children, therapists focused on reflecting emotions and thoughts about children's play, and therapists participated in the children's play with their toys on the screen. On the other hand, they suggested that Zoom's whiteboard and online video games via screen share were preferred in sessions while working with school-aged children (Burgoyne &Cohn 2020).

Furthermore, according to Shulman and Saroff (2020), teletherapy sessions eliminated the body portion of therapy, which is a vital element of psychotherapy since children often express themselves by bodily actions. They discussed how children had the chance to end the session with the click of a button and how teletherapy sessions caused the therapist to lose control. As a result, they recommended that therapists should re-examine their working practices and modify them as needed. In addition, Racine et al. (2020) addressed the issue of trauma-based interventions for maltreated children during the pandemic. They argued that due to increasing domestic and child violence, there was an urgent need to provide trauma-based therapies remotely. They supposed that online trauma treatment for maltreated children has advantages such as more accessibility and low costs. On the other hand, they discussed the limitations such as not having a stable internet connection and private space at home and therapists' difficulty in assessing and intervening in severe cases. In the end, they

defended that online trauma treatment can apply to maltreated children by taking into consideration both benefits and limits. Scharff and friends (2020) also suggested that even though working with children in online sessions was challenging, online sessions provided an opportunity to examine the family relations of children and understand the family dynamics in depth. Furthermore, MacEvilly and Brosnan (2020) discussed their experiences of how they have adapted emotion regulation and social skills group programs to the online setting. Before the pandemic, they provide face-to-face group sessions to teach children emotion regulation and social communication skills. However, they decided to change their group modality to child-parent sessions to help children in depth during the pandemic. Even if the results of their study are not published yet, they anticipated that individual sessions about emotion regulation and social skills will help children during Covid-19.

To sum up, even though teletherapy with children during Covid-19 has been widely used, articles are mostly based on clinicians' views about teletherapy in which advantages and limitations of teletherapy are discussed. These articles mostly include the therapists' experiences and their observations about the children's situation or therapy setting. There is a lack of literature regarding what specific treatment methods should be used with children in these stressful times. Therefore, it will be important to take an in-depth look at the previous research on treatment methods used with children in traumatic times.

1.3.2 Treatment of Children in the Context of Trauma

Two important protective factors for children during traumatic periods were mentioned above. These were the mother-child's capacity of mental state talk which is an indicator of explicit mentalization capacity and emotional dialogue. It was mentioned that it is important to develop these capacities in traumatic times. Firstly, it has been mentioned that emotional dialogues between mother-child are very crucial for a child's psychological development as well as coping with stress. It has been found that emotional dialogues help to create narratives in the context

of trauma. So, creating narratives is one of the important things for coping with stress in traumatic times. In compliance with this, trauma-focused cognitive behavioral therapy is one of the most used approaches in therapy studies of traumatized children.TF-CBT is an evidence-based treatment for children with a history of sexual abuse, family violence and disaster (Cohen et al.,2016). The treatment mode is divided into three stages that include child and parent individual sessions and child-parent sessions. These stages are stabilization and skill development, trauma narration and processing and consolidation. In the trauma narration and processing stage, children create detailed written and oral trauma narratives with the help of a secure base therapist. It has been proposed that creating narratives allows children to examine feelings, thoughts and make meanings of what happened. (Cohen et al. 2016). Creating a trauma narrative is an important part of this treatment model. Therefore, Deblinger et al. (2010) compared TF-CBT with the narrative part to TF-CBT with the out narrative part and examined how it affected the children's and parents' symptoms. They found that while both TF-CBT treatments caused positive outcomes, TF-CBT treatment with a narrative part specifically assisted parents in reducing trauma-specific stress and reducing trauma-related fear and general anxiety in children. In addition to this comparison, research has shown that TF-CBT helped a different group of children such as sexually abused children (Cohen et al.,2004), foster care children (Weiner et al.,2009) and refuge children (Unterhitzenberger &Rosner, 2016) to reduce PTSD symptoms and enhance their coping skills.

In addition to evidence-based TF-CBT treatment, it is suggested that mentalization is a protective factor as discussed before and enhancing mentalization capacity during the psychotherapy process helps children to function better and reduces trauma-related symptoms (Oehlman Forbes et al., 2021). In line with this, Ramires et al. (2012) reported that mentalization-based therapy with a 7-year-old boy who had been abused and lived in a shelter has been effective on reducing depressive symptoms after six months of treatment. They argued that the therapist's reflective attitude toward the child created a safe space for him to label emotions and create a narrative of his life, which helped him to

constitute a more cohesive and integrated self. Furthermore, Tessier et al. (2016) investigated the pretend play capacity of sexually abused and non-abused children, as well as its effect on the mentalization capacity of children. They discovered that the traumatic history of abused children made it difficult for them to create play narratives which subsequently harmed their capacity to mentalize toward others. As a result, they suggested that improving the mentalization capacity of children through play may be important for gaining resilience after trauma. Finally, studies on the treatment of foster care children with mentalization-based therapies have been found to be effective and applicable. When compared to other treatments such as CBT, counseling, and play therapy, it is suggested that mentalization-based therapy tends to reduce the internalization symptoms of these children (Midgley et al., 2017; Midgley et al., 2019).

Moreover, psychodynamic child therapy is also one of the treatment modalities used with traumatized children. Psychodynamic child therapies aim to improve attachment relationships, create healthy internal working models and teach affect regulation. It has been suggested that psychodynamic therapies help heal trauma symptoms by focusing on the inner world of children and attempting to explain children's symptoms with their developmental history (Lieberman et al.,2009). Various studies demonstrated that psychodynamic therapy helps reducing post-traumatic symptoms of children and adolescents (Lush et al., 1998; Trowell et al., 2002; Heede et al., 2009; Gilboa-Schechtman et al., 2010). Psychodynamic child therapy also aims to improve the children’s mentalization and affect regulation capacities as mentalization-based therapies do. It has been suggested that psychodynamic child psychotherapy helps children improve mentalization (Goodman et al., 2016; Goodman &Midgley, 2019).

On the other hand, there is limited research on the treatment of traumatized children in Turkey. Research and therapy with traumatized children mainly focused on two groups: orphans and refugee children in Turkey. Experiential play therapy (Çelik, 2017), developmental play therapy (Altun et al., 2019), child-centered play therapy (Çiftçi, 2019) were found to help reduce trauma symptoms of orphans. While these play therapies differ from each other, a common feature

has been that play therapy provides a safe space for children to express traumatic experiences. Providing a safe space for the expression of emotions through play therapy has helped children regulate their emotions. Another therapeutic intervention used in traumatized children is EMDR (eye movement desensitization and reprocessing). It was stated that this therapy technique has just begun to be used in children and it is aimed to heal children suffering from PTSD by giving bilateral stimulation while imagining trauma memory. EMDR has been found to help decrease PTSD and anxiety symptoms in children and adolescents (Karadağ et al.,2019). Furthermore, refugee children are a group of children at risk for having PTSD symptoms and studies are focusing on interventions with this group of children. Art therapy (Uğurlu et al., 2016), cognitive behavioral therapy (Görmez et al., 2017), and theraplay (Eruyar &Vostains) techniques were used with refugee children, and it has been suggested that these therapy techniques help reduce the trauma symptoms of children. To sum up, Turkish studies have shown that different play therapy approaches are widely used in the treatment of traumatized children. In addition to these, it was found that behavioral cognitive therapy, EMDR therapy, and art therapy have been found to provide good improvements in the treatment.

To conclude, previous studies with traumatized children have shown that there are various treatment modalities that are effective and help treat trauma. Besides the effectiveness of the therapies with traumatized children, it is also important to understand the nature of the therapy sessions during traumatic times. Psychodynamic process research helps us to understand the nature of therapy sessions and how the different capacities of children relate to therapy processes. Therefore, in the following section, psychodynamic research literature, especially process research, will be discussed in detail.

1.3.3 Psychodynamic Child Therapy: Effectiveness and Process Research

As mentioned above, psychodynamic therapy is one of the important therapy models while working with children with trauma. Therefore, it is

important to take an in-depth look at psychodynamic therapy research in the literature. Psychodynamic therapy research focuses on two issues. These are effectiveness/outcome and process research.

There is a growing number of studies investigating the effectiveness of child psychodynamic treatments on children and adolescents' symptoms. Three review studies are seeking an answer to the question of how effective psychodynamic treatments with children and adolescents are (Midgley & Kennedy,2011; Midgley et al.,2017; Midgley et al., 2021). Thirty-five studies were examined in the 2011 review, and twenty-five additional studies were included in 2017. In the final review, thirty-seven papers were included. It was concluded that psychodynamic therapy with children and adolescents is effective as other treatment modalities. In addition to this, psychodynamic therapies have been suggested to help younger children more than older children, and children with internalizing problems more than children with externalizing problems. Finally, it has been claimed that the effectiveness of psychodynamic therapies continues after the end of treatment (Midgley& Kennedy,2011; Midgley et al., 2017). In addition to these reviews, Abbas and colleagues (2013) conducted a meta-analysis research including eleven short-term (less than 40 sessions) psychodynamic psychotherapy sessions with children. They also claimed that STPP could be effective in different types of disorders such as anxiety, depression and borderline personality disorder.

In addition to the effectiveness of child psychodynamic psychotherapies, answers are sought about how child psychotherapies work and which components of the treatments cause change, and affect the process, as well as what the foundations of therapeutic change with particular therapeutic couples are. Research that seeks the answer to these questions is called process research. (Goodman et al., 2015). To help answer these questions, Schneider and Jones (2004) developed Child Psychotherapy Process Q Set (CPQ) based on Psychotherapy Q Set, which helps to examine the adult psychotherapy process developed by Jones (2000). CPQ consists of 100 items that aim to define and classify an entire therapy session. Items can be divided into three categories: items define child, therapist and the interaction between them. After the evaluated entire

session, coders place 100 items into nine categories with the most characteristic items on one hand and the most uncharacteristic items on the other (Schneider&Jones,2004).

In a process research setting, CPQ can be applied in two ways. The first is to examine the adherence of sessions to prototypes such as cognitive behavioral therapy (CBT), psychodynamic therapy (PDT) and the second is to search for the interaction structures. Goodman et al. (2016) conducted a study on whether it is possible to determine an ideal CBT, PDT, and RF sessions based on evaluations of 31 experts with CPQ or not. They found that ideal CBT and PDT session prototypes can be distinguished whereas RF is found to be common in both of these two prototypes. In this study, CPQ was used to determine the ingredients of prototypes of CBT, PDT and RF sessions. After that, researchers have begun investigating which types of sessions are linked to specific treatment outcomes using adherence scores. By using CPQ adherence scores, Halfon and Bulut (2017) examined the symbolic play and affect regulation and its relationship with RF adherent sessions in psychodynamic psychotherapy. They found that mentalization adherent sessions are significantly related to symbolic play and affect regulation. In high RF adherent sessions, children's affect regulation displayed a quadric trend whereas there was no important difference in affect regulation in low RF adherent sessions. Moreover, Halfon et al. (2019) investigated whether mentalization adherent sessions, expression of negative emotion in session and symbolic play had an impact on affect regulation or not. Again, they found that children expressing negative emotions in high RF adherent sessions were associated with higher affect regulation compared to low RF adherent sessions. These two studies are an example of how different prototypes are associated with different outcomes in therapy. On the other hand, another question is whether the initial abilities of children at the beginning of therapy are related to different prototypes or not. In compliance with this question, Açıl (2020) examined the children's initial mental state talk and its relationship to psychodynamic adherence scores in sessions. Total and unique positive emotional mental state words, self-oriented emotional mental state words and

psychodynamic adherence scores were found to have a significant positive relationship with psychodynamic adherence scores. Unique positive emotional mental state words, on the other hand, were found to be important predictors of psychodynamic adherence. In terms of cognition mental state talk, it has been suggested that as children used more self-oriented cognition words, their sessions became more psychodynamically adherent. Lastly, it was proposed that unique opaqueness mental state words and psychodynamic adherence scores had a significant positive relationship. In summary, using the adherence scores, it was observed that the child therapy sessions differed according to different prototypes and these prototypes affected the therapy process in different ways and that the initial capacities of children at the beginning of the therapy were related to different prototypes.

Another use of CPQ in research is interaction structures. Interaction structures can be defined as repetitive and recurring patterns that are mutually created by therapist and patient through sessions (Ablon & Jones, 2005). Interaction structures refer to clusters of CPQ items developed from factor analytic methodologies that define the course of therapy (Jones, 2000; Schneider, et al., 2010). Interaction structures have been used for different purposes in process research. It is used to understand whether interaction structures between the same therapist and two different children, or same child and two different therapists are different or not. It is used to identify interaction structures in therapy sessions of children with a different diagnosis and different mentalization capacities. These studies will be given in detail.

By using CPQ, Schneider et al. (2009) found out that different interaction structures exist in the treatment of children with the same therapist. Reversely, Goodman and Athey-Lloyd (2011) examined the interaction structures between the child with Asperger syndrome treated by two different therapists. They mentioned four interaction structures in the course of treatment. These are "Reassuring, supportive, a non-directive therapist with a compliant, curious child building insight and positive feelings", "Helpful, mentalizing, a confident therapist with expressive, comfortable, help-seeking child", "Judgmental, a

misattuned therapist with emotionally disconnected, misunderstood child" and "Accepting therapist with playful, competitive child" (Goodman&Athey-Lyold, 2011, p.317). Furthermore, in the study of borderline personality children treated by two therapists, Goodman (2015) found that four different interaction structures exist. These are "Sensitive, a non-judgmental therapist with motivated, insightful, admiring child", "Interpretive therapist with passive-aggressive child", "Humorous, confident therapist with animated, playful child", and "Structuring, accommodating therapist with difficult, angry child" (Goodman, 2015, p.149). He, again, noted that as in the previous study of Asperger children treated by two therapists, there are different interaction structures between the borderline child and two therapists. As a result, these studies have shown that interaction structures are created by both the therapist and the child, and those different pathologies can also have an impact on interaction structures during sessions. Apart from these studies, there are various single case studies examining interaction structures with different profiles such as disruptive mood regulation disorder (Ramires et al., 2017) and adjustment disorder (Schmidt et al., 2018).

Another question is which interaction structure between therapist and child may contribute to children's symptoms at the end of the therapy. Halfon et al. (2018) investigated interaction structures in psychodynamic therapy and their relationship to outcome symptoms with children who have externalizing and internalizing problems. They found four IS namely "Therapeutic Alliance", "Children's Emotion Expression", "Child-Centered Technique", "Psychodynamic Technique" (Halfon et al., 2018, p.7). They stated that IS four named "Psychodynamic Technique" has a significant increase through treatment and only "Psychodynamic Treatment" predicts the changes in behavioral problems. It was found that items such as the therapist's interpretation of unconscious desires, explaining defenses, interpreting children's play, emphasizing emotions and making connections with the behaviors of these children loaded on the "Psychodynamic Technique" interaction structure.

Lastly, another question is that whether children's initial mentalization capacity is associated with different interaction structures or not. Ramires et al.

(2020) sought to answer this question. In their study, they included three children with different mentalization capacities, namely "able to mentalize", "mentalization impairments" and "significant mentalization impairments". They found that the process of a child capable of mentalization looked like psychodynamic psychotherapy. IS named “attuned and interpretive therapist with active, expressive and demanding child” showed an increasing trend in the treatment of this child. On the other hand, the IS named “directive and didactic therapist with a child aware of difficulties” becomes dominant in the treatment of the child with mentalization disturbances. It is suggested that this CBT style of the therapist might help the child with impaired mentalization capacity. Lastly, the IS named “active, confident and lively child competing with a reflective therapist” becomes dominant in the treatment of the child with significant mentalization impairments. They discussed that therapist’s mentalization-based techniques might help with children's significant impairment mentalization. They concluded that the mentalization capacity of the child is an important factor that affects the therapeutic process.

To summarize, the interaction structures in the therapy sessions help to have a better understanding of the child therapy process. It has been observed that not only the therapists but also the children contribute to the therapy process. It showed that the different profiles or pathologies of the children are important and may be related to the therapy processes. Finally, it was revealed that children's capacities, such as mentalization, are also associated with different interaction structures in sessions.

1.4 CURRENT STUDY

As discussed above, quarantine and COVID-19 have affected people's lives. The family environment, daily routines of parents and children were affected by quarantine. It has been discussed that quarantine puts a lot of stress factors on people’s lives, and studies showed that all these caused mental health problems in both adults and children. Studies both worldwide and in Turkey showed that

because of this stressful time, children had symptoms of anxiety, depression, regressive behaviors, sleep and eating problems. Therefore, it has been suggested that it is important to focus on protective factors in these stressful times.

As mentioned in the literature review section, emotional dialogues and mental state talk capacity of child-mother pairs were found to be a protective factor in children's mental health. It was emphasized that it was important to improve these capacities during traumatic times. Moreover, research has shown that teletherapy has been widely used during COVID-19, but the nature of therapies was only observed in the therapist's clinical sessions. No studies have been conducted investigating children's teletherapy sessions during COVID-19. In addition, previous studies investigating the therapy process have shown that the child's initial mental state talk capacity is related to the therapy process. However, the mental state talk capacity of the child-mother couples and their relationship with the child psychotherapy process have not been investigated during COVID-19. Lastly, emotional dialogues of child-mother pairs were also found to be protective during stressful and traumatic times. Again, these capacities of child-mother pairs during COVID-19 and its relation to therapy sessions have not yet been studied.

Therefore, the first aim of this study was to examine the nature of child teletherapy sessions during COVID-19. In the therapy sessions, it would be expected to find different interaction patterns. Based on previous research (e.g., Halfon et al.,2018 and Ramires et al., 2017), we expect that 1) interaction structures that reflect the psychodynamic therapy process and children's emotional expression would be found. The second aim of this study was to examine the relationship between different mental state talk capacities of mother-child and interaction structures. Based on the previous study of Açıl (2019) 2) we hypothesize that child-mother dyads' use of emotional mental state talk would be positively associated with the interaction structure that defines psychodynamic features. 3) We hypothesize that child-mother dyads' use of cognitive mental state talk would be positively associated with interaction structures that define psychodynamic features. The third aim of this study was to examine the relationship between different qualities of child-mother emotional dialogues and

interaction structures, and to examine the mean rank differences of interaction structures between different AEED categories. 4) We hypothesize those different qualities of child-mother emotional dialogues would be correlated with interaction structures. 5) There would be mean rank differences of interaction structures between different AEED categories.

CHAPTER 2

METHOD

2.1 DATA

The data of this study was gathered from the Psychotherapy Research Laboratory at Istanbul Bilgi University. The research lab aims to conduct studies on psychodynamic psychotherapy sessions. This laboratory's research is carried out at Istanbul Bilgi University Psychological Counseling Center, where low-cost outpatient psychotherapy with a psychodynamic focus is provided. Psychotherapies are carried out by master's degree clinical psychology students who are in their second or third year of study. Patients are referred by parents, school teachers, or mental health and medical professionals. A licensed clinical psychologist conducts interviews with parents and children to determine the reason for their referral, to assess the inclusion requirements. The following guidelines are used to decide on inclusion: 3-11 years old, no severe developmental delays, no psychotic symptoms, no substance abuse, and no significant risk of suicide attempts. Moreover, parents are given information about the research study and get informed consent forms from those who agree to participate in the study. Parents are told that this is a volunteer-based research project, and they have the option to participate or not. If they agree to participate in the study, they are asked if they give consent to audio or video recording for the sessions. As this study examined teletherapy sessions during Covid-19, additional consent was obtained from parents for this study before online sessions began. The ethics committee at Istanbul Bilgi University approved the study from which the data came.

2.2 PARTICIPANTS

Participants were 21 mother-child dyads who gave consent to participate in the study. Ages of children ranged from 5 to 10 years old (M = 6.9, SD = 1.26).

Considering mothers, ages of mothers varied between 30-47 years old (M = 37.3, SD = 5.37). Demographic characteristics of participants were given in Table 2.1 detailly.

Table 2. 1

Demographic Information of Participants

Categories		**Frequency (N)**	**Valid Percentages (%)**
Children's Age	5-7 years old	15	71,4
	8-10 years old	6	28,6
Children's Gender	Female	8	38,1
	Male	13	61,9
Children's Education Level	Preschool	2	9,5
	Elementary School	18	85,7
	Middle School	1	4,8
Reason of Referral	Anxiety Problems	8	38,1
	Behavioral Problems	7	33,3
	Learning-School Related Problems	3	14,3
	Adjustment Problems	1	4,8
	Relationship Problems	1	4,8
	Loss	1	4,8
Sibling	No Sibling	4	19
	1 Sibling	15	71,4
	2 Siblings	1	4,8
Mother's Age	30-40 Years Old	13	65
	40-47 Years Old	7	35

Mother's Education Level	Elementary School	2	10
	Middle School	3	15
	High School	6	30
	University (2 Years)	1	5
	University (4 Years)	8	40
Mother's Working Status	Working	11	52,4
	Not Working	10	47,6
Marital Status	Married	16	76,2
	Divorced/Other	5	23,8
Socioeconomic Level	Low	2	9,5
	Low-Middle	3	14,3
	Middle	12	57,1
	Middle-High	4	19

Note: N=21

2.3 THERAPISTS

The therapists were 17 clinical psychology master students who were in their internship year. There were 14 female (82.4%) and 3 male (27.6%) therapists. The age of the therapists ranged from 24 and 37 (M = 26.76, SD = 2.89). They all received the same training which is based on psychodynamic play therapy with mentalization principles. All therapists received 3 hours of group supervision per week during their first year of internship, as well as 1 hour of individual supervision, if they continue their second-year internship. The supervisions were carried out by licensed therapists with at least 10 years of experience.

2.4 THERAPY SESSIONS

Before the therapy sessions start, therapists arranged seven evaluation sessions with the child and parents to assess the child's clinical situation and needs.

These sessions include intake sessions with parents, Parental Development Interview (Aber et. al., 1985) with each parent, parent-child dyadic and free play sessions with each parent, a free play session with an only child and feedback session with parents. Before feedback sessions, the therapist makes clinical formulation about the child and decided on the treatment plan, and s/he shares these observations and the treatment plan with parents. Therapy sessions are conducted with a child at least once a week and with parents at least once a month. Although therapy sessions are not manualized, psychodynamic child therapy with the mentalization principle's view is followed by therapists. In this view, therapists encourage children to express their feelings through play, make interpretations about play and label emotions of child and characters.

In this study, 17 children started therapy with the traditional method and then switched to online sessions due to COVID-19, while four children began treatment directly online with the same assessment procedures. Before the sessions started, the parents were informed about teletherapy, and the suitability of the home environment for teletherapy such as internet access and a private room for the session was evaluated. The therapists and parents decided together where the sessions would take place. Zoom, Skype, or WhatsApp platforms were preferred for the sessions. The therapists, together with their supervisors, made the necessary adjustments to the online therapy session for each patient. Where necessary, therapists have made changes in the therapy framework and the form of treatment to ensure that the patient can benefit from the teletherapy sessions. For example, if needed, the time of therapy sessions was shortened, parents were included in sessions, and mother-child and father-child sessions were hold based on Watch, Wait, Wonder technique. Other than necessary adjustments, all therapy sessions were made based on psychodynamic therapy with mentalization principles.

2.5 MEASURES

2.5.1 Mothers Measures

2.5.1.1 Background information

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

2.5.1.2 Exposure to COVID-19 pandemic

The exposure levels of mothers and children to the COVİD-19 pandemic were obtained from a questionnaire filled out by mothers. In this questionnaire, mothers were asked questions such as how many days the family has been in quarantine, how much they felt the risk of getting infected by coronavirus, whether they or their loved ones got coronavirus or not, how coronavirus affected their physical and psychological health, job, and financial situation, and how mothers take precautions regarding coronavirus.

2.5.1.3 The Impacts of Event Scale-Revised (IES-R-Weiss and Marmar, 1997)

The Impacts of Event Scale-Revised was developed by Weiss and Marmar (1997) based on the Impacts of Event Scale (Horowitz et al., 1979). It is a short self-report consisting of 22 items. It aims to evaluate the symptomatic responses to the specific traumatic event. Participants are expected to answer questions assessing the degree of symptoms in the previous 7 days. Items are rated on a 5 Likert scale ranging from 0 (not at all) to 4 (extremely). It has three subscales which include items related to intrusion, avoidance, and hyperarousal. Items about intrusion include questions such as “Any reminder brought back feelings about it, I had dreams about it”. Items about avoidance consist of question such as “I avoided letting myself get upset when I thought about it or was reminded of it, I felt as if it

had not happened or was not real". Lastly, items about hyperarousal include questions such as "I felt irritable and angry, I had trouble falling asleep". Statistically, it has high levels of internal consistency for all subscales; intrusion (α = .87 – .94), avoidance (α = .84 – .87) and hyperarousal (α = .79 – .91). It has high levels of test-retest reliability (r= .89 to .94). Çorapçıoğlu et al. (2006) made the Turkish adaptation study of IES-R. They found that it has high levels of internal consistency (α = 0.93) and good test-retest reliability (r = 0.70). Test-retest reliability levels are also good for intrusion (r = .69) and hyperarousal subscales (r= .63) and moderate for avoidance subscale (r= .49).

In this study, mothers were expected to answer these questions considering COVİD-19 and quarantine. The Cronbach's alpha for the total scale was .92.

2.5.2 Children Measures

2.5.2.1 Children's Revised Impact of Event Scale (CRIES-Smith et al., 2003)

Smith and colleagues (2013) developed The Children's Revised Impact of Event Scale. It is a short questionnaire aimed to evaluate children's traumatic response symptoms to a specific event. It was developed based on The Impact of Event Scale created by Horowitz et al. (1979). As the original version was used by adults, CRIES-13 was developed for children aged 8 and older. It has three subscales which are intrusion, avoidance and arousal. The intrusion subscale consists of 4 items that include questions such as "Did pictures about it pop into your mind? Did you think about it when you didn't mean to?". The avoidance subscale comprises 4 items that include questions such as "Did you try to remove it from your memory? Did you stay away from reminders of it?". Lastly, the arousal subscale consists of 5 items that include questions such as "Did you startle more easily or feel more nervous than you did before it happened? Were you more alert and watchful even when there was no obvious need to be?". Children are expected to answer these questions on the 4-point scale in which 0 is not at all, 1 is rarely, 3 is sometimes and 5 is often. The total score of the children's responses (0-65)

indicates the severity of post-traumatic stress responses on this scale. The internal consistency of the total scale (α = 0.80) is high. Moreover, internal consistency levels of subscales are moderate; intrusion (α = 0.70), avoidance (α = 0.73) and intrusion subscale (α = 0.60).

Several items from the Revised Impact of Events Scale (Yule & Dyregrov, 1995) were modified by Şahin et al. (2007). They used factor analysis and generated three Turkish subscales: arousal subscale consisted of 11 items (α = .89), avoidance subscale consisted of 7 items (α = .87) and somatization subscale consisted of 12 items (α = .79).

In this study, the Cronbach's alpha for the total scale was .72.

2.5.3 Children and Mothers Measures

2.5.3.1 Autobiographical Emotional Events Dialogues (AEED- Koren-Karie et al., 2003)

In this task, five cards were shown to the mother and child. There were five written emotions on the cards: happy, sad, angry, scared and secure. Mother and child were expected to remember a timepoint that the child felt each emotion. Then, they were expected to create a story for each emotion together. As a result, they were required to come up with five stories in which the mother and children form a story together and talk about what the child felt, thought and did during the events. The dyad could determine the order of the emotion cards and the time it takes to tell the story. The task was considered to be completed best when the child and the mother created five different stories that match the five emotions. In addition to matching stories with emotions, dyads were expected to tell coherent, detailed and fluent stories. Moreover, the stories should be developed as a dialogue in which both mother and the child contribute. However, the role of the mother and child were different in this task. The mother's role in this task was to guide and assist the child in creating adequate, matched, and coherent stories. On the other hand, the role of the child was to cooperate with the mother, elaborate the stories and show involvement in the task.

The AEED task was video-recorded and then transcribed for coding. Coding was made based on the transcription of the task. There were seven mother scales, seven child scales and two scales evaluating the narrative quality of dialogues for coding. Scales were given scores from 0 to 9 point in which higher points indicate that the structure is more common. The mother and child scales were (behaviors in the parentheses describe the expected proper behaviors of dyad): (1) Focus on the task (Mother/child focus on finishing the task. Shift of focus or irrelevant details are not seen); (2) Clear Boundaries (Mother/child behaves according to their proper roles. Mother/child relates with other as a separate individual person); (3) Acceptance and Tolerance (Mother/child approaches the ideas with acceptance and tolerance so that each person is free to express his/her own ideas); (4) Involvement and reciprocity (Mother/child show involvement in the task and cooperates with each other to create matched stories); (5) Hostility (Mother/child does not show hostility and anger toward each other during conversation); (6) Resolution/Closure of Negative Feelings (Mother/child ends negative stories positively or emphasis is placed on strengths) (7) Structuring and Elaboration of the Interaction (Mother supports and assists the child in creating rich and coherent stories and the child tells elaborated stories with no irrelevant parts).

As a result, the "maternal sensitive guidance" score consists of the mean score of all maternal scales, and the "child cooperation and exploration" score consists of the mean score of all child scales. Lastly, two scales define the narrative quality of dialogues namely, Adequacy of the Story (Mother and child create five separate stories that match with emotions that they want to describe) and Coherence of the Story *(*Mother and child create coherent, believable, fluent, and clear stories). Based on the mean score of these two scales, "emotionally coherent narrative" scores were constituted. It has been reported that good internal consistency scores .80 for the maternal sensitive guidance, .83 for the child cooperation and exploration and .91 for the coherent narratives (Koren-Karie et al.,2008).

Internal consistency scores were .79 for the maternal sensitive guidance, .91 for the child cooperation and exploration and .81 for the coherent narratives in this study.

After the child and mother scales were scored, a final classification was made according to the interaction of the dyad and their ability to work together. There are four classification categories, namely Emotionally Matched, Emotionally Unmatched-Exaggerated, Emotionally Unmatched-Flat and Emotionally Unmatched-Inconsistent.

Categories of AEED:

Emotionally Matched- Task-Oriented, Engaged and Cooperative Dialogues: Emotionally matched dyads create understandable stories that match given emotions. Moreover, stories are constructed through the mutual engagement of mother and child. The mother provides structure and assistance for the child and the child cooperates with the mother. The openness and tolerance of the mother provide a safe base for the child, and the child freely explores his/her feelings. The closure of negative emotions and the emphasis on resolution are seen in emotionally matched stories. Finally, mother and child show patience to each other.

Emotionally Unmatched- Exaggerated, Over-reacting and Overwhelmed Dialogues: Emotionally unmatched-exaggerated dyads create confusing stories that usually do not match the given emotions or include excessive emotions. Stories are characterized by irrelevant details. Instead of structuring or helping the child, the mother is dominant and tries to control the interaction or child. There are no clear boundaries, tolerance and warmth between child and mother. Negative feelings cannot be resolved, but rather exaggerated.

Emotionally Unmatched-Flat, Uninvolved Dialogues:

Emotionally unmatched- flat dyads create short, undetailed stories that often involve naming an emotion and event. The same event can be told by the child or mother to express different feelings. Both mother and child do not show interest in the task. So, their involvement in the task is restricted.

Emotionally Unmatched- Inconsistent, Mismatched Dyads:

Emotionally unmatched-inconsistent dialogues are established through partners in which one of the partners tells stories as required in the task and s/he creates

emotionally matched dialogues. On the other hand, the other partner tells irrelevant, confusing stories. In short, there are two contradictory partners.

In this study study**,** six master level clinical psychology students got training by Sibel Halfon, Ph.D. All trainees coded training transcripts until ICC score of .70 was obtained by coders. After that, pairs of reliable coders coded mother-child dialogue transcripts that were allocated to them randomly. Coders were unaware the aim of the study and the scores were calculated by averaging two ratings of each transcript. Interrater reliabilities of codlings ranged between .70 to .97 (M = 0.88, SD = 0.08).

2.5.3.2 The Coding System for Mental State Talk in Narratives (CS-MST, Bekar et., al 2014)

Coding System for Mental State Talk in Narratives was developed by Bekar and colleagues (2014) to evaluate the mental state talk capacity of mothers and children. The coding manual was created based on stories about a wordless picture book "Frog, Where are You?" (Mayer, 1969). Children and mothers were expected to create a story about wordless pictures in the book. The stories were recorded and then transcribed for mental-state talk coding. Only transcripts were taken into account while coding mental state talk.

Mental state talk in narratives was coded based on 11 categories. The first five categories are the basic categories that evaluate the content of the mental state words. These are emotion words that can be positive or negative (e.g., love, sad); cognitive words (e.g., forget, remember); perception words (e.g. see, hear); physiological words (e.g. hungry, sleep); and action-based words (e.g. cry, help). For each category, the diversity of the mental words can be calculated by the sum of the unique mental state words. For example, when the storyteller uses the word "love" four times and "sad" three times, the number of unique words is two and the total number of mental state words is seven. Furthermore, each category can be coded based on causality references (e.g., because, so, that is why). Lastly, each of these categories can be coded based on the direction that is characters, self and other

such as listener. In addition to these, there are three additional categories in the manual which are still developing. The ninth category is the opaqueness (e.g., I think, maybe, perhaps) that evaluates the opaqueness of the mind and the narrator's ability to see the other's mind as something that is not fully known. The tenth category is the inappropriate/pseudo mental state words (e.g., Are you crazy?) that are inaccurate attributions of the other's mind. The eleventh category is the situational mental state words (surprising, scary, warm) that are used for context or situation, not for the one's mind.

CS-MST is a validated coding system that has been used in different studies and inter-rater reliability for all categories is high (.90; Bekar, 2014). Bekar and Çorapçı (2016) made the Turkish language adaptation of the coding system. Besides, additional adaptations of the CS-MST were also made with Turkish-speaking parents and children. These include "play-oriented mental state talk" in which play therapy sessions of the children or mother-child dyads were coded by using CS-MST (Halfon, Bekar, Gürleyen, 2017; Halfon, Bekar, Ababay, et al.,2017). Moreover, Cantaş (2018) and Coşkun (2018) also used CS-MST for coding Attachment Doll Story Completion Task narratives (ASCT: Bretherton et al., 1990).

2.5.3.2.1 Adaptation of CS-MST in This Study

In this study, mental state talk of the child-mother dyad in Autobiographical Emotional Events Dialogues (AEED; Koren-Karie et al., 2003) was coded by using CS-MST. As mentioned above, mothers and children together created five stories about five emotions in the AEED task. These story narratives were coded to understand both the emotional dialogue capacity and mental state talk capacity of the dyad.

In the CS-MST coding of AEED narratives, the mental state talk capacities of the mother-child dyad together and separately were evaluated. Five basic categories for evaluating the content of mental state talk as the original coding system; emotional, cognitive, perceptual, physiological and action-based were

used. In terms of direction, since narratives are stories that are told by a dyad based on real experiences, the direction of the character in the original coding was omitted, and mental state talk was coded based on two directions: self and other. The self-category refers to the mental attributions of the mother or child to oneself, while the other category refers to the mental attributions of the mother or child to others. Moreover, one category has been added to the direction which is “merged/ambiguous” mental state words. This refers to the use of mental state words for more than one person (for example, "Hugged") or an unclear state of mind.

Moreover, an adaptation was made to eliminate the repetitions of mental state words. Since the AEED task is based on talking about emotions, it has been observed that mothers and children sometimes used emotion words to repeat the instruction. However, this repetition of the instructions was not the actual mental state words produced by the mother or the child. Therefore, when the mother and child started to tell a true story, it was decided to code emotional words. Furthermore, it has been observed that mothers repeated what their children were told because it has not been heard due to technical problems. In this case, repeated mental state words were not coded.

In this study, two categories of mental state word (MSW) of child-mother dyad: Emotional MSW (positive and negative) and Cognitive MSW, and the total MSW use of both two categories and diversity (uniqueness) of MSW were included in the analysis. For the first two categories, self, or other orientations of MSW were also included.

Ayşenur Coşkun provided the coding training to six master students in clinical psychology. After five hours of training, six transcripts were coded, and the interrater reliability of each coder was calculated based on comparison to Bekar’s coding. Interclass Correlation Coefficient (ICC) was found to be above .80. For coding AEED narratives, five master students coded the same transcript and discussed the new adaptations with Ayşenur Coşkun. After deciding the new adaptations, five master students coded narratives individually.

2.5.4 Therapy Measure

2.5.4.1 Children Psychotherapy Process Q-Set (CPQ; Schneider & Jones, 2004)

Child Psychotherapy Process Q Set (CPQ) was developed by Schneider and Jones (2004) based on Psychotherapy Q Set (Jones, 2000), which helps to examine the adult psychotherapy process. CPQ consists of 100 items that aim to define and classify an entire therapy session in child treatments. The goal of CPQ is to consist of a standardized language that does not rely on any specific theory and describes the features of child-therapist interaction.

CPQ include three types of items: (1) items describing behavior and emotional situation of the child (e.g., "Item 7: Child is anxious and tense [vs. calm and relaxed]", "Item 19: Child asks for advice or information"), (2) items defining therapist characteristics and attitude (e.g., "Item 93: Therapist is neutral.", "Item 81: Therapist emphasizes on feelings to help the child experience them more deeply"), (3) items examining the interaction and relationship between therapist and child (e.g., "Item 38: Therapist and child demonstrate a shared vocabulary or understanding when referring to events or feelings", "Item 98: The therapy relationship is discussed").

The basic coding procedure is as follows, after watching a full session, the coders sort the 100 items into piles of nine categories. While the most characteristic items that define the session are placed at one end of the pile, the least characteristic items that define the session are placed on the other end. There are nine categories from 1 to 9 where 1 refers to the most uncharacteristic category and 9 refers to the most characteristic category. Uncharacteristic items are displayed in categories 1,2,3 whereas characteristic items are displayed in categories 7,8,9. Category 5 includes the neutral items that are neither characteristics nor uncharacteristic. Lastly, categories 6 and 4 show slightly characteristic or uncharacteristic items. Moreover, the number of cards to be placed in each category is determined to make a normal distribution. Number of cards to be placed in each category can be seen as following: five items to category 9 and 1, eight items to category 8 and 2, twelve

items to category 7 and 3, sixteen items category 6 and 4 and eighteen items to category 5.

Various studies are supporting the validity and reliability of CPQ. In the pilot study, it was found that the inter-rater reliability (ICC) between coders ranged from .58 to .88 (Schneider, 2004). In addition, Goodman, and Athey-Lloyd (2011) found that ICC ranged from .55 to .89 in their study. Hence, it has good inter-rater reliability. In terms of discriminant validity, it has been found that CPQ differentiated the therapy sessions of two individuals with the same therapist and two different therapists with the same patient. (Goodman & Athey-Lyold, 2011; Schneider et al., 2009).

In this study**,** Sibel Halfon, Ph.D. provided coding training to six master level clinical psychology students. All trainees coded training sessions until ICC score of .70 was obtained by coders. After that, pairs of reliable coders coded sessions that were allocated to them randomly. Coders were unaware the aim of the study and the scores were calculated by averaging two ratings of each session. Interrater reliabilities of CPQ used in this study ranged .63 to .93 (M = 0.82, SD = 0.58).

2.5.4.1.1 Adaptations of CPQ in Online Sessions

In this study, CPQ was used to code and describe the nature of online sessions. Therefore, some items of CPQ were reconsidered for online sessions before coding with coders. Based on the observations in online sessions, all CPQ items were reexamined with coders. The items that were reconsidered will be explained in this part. For item two, that is the therapist's comments on the child's nonverbal behavior (e.g., body posture, gestures), we decided to code the therapist's comments on the child's screen off / on behavior as a characteristic feature of the session. Item five is described as child having difficulty in understanding the therapist's comments. However, if the child failed to understand therapist comments due to technical problems during the sessions, we did not include it in the coding. For item eight, that is the situation in which the child is curious, we agreed to code

the child's curiosity about the therapist's room as a characteristic. Considering item ten that is child seeking greater intimacy with the therapist, if the children tell the memories of face-to-face interaction with therapists or therapy room, this was coded as characteristic of this item. Considering item fourteen in which physical symptoms or health are discussed, the conservations about coronavirus were coded as characteristically. Item fifteen in which child makes physical contact with the therapist was decided to be coded neutrally. Moreover, considering item twenty which is that child is provocative; challenges the therapist or rules and boundaries of the therapy hour, if the child leaves the room or turns off the camera provocatively, these behaviors of children were coded characteristically. Considering item twenty-one in which the therapist self discloses, if the therapist displays her room to the child, this behavior of the therapist was coded characteristically. Lastly, considering item forty-eight which is the therapist setting limits, the therapist's warnings to the child about not turning off the camera or not leaving the room were coded characteristically.

2.6 PROCEDURE

After a consent form for participation in the study, the mother-child dyads were invited to a research meeting held on the Zoom platform. In the online presence of a master's level research assistant, the parents and children first filled out the scales, which were shown through Qualtrics. Later, the AEED task was given to the mother-child dyads. Emotion cards were shared on screen. In this study, mother child-emotional dialogue tool that is Autobiographical Emotional Event Dialogues (AEED) was used for coding mental state talk via CS-MST and emotional dialogue capacity of dyad via AEED. Therefore, during the research meeting, video and audio recordings were taken. Following the research meeting session, video and audio recordings of the sessions were transcribed by research assistants. Then, five coders who had been educated in CS-MST coding coded mental state talk and four coders coded AEED.

Video and audio recordings of all therapy sessions were taken, and they were transcribed by the research assistants. For Child Psychotherapy Q-Set (CPQ) coding, one session in every five sessions (e.g., 1-6, 6-11, 11-16, 16-21, etc.) of the child was randomly selected. Six trained research assistants coded the selected sessions as pairs.

2.7 DATA ANALYSIS PLAN

To understand the nature of online therapy sessions during COVİD-19, a principal component factor analysis will be used, and interaction structures will be found as a result of this analysis. For every child, the mean score of each interaction structure will be calculated. After this, bivariate Spearmen correlation will be used to investigate the relation between the interaction structures in our data and baseline mental state talk variables of child-mother. For mental state talk variables, emotional mental state talk (EMST) and cognitive mental state talk (CMST) will be included in the analysis. For each of these categories, total words, self-other-directed words, causal and unique words will be included in the analysis. To examine the relationship between the interaction structures and AEED stories, a bivariate Spearman correlation will be made. “Mother sensitive guidance” scores which are the average of all mother scales and “Child cooperation and exploration” scores which are the average of all child scales and “Emotionally Coherent Stories” scores which are the average of coherence and adequacy subscales will be used in correlation analysis. Finally, the Kruskal-Wallis H test will be used to compare the mean rank differences in interaction structures between the Emotionally Matched, Emotionally Unmatched-Flat and Emotionally Unmatched-Exaggerated AEED groups.

CHAPTER 3

RESULTS

3.1 DESCRIPTIVE ANALYSIS

Descriptive statistics for child measure of Children Revised Impact Scale (CRIES), mother measure of Impact of Events Scale-Revised (IES-R) and child-mother measures of The Autobiographical Emotional Events Dialogue (AEED) and Emotional and Cognitive Mental State Talk (EMST, CMST) were displayed in Table 3.1 with minimum and maximum levels, means and standard deviations.

Table 3. 1

Descriptive Statistics Children Revised Impact of Events Scale (CRIES), Impact of Events Scale-Revised (IES-R), The Autobiographical Emotional Events Dialogue (AEED), Child-Mother Emotional and Cognitive Mental State Talk (EMST, CMST) Variables

Measures	Minimum	Maximum	M	SD
CRIES				
Total Score	3.00	47	22.5	12.65
IES-R				
Total Score	.00	6.42	2.33	1.76
AEED				
Maternal Sensitive Guidance	4.14	7.29	5.90	.84
Child Cooperation and Exploration	3.57	7.57	5.97	1.11
Emotionally Coherent Narrative	3.50	8.00	6.33	1.21

MENTAL STATE TALK				
Emotional Mental State Talk				
Total EMST	5.00	42.00	20.72	9.56
Self EMST	.00	18.00	6.83	5.46
Other EMST	1.00	39.00	12.33	9.38
Positive EMST	1.00	16.00	7.17	4.16
Negative EMST	4.00	31.00	11.44	6.29
Positive Unique EMST	1.00	5.00	2.94	1.05
Negative Unique EMST	2.00	7.00	4.28	1.36
Causal EMST	.00	8.00	2.00	2.52
Cognitive Mental State Talk				
Total CMST	.00	36.00	16.05	9.65
Self CMST	.00	15.00	7.33	5.23
Other CMST	.00	20.00	7.28	5.16
Unique CMST	.00	10.00	6.67	2.54
Causal CMST	.00	1.00	.33	.48

Mothers answered questions about the state of the family during the COVID-19 process and the effects of the pandemic on their lives (Table 3.2). Six mothers (28.6%) stated that their children had to be separated from important people in their lives due to COVID-19. While most mothers were not expected to be physically harmed by COVID-19, the majority of mothers (61.9%) expected to be financially affected by COVID-19. Moreover, most of the families (66.7%) have been in quarantine for more than 30 days. There are six mothers or their relatives who had COVID-19 infection. While only one mother is working as a health worker, two mothers are working in the high-risk condition in terms of COVID-19.

Table 3. 2

Descriptive Statistics for the Information About the Exposure Level of COVID-19 Pandemic (N=21)

Variables	Categories	Frequencies (N)	Valid Percentages (%)
Separation from Child	Yes	6	28.6
	No	15	71.4
Chronic Illness	Yes	0	0
	No	21	100
Expected Physical Harm	Very Little	3	14.3
	A Little	7	33.3
	A Moderate Amount	9	42.9
	A Lot	2	9.6
Expected Financial Harm	Very Little	1	4.8
	A Little	2	9.5
	A Moderate Amount	5	23.8
	A Lot	11	52.4

	Very Much	2	9.5
Quarantine Day Number	0	4	19.0
	15-21 Days	1	4.8
	22-28 Days	2	9.5
	More Than 30 Days	15	66.7
COVID-19 Diagnosis	Yes	6	28.6
(Self or Relative)	No	15	71.4
Health Worker	Yes	1	4.8
	No	20	95.2
High COVID-19 Risk (Job)	Yes	2	9.5
	No	19	90.5
Working Online	Yes	8	38.1
	No	4	19.0
	Not Working	9	42.9

3.2 RESEARCH QUESTION AND HYPOTHESIS ANALYSIS

3.2.1 Extracting Interaction Structures

A principal component factor analysis with direct oblimin rotation was used to examine the first research question. It yielded five IS, which accounted for 51.5 % of the total variance. Items with the loading of more than 0.40 were used to build factor scales. Descriptive statistics for five interaction structures were displayed in Table 3.4.

IS 1 accounted for 20.84% of the variance ($\alpha = 0.95$) and was named as Psychodynamic Therapist with Regulated, Insightful and Intimacy Seeking Child. This interaction structure reflected that psychodynamic therapist coincided with a more regulated, insightful, and intimacy-seeking child. For the therapist, positive

loading items included psychodynamic interventions such as pointing out the child's use of defense, clarifying, restating, or rephrasing the child's communication whereas negative loading items for the therapist refer to the items that the therapist is more directive. Items for a positive loading for a child reflected a more insightful, regulated, intimacy- and help-seeking child whereas items for a negative loading for the child reflected a misunderstood, competitive, socially misattuned and blaming child. IS 2, labeled Unaccepting Directive Therapist with Distant Child, accounted for 11.50% of the variance ($\alpha = 0.88$). This interaction structure showed that the unaccepting, directive therapist coincided with the distant child. Positively loading items included the therapist's unaccepting, directive, and structuring attitude toward the child whereas negatively loading items included more sensitive and protective therapist and intimate child. IS 3, named as Child's Spontaneous Emotion Expression, accounted for 7.76 % of the variance ($\alpha = 0.85$). Items positively loaded on this IS defined the child's natural affective communication and expression positive feelings (curiosity, excitement) and curiosity. On the other hand, negatively loaded items represented the child's depressed mood, anxiety, and emotional inhibition. The fourth IS, labeled Dependent and Introvert Child with Explorative Therapist, accounted for 6.24% of the shared variance ($\alpha = 0.87$). This interaction structure reflected that dependent and introverted child coincided with the explorative therapist. Items loading positively on this described a more dependent, introverted, and non-spontaneous child and therapist asking questions for more information or elaboration whereas negatively loading items defined provocative, demanding, and suspicious child and more interpretative therapist. The last IS, named as Non-Responsive Therapist with Fearful Child, accounted for 5% of the shared variance ($\alpha = 0.76$). This interaction structure showed that a non-responsive therapist coincided with a fearful child. Positively loading items defined non-responsive therapist and fearful and phobic child whereas negatively loading items described confident therapist who can understand therapeutic process.

Table 3. 3

Five-factor Solution and Item Loading

Items	Factor Loading
IS1: Psychodynamic Therapist with Regulated, Insightful, and Intimacy-Seeking Child	
Item 62: Therapist points out a recurrent theme in the child's experience or conduct.	0,856
Item 24: Therapist's emotional conflicts intrude into the relationship.	0,849
Item 32: Child achieves a new understanding or insight.	0,757
Item 25: Child has difficulty leaving the session.	0,701
Item 100: Therapist draws connections between the therapeutic relationship and other relationships	0,688
Item 36: Therapist points out child's use of defenses.	0,676
Item 38: Therapist and child demonstrate a shared vocabulary or understanding when referring to events or feelings.	0,631
Item 2: Therapist comments on the child's nonverbal behavior (e.g., body posture, gestures).	0,604
Item 33: Child expresses feelings about needing someone or being close to someone.	0,602
Item 10: Child seeks greater intimacy with the therapist.	0,597
Item 53: Child conveys awareness of own internal difficulties.	0,575
Item 97: Therapist emphasizes verbalization of internal states and affects.	0,53
Item 65: Therapist clarifies, restates, or rephrases child's communication	0,528
Item 82: Therapist helps the child manage feelings	0,475
Item 19: Child asks for advice or information.	0,455
Item 48: Therapist sets limits.	0,439
Item 14: Physical symptoms or health are discussed	0,418
Item 91: An earlier developmental phase is a topic.	0,41
Item 75: Interruptions, breaks in the treatment, or termination of therapy are discussed	0,408
Item 63: Child explores relationships with significant others.	0,401
Item 89: Therapist acts to strengthen existing defenses.	-0,401
Item 92: Child's feelings or perceptions are linked to situations or behavior of the past.	-0,464
Item 27: There is a focus on helping the child plan behavior outside the session.	-0,498
Item 34: Child blames others, or external forces, for difficulties.	-0,511
Item 16: There is discussion or evidence of bodily functions (e.g., bowel movements).	-0,514
Item 50: Therapist draws attention to feelings regarded by the child as unacceptable (e.g., anger, envy, or excitement).	-0,516

Item 26: Child is socially misattuned or inappropriate.	-0,521
Item 88: Material of the hour is meaningful and relevant to the child's conflicts.	-0,555
Item 1: Child expresses negative feelings (e.g., criticism, hostility) toward the therapist.	-0,566
Item 66: The therapist is directly reassuring.	-0,622
Item 7: Child is anxious and tense [vs. calm and relaxed].	-0,658
Item 39: The child is competitive, rivalrous with the therapist.	-0,682
Item 41: Child does not feel understood by the therapist	-0,722
Item 47: When the interaction with the child is difficult, the therapist accommodates the child.	-0,857
Item 45: Therapist tolerates child's strong affect or impulses.	-0,859
IS 2: Unaccepting and Directive Therapist with Distant Child	
Item 18: Therapist is judgmental and conveys a lack of acceptance.	0,87
Item 55: Therapist directly rewards desirable behaviors	0,84
Item 17: Therapist actively exerts control over the interaction (e.g., structuring, introducing new topics).	0,746
Item 57: Therapist attempts to modify distortions in child's beliefs.	0,746
Item 99: Therapist offers help or guidance.	0,467
Item 81: Therapist emphasizes feelings to help child experience them more deeply.	-0,415
Item 30: Child's aspirations or ambitions are themes.	-0,465
Item 76: Therapist makes links between child's feelings and experience.	-0,477
Item 87: Therapist informs child of the potential impact of his or her behavior on others (not including the therapist).	0,513
Item 60: Therapist is protective of the child.	-0,547
Item 77: Therapist's interaction with child is sensitive to the child's level of development.	-0,878
Item 15: Child makes physical contact with the therapist.	-0,956
IS 3: Child's Spontaneous Emotion Expression	
Item 13: Child is animated or excited.	0,636
Item 72: Child is active.	0,623
Item 54: Child is clear and organized in verbal expression.	0,612
Item 8: Child is curious.	0,599
Item 74: Humor is used	0,539
Item 58: Child appears unwilling to examine thoughts, reactions, or motivations related to problems.	-0,486
Item 59: Child feels inadequate and inferior [vs. effective and superior].	-0,53
Item 56: Child is distant from his or her feelings.	-0,56
Item 5: Child has difficulty understanding the therapist's comments.	-0,565

Item 94: Child feels sad or depressed [vs. cheerful and joyous].	-0,62
Item 40: Child communicates without affect.	-0,662
Item 61: Child feels shy and embarrassed [vs. un-self-conscious and assured].	-0,672
IS 4: Dependent and Introvert Child with Explorative Therapist	
Item 78: Child is compliant.	0,837
Item 85: Child's aggression is directed toward self.	0,679
Item 80: Child behaves in a dependent fashion [vs. insists on independence].	0,544
Item 95: Child's play lacks spontaneity.	0,476
Item 31: Therapist asks for more information or elaboration.	0,452
Item 52: Therapist makes explicit statements about the end of the hour, upcoming weekend, or holiday.	0,446
Item 29: The quality of child's play is fluid, absorbed [vs. fragmented, sporadic].	0,407
Item 44: Child feels wary or suspicious [vs. trusting and secure].	-0,434
Item 42: Child ignores or rejects therapist's comments and observations.	-0,476
Item 49: Child conveys or expresses mixed or conflicted feelings about the therapist.	-0,488
Item 67: Therapist interprets warded-off or unconscious wishes, feelings, or ideas.	-0,508
Item 46: Therapist interprets the meaning of child's play.	-,0,561
Item 84: Child expresses anger or aggressive feelings.	-0,584
Item 83: Child is demanding.	-0,601
Item 20: Child is provocative; challenges the therapist or rules and boundaries of the therapy hour.	-0,72
IS 5: Non-responsive Therapist with Fearful Child	
Item 9: Therapist is nonresponsive [vs. affectively engaged]	0,779
Item 43: Therapist suggests the meaning of the behavior of others.	0,635
Item 71: Child engages in make-believe play.	0,524
Item 90: Child’s dreams or fantasies are discussed.	0,457
Item 73: Child expresses fears or displays phobic behavior.	0,43
Item 22: Child expresses fears of being punished or threatened.	0,425
Item 28: Therapist accurately perceives the therapeutic process.	-0,458
Item 3: Therapist’s remarks are aimed at encouraging the child's speech	-0,465
Item 86: Therapist is confident, self-assured [vs. uncertain or unsure].	-0,508

Notes. IS= Interaction Structures

Table 3. 4

Descriptive Statistics for the Five Factors

	Number of Items	Mean	Standard Deviation	Explained Variance	Cronbach's Alpha
Factor 1	35	5.32	.63	20.84	0.95
Factor 2	12	3.21	.50	11.50	0.88
Factor 3	12	5.89	.75	7.76	0.85
Factor 4	15	4.99	.71	6.24	0.87
Factor 5	9	3.73	.55	5.00	0,76

3.2.2 Associations Between Mental State Talk Variables and Interaction Structures

The bivariate Spearman correlations of the mental state talk variables and interaction structures were displayed in Table 3.5 and 3.6 Considering emotional mental state talk (EMST) subcategories, it was found that there was a significant negative relationship between causal EMSW and interaction structure four, namely Dependent, Introvert Child with Explorative Therapist. On the other hand, total EMST, self EMST, other EMST, positive EMST, negative EMST, and unique positive and negative EMST were not significantly correlated with interaction structures.

In cognitive mental state talk (CMST) subcategories, total CMST, self-oriented CMST, other-oriented CMST and unique CMST were negatively and significantly associated with interaction structure two, namely Unaccepting and Directive Therapist with Distant Child while causal CMST was not significantly correlated with interaction structures.

Table 3. 5

Bivariate Correlations Between Interaction Structures and Emotional Mental State Talk (EMST) Subcategories

Variables	1	2	3	4	5	6	7	8	9	10	11	12	13
(1) Total EMST	.												
(2) Self ESMT	0,19	.											
(3) Other ESMT	0,006**	0,18	.										
(4) Positive EMST	0**	0,24	0,019*	.									
(5) Negative EMST	0**	0,22	0,002**	0**									
(6) Unique Positive EMST	0,002**	0,48	0,021*	0,014**	0**	.							
(7) Unique Negative EMST	0,007**	0,95	0,009**	0,002*	0,029*	0,03	.						
(8) Causal EMST	0,048*	0,69	0,021*	0,05*	0,006**	0,001**	0,021*	.					
(9) IS-1	0,79	0,64	0,52	0,97	0,62	0,62	0,19	0,73					
(10) IS-2	0,63	0,17	0,76	0,54	0,46	0,76	0,20	0,29	0,13	.			
(11) IS-3	0,38	0,80	0,93	0,21	0,68	0,27	0,07	0,80	0,15	0,33	.		
(12) IS-4	0,41	0,96	0,38	0,50	0,14	0,06	0,11	-0,004**	0,17	0,46	0,85	.	
(13) IS-5	0,60	0,30	0,29	0,76	0,40	0,56	0,60	0,64	0,01	0,25	0,19	0,41	.

Notes. CMST = Cognitive Mental State Talk, IS= Interaction Structures. *$p \leq .05$. **$p \leq .01$

Table 3. 6

Bivariate Correlations Between Interaction Structures and Cognitive Mental State Talk (CMST) Subcategories

Variables	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
(1) Total CMST	.									
(2) Self CSMT	0**	.								
(3) Other CSMT	0,001**	0,18	.							
(4) Unique CSMT	0**	0**	0,012*	.						
(5) Causal CSMT	0,86	0,72	0,96	0,67	.					
(6) IS-1	0,68	0,84	0,62	0,55	0,06	.				
(7) IS-2	-0,009**	-0,019*	-0,019*	-0,026*	0,82	0,13				
(8) IS-3	0,99	0,96	0,59	0,70	0,59	0,15	0,33			
(9) IS-4	0,87	0,52	0,84	0,82	0,72	0,17	0,46	0,85	.	
(10) IS-5	0,28	0,55	0,85	0,13	0,79	0,01	0,25	0,19	0,41	.

Notes. CMST = Cognitive Mental State Talk, IS= Interaction Structures. *$p \leq .05$. **$p \leq .01$

3.2.3 Associations Between the Autobiographical Events of Emotional Dialogues Variables and Interaction Structures

The bivariate Spearman correlations of Autobiographical Emotional Events of Dialogues' variables and interaction structures were shown in Table 3.7. It was found that there is a negative relationship between emotionally coherent stories and interaction structure five, namely Non-responsive Therapists with Fearful Child. On the other hand, there is no significant relationship between mother-sensitive guidance scores of AEED and interaction structures, and child cooperation and elaboration scores of AEED and interaction structures.

Table 3. 7

Bivariate Correlations Between Interaction Structures and Autobiographical Emotional of Events Dialogues Variables

Variables	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**
(1) Mother Sensitive Guidance	.							
(2) Child Cooperation and Elaboration	0**	.						
(3) Emotionally Coherent Stories	0,001**	0**	.					
(4) IS-1	0,48	0,35	0,32	.				
(5) IS-2	0,88	0,95	0,68	0,13	.			
(6) IS-3	0,82	0,72	0,51	0,15	0,33	.		
(7) IS-4	0,95	0,58	0,73	0,17	0,46	0,85	.	
(8) IS-5	0,18	0,06	-0,017*	-0,01**	0,25	0,19	0,41	.

Notes. IS= Interaction Structures. *$p \leq .05$. **$p \leq .01$

3.2.4 Mean Rank Differences Between AEED Categories and Interaction Structures

The results of the A Kruskal-Wallis H test were displayed in Table 3.8. A Kruskal-Wallis H test showed that there was not a statistically significant difference in interaction structure scores between the different AEED categories (emotionally matched, emotionally unmatched-flat, emotionally unmatched- exaggerated). Mean ranks of interaction structure in different AEED categories are shown in Figures.

Table 3. 8

Mean Rank of Interactions Structures Between Different AEED Categories

Averaged Values of IS1, IS2, IS3, IS4, IS 5	AEED Classification	N	Mean Rank	*df*	H	p
Averaged Value of IS 1	Emotionally Matched	5	10.80	2	1.031	.579
	Emotionally Unmatched Flat	9	8.22			
	Emotionally Unmatched Exaggerated	4	10.75			
Averaged Value of IS2	Emotionally Matched	5	9.40	2	3.520	.172
	Emotionally Unmatched Flat	9	11.39			
	Emotionally Unmatched Exaggerated	4	5.38			
Averaged Value of IS3	Emotionally Matched	5	8.30	2	.360	.835
	Emotionally Unmatched Flat	9	10.06			
	Emotionally Unmatched Exaggerated	4	9.75			
Averaged Value of IS4	Emotionally Matched	5	9.20	2	2.318	.314
	Emotionally Unmatched Flat	9	11.11			
	Emotionally Unmatched Exaggerated	4	6.25			
Averaged Value of IS4	Emotionally Matched	5	8.00	2	1.619	.445
	Emotionally Unmatched Flat	9	9.06			
	Emotionally Unmatched Exaggerated	4	12.38			

Notes. IS=Interaction Structures, AEED=Autobiographical Emotional Events Dialogues

Figure 3. 1

Mean Ranks of IS 1 Between Different AEED Categories

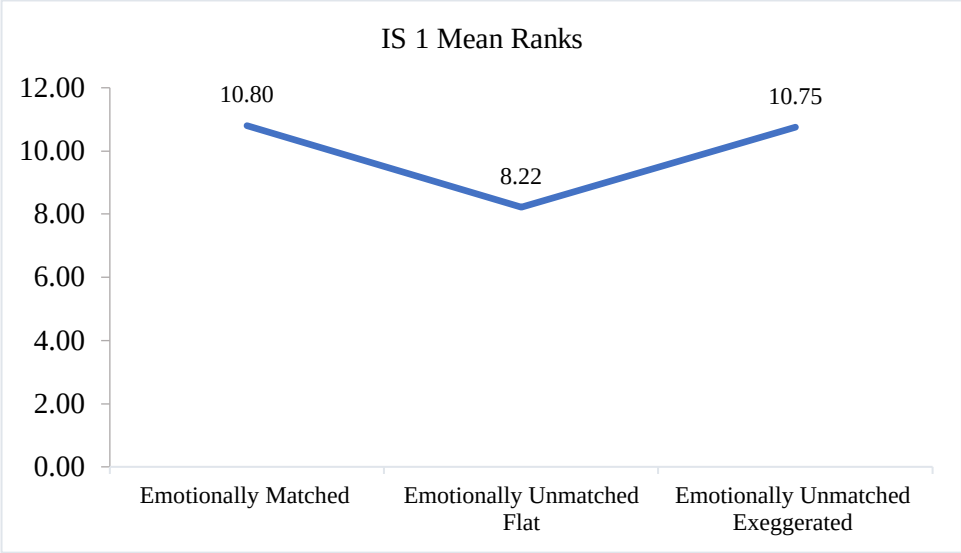


Figure 3. 2

Mean Ranks of IS 2 Between Different AEED Categories

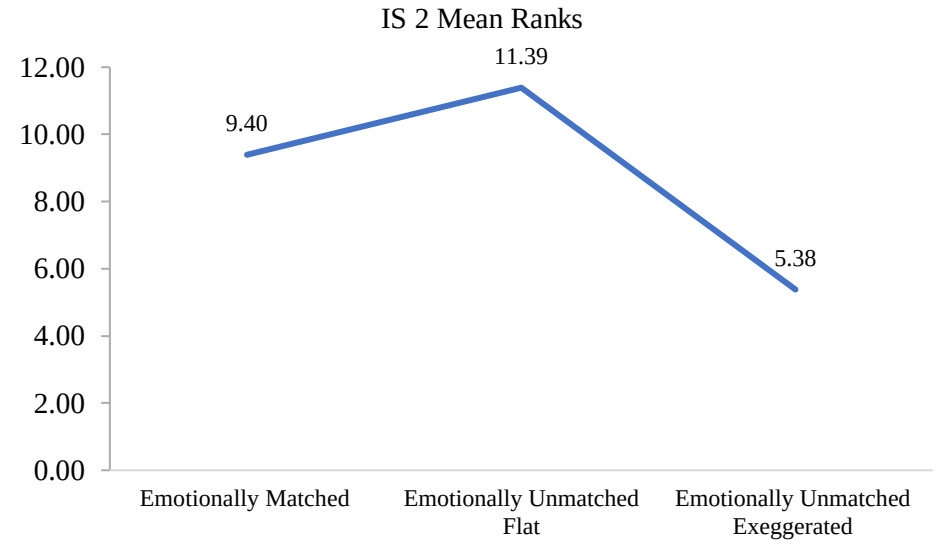


Figure 3. 3

Mean Ranks of IS 3 Between Different AEED Categories

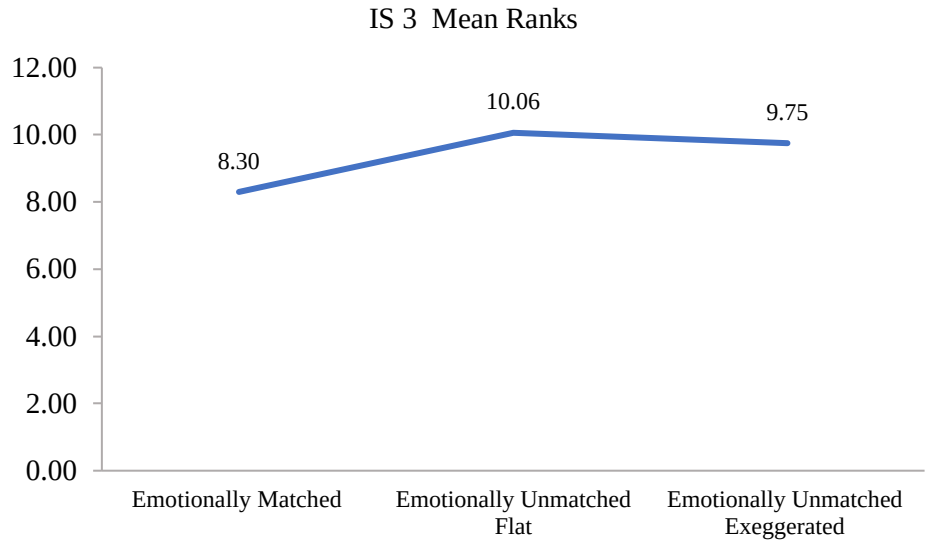


Figure 3. 4

Mean Ranks of IS 4 Between Different AEED Categories

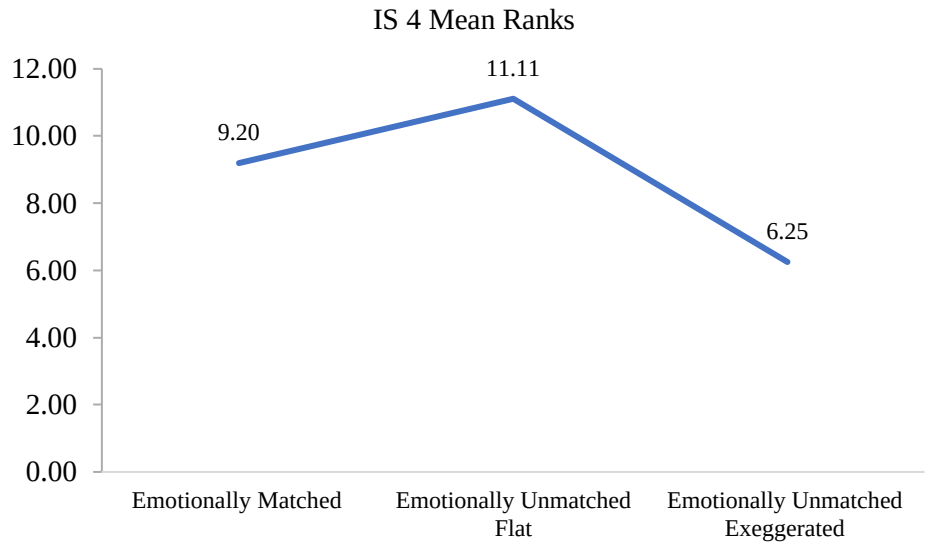
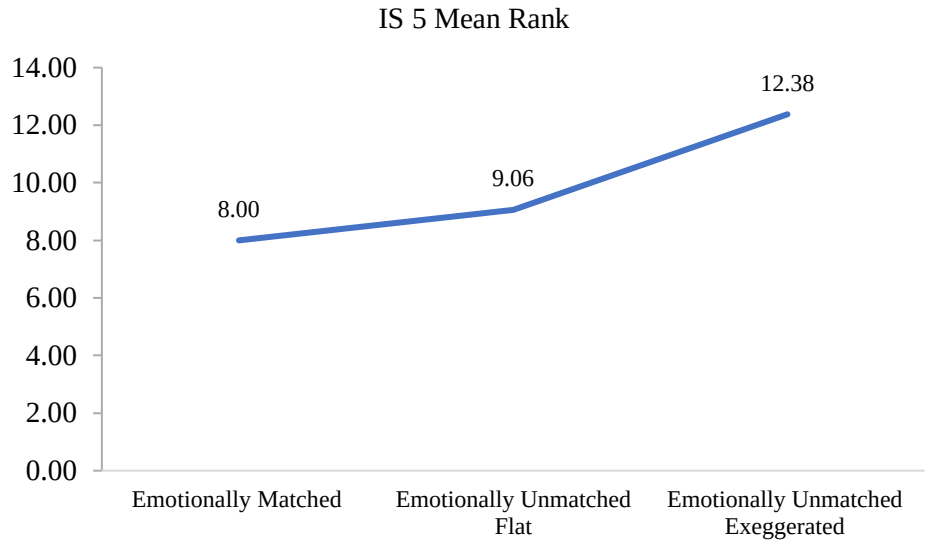


Figure 3. 5

Mean Ranks of IS 5 Between Different AEED Categories



CHAPTER 4

DISCUSSION

This study aimed to examine the nature of online child therapy sessions during the pandemic and the association between child-mother dyads' mental state talk and interaction structures of the children's sessions, and emotional-dialogue capacities and interaction structures of the children's sessions. Therefore, the initial step of data analysis was to identify the interaction structures that appeared in our data. After that, the second step was to investigate their relationship with child-mother dyads' mental state talk and emotional-dialogue capacities. Based on the literature review, we expected that 1) there would be specific interaction structures that reflect psychodynamic therapy process and children's emotion expression, 2) child-mother dyads' use of emotional mental state talk would be positively associated with interaction structures that define psychodynamic features, 3) child-mother dyads' use of cognitive mental state talk would be positively associated with interaction structures that define psychodynamic features, 4) there would be a relation between interaction structures and mother-child emotional dialogue capacities and 5) there would be mean rank differences between interaction structures and different categories of AEDD.

Five different interaction structures have appeared in our data set. As expected, we found the IS related with psychodynamic therapy, which is Psychodynamic Therapist with Regulated, Insightful, Intimacy Seeking Child (IS 1) and the IS associated with children's emotion expression which is Children's Spontaneous Emotion Expression (IS 3). The other interaction structures that emerged were named Unaccepting, Directive Therapist with Distant Child (IS 2), Dependent, Introvert Child with Explorative Therapist (IS 4) and Non-responsive Therapist with Fearful Child (IS 5).

Our second hypothesis was partially supported by results. As expected, there was no significant positive relationship between mother-child emotional mental state talk and IS 1 which is Psychodynamic Therapist with Regulated, Insightful, Intimacy Seeking Child. However, there was a negative significant relationship

between causal emotional mental state talk of mother-child dyads and IS 4 which is Dependent, Introvert Child with Explorative Therapist.

Our third hypothesis was also partially supported by the results. Positive relationship between cognitive mental state talk and IS1 could not be found. On the other hand, mother-child dyads' total, self, other and unique cognitive mental state talk were negatively correlated with IS 2 which is Unaccepting, Directive Therapist with Distant Child.

Our fourth hypothesis was partially supported by results. Although there was no significant relationship between interaction structures and "mother sensitive guidance", and interaction structures and "child cooperation and elaboration" scores, there was a negative relationship between "emotionally coherent stories" and IS 5 which is Non-responsive Therapist with Fearful Child.

Considering different categories of AEED and its relation to interaction structures, there was no significant mean rank differences between AEED categories and different interaction structures.

All these results will be explored below.

4.1 Research Question and Hypothesis

4.1.1 Extracting Interaction Structures in Teletherapy Sessions

The first IS was named Psychodynamic Therapist with Regulated, Insightful, Intimacy Seeking Child. Positive loading items for therapist include the therapist's psychodynamic interventions such as pointing out children's use of defense, emphasizing feelings, clarifying, restating child's communication, and pointing out to the recurrent theme in the child's experience. Items with a positive loading for a child describe a child who is insightful, regulated, intimacy and help seeking. Negative loading items for a therapist include directive techniques of therapist such as directly reassuring, strengthening existing defense, tolerating child's strong affect, and helping the child plan behavior outside the session. Items with a negative loading for a child describe a child who is dysregulated,

competitive, misunderstood, and hostile child. This finding is compatible with the literature considering that previous study suggested that CPQ had discriminative validity in terms of discriminating PDT process in sessions (Goodman et al.,2016). In this interaction structure, positively loading items for therapist are also among the most common items of PDT (Goodman et al.,2016). Moreover, this interaction structure in our data is similar to "Psychodynamic Technique" interaction structure in the study of Halfon et al. (2018). They also found an interaction structure that defines therapist's psychodynamic interventions such as pointing out child's use of defense and pointing out recurrent theme in child's experiences in their study.

Moreover, it is important to take into account why this interaction structure might have occurred in psychotherapy during COVID-19. As mentioned above, Covid-19 and quarantine made children feel sad, unhappy, scared, and angry, with all the uncertainties it brought to children's lives. In our sample, 66.7% of participants stated that they were being in quarantine more than thirty days. This was a high stressful time for children. In the times of trauma, children might need someone who helps him/her look into inner worlds, recognize the emotions that they have, make the connection between what they experience and how they feel, and reorganize their inner world. Lieberman et al. (2009) suggested that psychodynamic interventions focus on children's inner worlds and interpret children's actions in relation to their inner worlds and developmental history, thus assisting in trauma healing. Moreover, Alessi and Kahn (2017) emphasized the importance of psychodynamic interventions while working with trauma. They proposed that basic principles of psychodynamic approach such as holding environment, containment and seeing the self-object needs of patient are very helpful in trauma work. So, our results suggested that therapists were benefited from psychodynamic techniques with regulated children who had the capacity to understand their inner world during the pandemic. As a result, with insightful and regulated children, the therapists may have aimed to contain and reorganize the children's experience of COVID-19 stress using more psychodynamic techniques. On the other hand, with more emotionally dysregulated children, they preferred more directive and CBT style of interventions as stated in the previous studies.

These two studies also found that therapist first used CBT techniques with dysregulated and aggressive children (Ramires et al.,2020; Goodman, 2015).

The second IS was named as Unaccepting, Directive Therapist with Distant Child. Positive loading items for therapist refer to more directive interventions of therapist such as rewarding behavior, structuring the session, and attempting to modify child's distortions. Negative loading items for therapist include more emotion-focused and sensitive interventions of therapist such as emphasizing feelings and making connections between feelings and behaviors. Negative loading items for child describe a child who wants to make physical contact with therapist and share his/her aspirations. Considering the previous studies, this interaction structure in our data is similar to "Structuring, accommodating therapist with difficult child" in the study of Goodman (2015) and "Didactic, directive therapist with aggressive and defensive child" in the study of Ramires et al. (2020). These two studies suggested that therapists first used more directive techniques to include these resistant and distant children in the therapy process. Moreover, although the mean of this interaction structure in our data set was the lowest one, it showed that therapists used directive treatment strategies in teletherapy sessions. One explanation for this interaction structure might be that therapists of this study were the intern psychotherapists who did not provide online therapy sessions with children before Covid-19. Online therapy sessions were also a new experience for therapists as well as face to face sessions. Scharff et al. (2020) addressed the trainers' experiences in online sessions and hypothesized that the lack of control over the therapy process made the trainers feel vulnerable and unsettled. In line with this, our therapists might had experienced the issue of losing control and preferred more directive strategies in which they had some control to structure the sessions. Moreover, another issue of online session with children was to keep children engaged in sessions. Burgoyne and Cohn (2020) suggested that while working with children, therapists had to add new treatment strategies and structure the sessions to keep the children's attention alive. Another explanation for this directive interaction structure in our study might be that therapists may have tried to include

and keep more distant children in the sessions by planning the sessions and making more directive interventions.

The third IS was named Child's Spontaneous Emotion Expression. In the positive loading side, there are items in which child is connected with emotions and is curious and cheerful. In the negative loading side, there are items in which child is more resistant to connect with emotions and distant from emotions. We expected to find IS related to emotion expression because emotions and emotion expression are one of the basic core features of psychodynamic therapies. It was proposed that psychodynamic therapies are different from cognitive behavioral therapies in terms of approaching emotion in the sessions. While psychodynamic therapies aim to explore and express emotions, cognitive behavioral therapies aim to control and modify emotions (Blagys and Hilsenroth, 2000). Emphasizing emotions and linking connections between feelings and behaviors are the techniques used by therapists in psychodynamic therapy sessions (Goodman et al.,2016). Emotional features of children were also discovered as interaction structures in previous research using the CPQ in psychodynamic settings (Ramires et al., 2017, Halfon et al., 2018). Our results also found the similar interaction structures as previous studies supposed. This interaction structure is similar to "Child's Emotion Expression" in the study of Halfon et al., (2020). There are common items such as "Child is animated or excited", "Child is curious" and "Child is active" in both our study and Halfon et al. (2018) study. Moreover, when working with children for healing trauma, different play therapy techniques such as mentalization-based (Ramires et al., 2012), experiential play therapy (Çelik, 2017), child-centered play therapy (Çiftçi, 2019) and theraplay (Eruyar & Vostains, 2020) were found to be effective. One common feature of these different approaches is to provide children with a safe space in which children can understand different emotions and express them. If we consider Covid-19 and the quarantine period to be a stressful event, it is important for children to express their feelings in a secure environment in order to endure this stressful time in the healthiest way possible. Thus, our third interaction structure is consistent with previous studies that emphasized the common feature of expression of emotion in traumatic times.

Our fourth IS was Dependent, Introvert Child with Explorative Therapist. While positively loading items for a child describe obedient, non-spontaneous and introvert child, negatively loaded items define demanding, extrovert child. Moreover, positively loaded items for therapist refer to a therapist who is more explorative, and negatively loaded items describe a therapist who make interpretations such as interpreting the meaning of child's play and interpreting unconscious material. Similar interaction structure was found in the study of Schneider et al. (2010). They named their interaction structure as "Bringing Out the Withdrawn Child". In this interaction structure, positive loading items for child define a child who is dependent, shows little affect and turns aggression to self, and positive loading items include the therapist's intervention such as emphasizing internal states and emotion and making associations between child's feelings and behaviors. They noted that in response to child's dependent behavior, therapist tried to encourage the child in the session. Although, therapist's intervention in our interaction structure is not the same with Schneider et al. (2010), we found that therapist tried to encourage dependent child to make exploration in the session. Moreover, it is known that children were affected differently by the Coronavirus. While some children displayed dependency and clinginess in response to Covid-19 and the quarantine phase, others displayed rage (Jiao et al., 2020). It can be inferred that these differences in children's reactions coincided with the interaction structure we found in our study. In this interaction structure, we found two opposite behaviors of children in sessions; on the positive loading side, children were introvert and dependent on therapists, and on the negative loading side, children were more extrovert and demanding, and had ability to express themselves. Moreover, in response to children's situation in the session, therapists preferred different ways of interacting with them. With children who are introvert and obedient, therapists focused on exploration such as asking more questions for elaboration. As stated before, in the times of trauma, children needed a safe space in which they explored emotions. By focusing on elaboration, therapist may have helped children to label and explore what they experienced. On the other hand, when the children had the ability of expressing both themselves and emotions, therapists preferred making

interpretations. It is possible to infer that when the emotions can be expressed, therapists attempted to assist children in forming relationships about what they experienced and more unconscious material of the children, rather than elaboration.

Our last IS was named Non-responsive Therapist with Fearful Child. While positively loaded items for therapist include non-responsive attitude of therapist, negatively loaded items refer to confident therapist who accurately perceive the therapy process. Furthermore, positively loaded items for child describe a fearful and phobic child. There was no similar interaction structure in previous studies. The reason for this interaction structure might be related to COVID-19 specific features. As stated before, this unexpected new situation created new challenges for children's lives. Idoiga et al. (2020) discovered that children perceived coronavirus as a bad enemy that must be defeated. "Fear of coronavirus" was one of the common themes among children. They stated that children described feelings of fear, mostly fear of losing the loved ones and fear of transmission of the virus to elderly people (Idoiaga et al.,2020). Moreover, Schimmenti et al. (2020) examined the fear during COVID-19 using four domains. These are "fear of body/fear for body", "fear of significant others/fear for significant others", "fear of not knowing/fear of knowing" and "fear of taking action/ fear of inaction". They specifically emphasized that those fears are multidimensional and multilateral. As a result, it can be concluded that these stressful times were very frightening for both adults and children, and fear was not as simple as the fear of contagion but had many facets. It is probably that some children also had similar fears to those mentioned above, or coronavirus triggered the other fears that children might have had. In line with this, we discovered that the fearfulness experienced during COVID-19 was expressed in the teletherapy sessions by children. Moreover, we found that with these children, the therapists were unresponsive and not emotionally involved in the sessions. One reason for this behavior of therapists may be related to the therapist's shared experience with patients. Probably, therapists in this study felt various fears related to COVID-19. Even though this shared experience has helped therapists have a better understanding of the patients' feelings, the therapists may have felt overwhelmed by these feelings. As Ronen-Setter and Cohen (2020)

suggested, therapists may have shown some avoidance by remaining unresponsive due to the overwhelmed feelings of this shared experience. Referring to the therapist's lack of focus in the sessions, Burgoyne and Cohen (2020) suggested that some therapists saw teletherapy as a temporary step, and this may have caused the therapists not to settle and focus on teletherapy sessions. As suggested, the explanation for the therapist's unresponsiveness might be that in this study, the therapists also did not know how long to offer teletherapy sessions, and that these services were also initially seen temporary. Moreover, the therapists were not ready for this transition. All of this may have caused the therapist to be unfocused and non-affective in the sessions.

4.1.2 Associations Between Child-Mother Emotional Mental State Talk and Interaction Structures

The findings proposed that causal emotional mental state talk of child-mother dyads was negatively correlated with IS 4 which is Dependent, Introvert Child with Explorative therapist. This suggests that the child and mother's use of less causal emotional mental state speech is associated with the dependent, introverted child and exploratory therapist in the sessions, while the child and mother's more use of causal emotional state speech is associated with the expressive child and the interpretive therapist in the sessions.

To better see the differences between child-mother causal emotional mental state talk use capacities, vignettes from emotional dialogues of a child with a high IS 4 score and a child with a low IS 4 score will be illustrated. Causal emotional mental state words will be highlighted in vignettes.

Child with Average IS 4 Score of 6.52 (Ç: Child, A: Mother)

A: Benim de aklıma gelmiyor ama sanıyorum güvende hissetmek hani biraz şey oluyor ya mutlu heyecanlı biliyorum da güvende… Yani babası ile beraberken çok güvende oluyor güvende hissediyor. Onunla beraber vakit geçirdiği zaman çok güvende hissediyor. Mesela babanla geçirdiğim bir günü sen anlatabilirsin. Oyun oynadığında mesela ya da işte babanla sırlarını paylaştığında…

Ç: Mesela babamla oyun oynadığımda mutlu oluyorum.

A: Iıı bir takım mesela D.'in internetten izlemek istediği videolar oluyor. İzlesem olur mu bana zarar verir mi gibi bir takım…

Ç: Ama hayır eskiden korkunç şeyler izliyordum, şimdi o kadar bıraktım yani. Ama izliyorum yani. Ama bazen ama bazen böyle daha korkunç şeyler açıyorum ben gözlerimi kapatıyordum A. hemen değiştiriyordu…

This child is one of those children with high average IS 4 score. As mentioned above, our results showed that use of child-mother causal emotional mental state words is negatively associated with IS 4. This means that less use of causal emotional mental state talk is associated with high average IS 4 scores. In the example from the emotional dialogues of child-mother, we see that although the child and mother use emotion words, they cannot establish causal connections between emotions. As a result, the mother-child's inability to establish causal links is also related to the child having higher IS 4 scores during the therapy process.

Child with Average IS 4 Score of 4.07 (Ç: Child, A: Mother)

A:Neyde en çok kendini güvende hissettin? Nasıl bir anıda?

Ç: Bilmiyorum ki. Bu şu anki yıllarda. Korona virüsten ***korktuğum için*** *bahçeye de çıkmıyorum. Bu bir anı değil. Bilmiyorum şu anda bilmiyorum.*

A: Anı değil evet. Şu andaki bir hissiyatını anlattın.

Ç: Tam bilmiyorum anne. Sen biliyor musun?

A: Mesela ne bileyim okulda korkmuşsundur da biz gelmişizdir falan veya başka bir şey.

Ç: Hımm. Şey. Şimdi serviste yaşandı bu olay.

A: Hım.

Ç: Şimdi benim A. diye bir arkadaşım vardı ikinci sınıfa giden. Servis arkadaşım sonra işte o birgün serviste kustu. Önlerde oturduğu için. Ben arkada oturduğum ***için kendimi güvende hissettim****. Arkalar güvenli diye düşündüm. Hiç kimse arkalarda kusmuyor. Çünkü o zamanlar ben domuz gribinden kurtulmuştum. Annem bana çok mide bulandırıcı bir ilaç vermişti.*

Böyle servis çok oynak olduğu için. O zamanlar kusmuştum. Annem sonra hiç vermedi ama bir de okula gittiğimiz zaman bir girdim okula …

This child is one of those children with low average IS 4 score. In the example from the emotional dialogues of child-mother, we see that child does not only use emotion words but also makes explanations about the reasons for these feelings. As a result, the mother-child's ability to establish causal links is associated with the child's lower IS 4 score during the therapy process.

It is important to think about the reasons of this relationship. Causal emotional mental state talk refers to making causal explanations or interpretations for emotions or behaviors. It is similar to the definition of mentalization which is the people's ability to see behaviors of others and self in terms of mental states and forming connections between mental states and behaviors (Fonagy & Target, 1997). Based on these views, constituting causal explanations for emotions can be indicator of more developed mentalization capacity. Moreover, in one study, Laible (2004) investigated how the mothers' elaboration, which means giving causal explanation for emotions while reading story books or discussing children's behaviors, affected children's understanding of emotions. It was found that as mothers offered causal relations more often, children became better at understanding and interpreting emotions. In line with these, our results also showed that more use of mother-child causal emotional mental state talk is associated with children expressing both themselves and their emotions freely in the sessions. It can be inferred that making causal connections for emotions helped children understand emotions better, and this might be related to the fact that these children did not have difficulty in expressing themselves or their emotions in the sessions. In response to this situation of children, therapists preferred to make interpretations such as interpretating the child's play, interpreting the child's wishes and unconscious material. These items are some of the psychodynamic prototype items (Goodman et al. 2016). It can be said that therapists used psychodynamic techniques with these children. As mentioned above, using causal emotional mental state talk can be considered as developed mentalization capacity, and hence it might be easier for therapist to make interpretations in the sessions with these children. For example,

Halfon, Bekar and Gürleyen (2017) discovered that therapists focused on making interpretations about the child's conflict and relating the underlying mental contents to the child's experiences when the child had explicit mentalization capacity. In other words, child's mentalization capacity offered a space in which interpretations were made rather than just labeling emotions. Moreover, Ramires et al. (2020) found that with a child who had a developed mentalization capacity before therapy, the interaction structure, in which therapist was more interpretive, became dominant in treatment process. In line with these findings, in our study, therapists' more use of interpretations in sessions was associated with child-mother more use of causal emotional mental state talk.

On the contrary, we discovered that less use of causal emotional mental speech of child and mother was associated with dependent and introvert children whose play was not spontaneous, and who directed anger towards themselves. Making causal emotional explanations provided children with better emotion comprehension, as previously mentioned; however, less use of causal emotional explanations could be associated with more emotionally inhibited children in the session. In other words, less use of causal emotional talk could be an indicator of less complex emotional and mentalization development, and as a result these children might be more introvert in terms of emotion expressions in the sessions (Laible 2004). In response to this situation of children, we found that therapists focused more on elaboration rather than interpretations in the sessions. Because these children had difficulty in linking causal relationships between mental states, therapists might prefer elaboration to help these children link causal relations. This result was similar to the results of Halfon, Bekar and Gürleyen (2017) study. In their study, which compares the treatment process of two girls with same diagnosis but different mentalization capacity before treatment, they found that therapist preferred labeling emotions and understanding emotions instead of interpreting conflicts or unconscious material with a child who had less developed mentalization capacity. Verheugt-Pleiter et al. (2018) suggested that therapists should pay attention to child's capacity in terms of mentalization. So, the reason of the relationship between less causal emotional mental state talk and more elaboration

focused therapist might be that therapists adjusted themselves and their techniques according to level of children's mentalization capacity.

4.1.3 Associations Between Child-Mother Cognitive Mental State Talk and Interaction Structures

The results showed that there is a significant negative relationship between mother-child total, self, other, unique cognitive mental state talk and IS 2 which is Unaccepting Directive Therapist with Distant Child. This means that while the child-mother less use of cognitive mental state talk is related to distant child and unaccepting, directive therapist in the sessions, the child-mother's more use of cognitive mental state talk is related to therapists' emotion focused interventions such as emphasizing feelings, making connections by feelings and experiences in the sessions.

To understand the differences between child-mother cognitive mental state talk use capacities, vignettes from emotional dialogues of a child with a high IS 2 score and a child with a low IS 2 score will be illustrated. Cognitive mental state words will be highlighted in vignettes.

Child with Average IS 2 score of 3.88 (Ç: Child, A: Mother)

C: mutlu

Ç: (sessizlik)

A: en son ne zaman mutlu oldun?

A: biz oyun oynadığımız zaman çok mutluydun. Söyler misin hadi.

Ç: ??

Ç: oyun oynadığımı ona söyledim? [13:45]

A: hadi. Top saklamak

Ç: top saklamak

T: top saklamak

A: saklambaç, top saklamak, güreş,

Ç: ? [14:18]

A: oyun oynuyoruz evin içinde mutu oluyoruz. Arada dövüş çıkıyor ama idare eder. Pürüzler çıkıyor ama idare eder. Oyuna devam ediyoruz.

This child is one of those children with high average IS 2 score. As mentioned above, our results showed that use of child-mother cognitive mental state words is negatively associated with IS 2. In the example from the emotional dialogues of child-mother, we see that neither mother not child used cognitive mental state words in their dialogues. As a result, the mother-child's less use of cognitive mental state words was found to be associated with a higher IS 2 score during the therapy process.

Child with Average IS 2 Score of 2.96 (Ç: Child, A: Mother)

*C: ben mutlu olmak **istiyorum.***

A: tamam o zaman.

T: o zaman mutludan. Tamam. Evet şimdi hikayenizi dinleyebilirim.

*A: K. spiderman kostümü **istemişti** bizden. İnternette birkaç gün boyunca kendisi giydi baktı. Annecim bunu alalım annecim bunu alalım. Sipariş verdik kıramadım en sonunda onu. K. günlerce böyle her kapı çaldığında kargocu geldi benim kargom geldi diye kapıya koştu. Bu kamerayı ayarlamam çok zor oluyor bu arada.*

*A: 5 gün sonra kargosu geldi. Kargosunu aldı. İçinde tabi bir **süprizi** daha vardı o sadece kıyafeti geleceğini **düşünüyordu** ama eldiveni ve saati gibi bir şeyi vardı. O da geldi. O zaman çok mutlu oldu. Gördüğünüz üzere şu anda üzerinde.*

This child is one of those children with low average IS 2 score. In the example from the emotional dialogues of child-mother, we see that both child and mother used different cognitive mental state words that are self/other oriented. As a result, the mother-child's ability to use cognitive mental state words is associated with the child's lower IS 2 score during the therapy process.

As stated above, less use of cognitive mental state talk use (total/other/ self/unique) of child-mother dyads was associated with the therapists' more direct techniques such as structuring session, introducing new topics and attempting to modify distortions in child's beliefs. These techniques are similar to CBT prototype

sessions (Goodman et al.,2016). One explanation for the therapist's preference of using of more directive and CBT interventions with children who used less cognitive mental state words might be to aid the development of these children's cognitive mentalization abilities. According to Björgvinsson and Hart (2008), cognitive behavioral therapies help people improve mentalization by making people think about their way of thinking. They believed that cognitive behavioral therapy interventions helped to improve explicit mentalization ability. They proposed that one important point of CBT is to make people think about their distorted beliefs, and they claimed that these help people to understand how their mind works and affects emotions and behaviors. In short, it was proposed that these techniques help to enhance mentalization skill of people. Moreover, in their study, Ramires et al. (2020) also discovered that when working with a child who had limited mentalization capacity before therapy, therapist used more cognitive behavioral therapy techniques. They discussed that it might be necessary for therapist to use more direct techniques because the child had emotion regulation problems due to limited mentalization capacity. While the less use of cognitive mental state talk does not directly imply a lack of mentalization capacity, it may be an indication of some limited mentalization capacity. Therefore, in our study, which is similar to a Ramires et al. (2020) findings, less use of the mother-child self/total/unique cognitive mental state talk is related to more use of therapist's direct and CBT style interventions.

On the other hand, self or other oriented cognitive mentalization provides a room for emotion to be thought and regulated (Allen et al., 2008; Wells, 2000). Previous research found that there is negative relationship between mother's cognitive mental state talk and children's behavior problems (Bekar et al., 2018, Carr et al. 2018). According to Göcek (2017), mothers' cognitive mental state talk was associated with mothers' emotional availability and children's pathology. In line with this, our findings revealed that therapist focused more on emotions and made connections between emotions and behaviors with children who used more total/self/other or unique cognitive mental state words in sessions. It is possible to deduce that when children have the ability to think about thoughts and emotions,

therapists' interventions in sessions could shift to emotions because there was a space that emotions can be explored with these children. Moreover, Açıl (2020) examined the relationship between children's cognitive mental state talk and psychodynamic adherence of sessions. She found that there was a positive significant relationship between self and unique cognitive mental state talk and psychodynamic adherence of therapy sessions. She also discussed that children's cognitive mental state talk capacity is associated with more psychodynamic sessions in which emotions were explored. As a result, our finding, that is more use of cognitive (total/self/other/unique) mental state talk is associated with therapist's focus on emotions in sessions, is similar to results of the study of Açıl (2020).

4.1.4 Associations Between Child-Mother Emotional Dialogues and Interaction Structures

We searched for the relationship between interaction structures and 1) "mother sensitive guidance" which is the mean of mother scale scores in AEED, 2) "child cooperation and exploration" which is the mean of child scale scores in AEDD, 3) "emotionally coherent stories" which is the mean of adequacy and coherence scores in the sessions. Although we could not find significant relationships between "mother sensitive guidance" and interaction structures, and "child cooperation and exploration" and interaction structures, we discovered a negative relationship between "emotionally coherent stories" and IS 5 which is Non-responsive Therapist with Fearful Child. This result suggested that the quality of the narrative created by dyad's rather than their way of expressing the emotions in the narrative separately was found to be linked to one of the interaction structures in the research.

The aim of the AEED was to evaluate the capacity of talking about emotions in a dyadic relationship. Even if the separate scores for child and mother were composited based on mother and child's behaviors while talking about emotions, the final categorization, or the quality of the narrative was made based on the child-mother dyadic relationship. That may explain why no significant relationship was found between interaction structures and "mother sensitive

guidance", and interaction structures and "child cooperation and elaboration" scores. It can be discussed that instead of separate characteristics of mother or child while talking about emotions, the mutual engagement and the process while talking about emotions were more important and found to be related to child's therapy process.

On the other hand, "emotionally coherent stories" score represented the quality of interaction of the dyad and narrative that they created. This score was constituted by the mean of "adequacy" and "coherence" scores. Adequacy of the stories is evaluated to observe whether dyads created five stories that suited the emotions or not. The coherence of the stories is evaluated by examining the entire story-telling process to observe whether the dyad could construct matched, believable stories or not. Although emotionally less coherent stories resembled those in which a mother-child created complex, bizarre and unconnected stories, emotionally more coherent stories resembled those in which a mother-child created stories that suited the emotions and that were believable. Furthermore, coherent stories had a straightforward structure with a clear beginning, middle and end. Lastly, in coherent stories, both child and mother contributed to creating a story (Karie et al., 2003).

In our study, we found that child-mother's emotionally less coherent stories are associated with more fearful children in the sessions. In other words, coherence of the stories was negatively associated with children's fearfulness in the session. It can be inferred that those emotionally coherent dialogues, in which children created with mothers, might be associated with regulation of emotions felt in these stressful times. Children could regulate their fears during these challenging times when they had the opportunity to participate in coherent, believable and focused emotional dialogues. On the other hand, children could feel more fearful, when they participated in bizarre, uncoherent and unfocused emotional dialogues, and this was also seen in the sessions. According to Koren-Karie et al. (2008), emotional dialogues helped children shaping internal working models by creating a safe place where emotions can be expressed and explored. Besides helping to create coherent narratives and internal working models, previous researchers suggested that

emotional dialogues in stressful times were associated with better coping mechanisms of children (Sales & Fivush, 2005; Fivush & Sales, 2006; Gentzler et al., 2005; Ellis & Allisic, 2013). Covid-19 brought sudden changes and uncertainties to children's lives, making them feel fearful and anxious. It can be inferred that those children having coherent dialogues with mothers can regulate their fears better during COVID-19, and thus these children behave less fearful in the sessions. On the other hand, those children having less coherent dialogues with mother cannot have a chance to regulate their fears during COVID-19, and thus these children behave more fearful in the sessions.

4.1.5 Mean Rank Differences in Interaction Structures Between Different AEED Categories

Child-mother emotional dialogues can be classified as Emotionally Matched or Emotionally Unmatched-Flat/Exaggerated/Inconsistent. These categories gave us an idea about how emotions are expressed in dyadic relationship. Therefore, we wanted to investigate whether there was a difference in interaction structure scores between the different AEED categories. Statistically significant differences have not been found. However, even if there were not statistically meaningful results, some mean rank differences were observed, and they will be discussed in this part. Firstly, emotionally matched dyads had the highest mean rank in IS 1, namely Psychodynamic Therapist with Regulated, Insightful, and Intimacy Seeking Child. Even if these differences were not statistically significant, it can be clinically meaningful. A feature of emotionally matched dyads is the ability of mother and child to mutually create understandable stories. While mothers can properly support their children in telling stories, children can freely explore and express their emotions. The dyad has a secure relationship which provides a base for emotions to be explored (Karen Karie et al., 2003). In compliance with this, we also found that children in these dyads had the highest mean rank scores in IS 1 in which the child was more insightful, emotionally regulated and comfortable about seeking help and intimacy from therapist. Moreover, it is interesting that the child's ways of expressing emotions in dialogues can be seen in the sessions in a similar way. Since

it has been suggested that emotional dialogues can help children develop internal working models (Koren Karie et al., 2008), children in emotionally matched dyads have secure representations in their internal working model, and possibly reflect this in their relationship with the therapist. However, as I stated before, because these are not significant differences, it is not possible to make inferences based on these results.

Secondly, emotionally unmatched dyads had the highest mean rank in IS 2, namely Unaccepting and Directive Therapist with Distant Child in our study. When talking about feelings, emotionally unmatched flat dyads display their lack of interest in dialogues. Both child and mother are restricted in their ability to elaborate on their emotions. They create short and undetailed stories (Koren Karie et al.,2003). It is also clinically meaningful that these dyads had the highest mean rank score in IS 2 in which the child was distant in the session. Their lack of interest and unwillingness to explore emotions in dialogues can be seen in the sessions in similar ways. These children were also found to be distant in sessions in our data. Moreover, it is interesting that therapist's attitudes towards these distant children were similar to the behaviors of mothers. In this dyad, mothers show unaccepting and critical attitude, and sometimes try to structure the dialogues too much. It is similar to the ways of the therapists' attitudes toward these children in sessions. We also found that therapists preferred to be more structured with these children.

Lastly, emotionally unmatched exaggerated dyads had the highest mean rank scores in IS 5, namely Non-responsive Therapist with Fearful Child. Even though this was not a statistically significant difference, again it can be meaningful clinically. Emotionally unmatched exaggerated dyads tell complex and emotionally loaded, confusing stories. They create non-coherent stories that include lots of irrelevant details. One important feature of these dyads is their ability to exaggerate negative feelings instead of resolving (Koren Karie et al.,2003).We also found that children in emotionally unmatched exaggerated category were fearful in the sessions. Their way of exaggerating especially negative emotions was seen in their sessions in our study. Since these children or mothers were unable to form dialogues

in which emotions were both discovered and contained, these children may have manifested fear in extreme forms such as phobic behavior during sessions.
In short, even of these results were not significantly statistical, it gave us some information about that the way of children talking about emotions in emotional dialogues with mothers were similarly reflected in their sessions.

4.2 Clinical Implications

Although there are articles that discuss the limitations and advantages of child teletherapy sessions based on clinical observations, the nature of child therapy sessions during the pandemic is not fully known. This study demonstrated what child teletherapy sessions looked like during COVID-19 with small and clinic population. Different interaction structures occurred throughout the therapy process, and we think that this interaction structures cannot be considered separate from COVID-19's features. It has been argued that the changing framework in teletherapy reduces the therapist's control in sessions (Burgoyne & Cohn, 2020). We also thought that the therapist's use of directive and structured techniques might be related to the issue of control. Moreover, this period was a traumatic shared by the therapist and the client (Ronen-Setter &Cohen, 2020). We thought this shared traumatic experience might be related to the unresponsiveness of the therapist during the sessions. Considering these findings, it will be very important for the therapists to understand how they are affected by this traumatic experience and how this reflects on the sessions and their relationships with the clients.

Moreover, we found that different capacities of children are associated with different interaction structures in therapy process. Previous research also demonstrated that different diagnosis of children and mentalization capacity is associated with different interaction structures in the therapy process (Goodman & Athey-Lyold, 2011; Goodman, 2015; Ramires et al., 2017). However, there is no study investigating mentalization capacity and its relation to therapy process during traumatic times. Our results are in line with previous findings. Child-mother's different mental state talk use was associated with different interaction structures in

therapy sessions. We found that the emotional and cognitive mental state talk capacity of the dyad was associated with more psychodynamic, which is emotion and interpretation focused interventions, of the therapist in the session. On the other hand, the less use of emotional and cognitive mental state talk was related to more directive and explorative techniques of the therapist in the session. Previous studies also suggested that it is more useful to use psychodynamic techniques with children who have developed mentalization capacity. On the other hand, more directive techniques in sessions were suggested to use with children who have less developed mentalization capacity (Ramires et al., 2020). It is known that therapists suddenly changed their therapy frameworks due to pandemic and restrictions, and teletherapy sessions have been widely used during the pandemic. However, teletherapy was not commonly used with children before and most of the therapists were not familiar with this new setting. Additionally, therapists were required to provide teletherapy during traumatic and stressful time. At this point, it may be important for therapists to evaluate the different mentalization capacities of children and adjust their interventions according to these different capacities during trauma periods and teletherapy sessions. The intervention strategies can be tailored to the child's stage of mentalization capacity. As a result, their therapy process can be more helpful.

Moreover, emotional dialogues between mother-child are associated with children’s emotional regulation and better coping mechanisms during stressful times (Fivush, 2006). However, there is no study which investigating relationship between this capacity and children’s psychotherapy sessions. Our results showed that this capacity, particularly the dyad’s creation of emotionally coherent stories, was associated with an interaction structure in the therapy process. Creating coherent narratives is very important for children’s mental health in the times of trauma. Children can regulate their emotions if they participate in emotionally focused, coherent dialogues with their parents. Our results also found that creating less coherent stories was associated with more fearful children in the sessions. Considering this result, it may be important for therapist to evaluate the emotional dialogue capacity of the dyad during traumatic times. This evaluation can give an idea about what kind of environment the child has in expressing own feelings during

the traumatic period. Moreover, therapists can also see how the child's emotions are regulated and make the necessary adjustments in the therapy sessions based on this evaluation Lastly, it may be important to assist parents to develop proper emotional dialogue capacities with children during traumatic periods, which can help children regulate their emotions.

4.3 Limitations and Future Research

There are several limitations in this study. First and the most important limitation is that the sample size of the study is very small. Even if there were significant relationships found, it was difficult to generalize these results with this sample size. Therefore, future studies might try to understand the relationship between interaction structures and mental state talk, and interaction structures and emotional dialogue of mother-child dyads with larger sample sizes. Secondly, we did not use any control variables while examining the relationship between interaction structure and mental-state talk, and interaction structure and emotional dialogues. Therefore, age, gender, behavioral problems of the children could be used as control variables in future research. Besides that, future studies can control language capacities of children because language is an essential predictor of verbal expressions and understanding mental states. Lastly, our data included only clinical sample, and there were no control groups with non-clinical sample.

Moreover, the primary aim of the study was to understand the nature of teletherapy sessions during COVID-19 period. Therefore, online therapy sessions were coded with Child Psychotherapy Q Set (CPQ). CPQ was originally developed to describe the natures of child sessions in traditional settings. There were no studies using CPQ to code teletherapy sessions. Even though some adaptations in CPQ items have been made for teletherapy sessions before coding, a coding system developed for teletherapy sessions that can capture the essence of these sessions can be used in future studies. Another limitation is that there were children with different number of sessions in our study. The means of all time points of the sessions for each child were used to calculate interaction structure scores, but

interaction structure scores may vary at various stages of therapy. It would be beneficial to examine the interaction scores' trends over the course of treatment in different therapy stages, as well as their relationship to mental state talk and emotional dialogues of child-mother dyads in further research.

Regarding mental state talk, we assessed mother-child mentalization capacity with CS-MST which was used in coding of emotional dialogue narratives. CS-MST was not used for coding emotional dialogue narratives before, and we did some adaptations for coding these narratives. Because emotional dialogue task was required to talk about emotions, it was confusing and difficult to decide which emotion words really were produced by the mother or child. Therefore, we wanted to create some principles to be used by coders and we decided to code emotion words when the dyad started to tell story. In future research, mental state talk capacities of child-mother might be evaluated with a more valid and standard procedure. Moreover, mental state talk capacities of both mothers and their children were assessed in this study with story-telling procedure which may be considered as structured and stressful context. Because of the different contexts' effect on mentalization, future studies might use different contexts where mothers and children may feel more relaxed such as free play and unstructured environments (Gocek,2007). Although the current research covered different types of mental state talk of child-mother dyad, there are still several categories that were left out. The relationship between action-based, perceptual, physiological mental state talks and interaction structures might be investigated in future research. Lastly, we coded only mothers and children's mental state talk use in this study. However, in the previous research (Gürleyen, 2016) it was found that therapist's use of mental state talk was related to affect modulation in children's play. Therefore, future studies may also code therapist's mental state talk in therapy or other setting and examine its relationship to interaction structures.

Emotional dialogue capacities of child-mother dyads were evaluated with Autobiographical Emotional Events Emotional Dialogues task. In the original application of the task, mother-child discussed about emotions in the absence of an observer, and their dialogues were recorded. However, since we applied this task in

an online environment, a research assistant attended the meeting and the research assistant sometimes had to interrupt the conversation of child-mother due to internet connection problems. These interruptions might have had some effects. Therefore, in future research, it would be better to apply the AEED task in accordance with the original procedures. Lastly, this study included only the child-mother dyads and assessed their mental state talk and emotional dialogue capacity as well as their relation to interaction structures in child sessions. In future studies, including child-father pairs, the relationship between the mental state talk, emotional dialogue capacity and interaction structures in child sessions can be examined.

4.4 Conclusion

The aim of this study was to examine the nature of online child therapy sessions during the pandemic and the association between child-mother dyads' mental state talk and interaction structures of the children's sessions, and emotional dialogue capacities and interaction structures of the children's sessions. Therefore, the initial step of data analysis was to identify the interaction structures that appeared in our data. After that, the second step was to investigate their relationship with child-mother dyads' mental state talk and emotional-dialogue capacities.

Results of this study demonstrated that there were five interaction structures children's teletherapy sessions during the pandemic. These are (IS 1) Psychodynamic Therapist with Regulated, Insightful and Intimacy Seeking Child, (IS 2) Unaccepting and Directive Therapist with Distant Child, (IS 3) Children's Spontaneous Emotion Expression, (IS 4) Dependent and Introvert Child with Explorative Therapist, (IS 5) Non-responsive Therapist with Fearful Child. Considering the relationship between child-mother emotional mental state talk and interaction structures, it was found that child-mother use of causal mental state talk was negatively associated with (IS 4) Dependent and Introvert Child with Explorative Therapist. Moreover, child-mother use of self/other/unique cognitive mental state talk had a negative relationship with (IS 2) Unaccepting and Directive Therapist with Distant Child. Regarding the relationship between the child-mother

emotional dialogues and interaction structures, it was found that there was a negative relationship between "emotionally coherent stories" and (IS 5) Non-responsive Therapist with Fearful Child. Lastly, there was no significant differences between interaction structures in different AEED categories.

There is no research on interaction structures in child teletherapy sessions during the pandemic. The findings of this study provided insight into the nature of children's teletherapy sessions during the pandemic. The results also revealed that interaction structures that emerged between the therapist and child during the sessions had a relationship with child-mother mental state talk and emotional dialogues. Although, previous studies have found the relationship between mentalization and psychotherapy process, the relationship between child-mother emotional dialogues and children's psychotherapy sessions has not been previously studied. This study suggested that two important protective factors: mental state talk and emotional dialogues between mother-child dyads were associated with children's teletherapy process during the pandemic.

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APPENDICES

APPENDIX A: Information About The Exposure Level Of Covid-19 Pandemic

1. Salgın nedeniyle çocuğunuz ile ayrı bir yerde yaşamak zorunda kaldınız mı?
- Evet
- Hayır

2. Kronik rahatsızlığınız var mı? (Örneğin; diyabet, kalp hastalığı, astım vb.)
- Evet
- Hayır

3. Korona virüs/COVID-19 pandemisinin uzun vadede FİZİKSEL SAĞLIĞINIZA olan etkisini nasıl tanımlarsınız?
- Çok Az
- Az
- Ne Az Ne Fazla
- Fazla
- Çok Fazla

4. Korona virüs/COVID-19 pandemisinin uzun dönemde maddi olarak sizi ne kadar etkileyeceğinizi düşünüyorsunuz?
- Çok Az
- Az
- Ne Az Ne Fazla
- Fazla
- Çok Fazla

5. Kaç gündür evde tecrit halindesiniz ya da karantinadasınız?
- 0
- 1’den az
- 1-7
- 8-14
- 15-21
- 22-28
- Bir ay ve daha fazlası

6. Siz ya da tanıdığınız biri korona virüs/COVID-19 tanısı aldı mı?
- Evet
- Hayır

7. Görevini sürdürmekte olan bir sağlık çalışanı mısınız?
- Evet
- Hayır

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

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

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

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

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

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

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

APPENDIX C: Children Revised Impact of Events Scale (CRIES)

Aşağıdaki listede stresli/zorlu yaşam olaylarına maruz kalan insanların ifade ettikleri bazı açıklamalar yer almaktadır. Lütfen aşağıdaki ifadelerden, son yedi gün içinde, sizin için de geçerli olanları, sıklıklarına göre belirtiniz. Bu ifadelerde belirtilen hususlardan son bir hafta içinde yaşamadıklarınız varsa, söz konusu ifade için 'Hemen Hiç' kutucuğunu işaretleyiniz.

	Hemen Hiç	**Nadiren**	**Bazen**	**Sıklıkla**
1. İstemediğin halde olay aklına geliyor mu?	**1**	**2**	**3**	**4**
2. Olayı hafızandan silmeye (aklından çıkarmaya) çalışıyor musun?	**1**	**2**	**3**	**4**
3. Bir şeye dikkatini vermekte ya da odaklanmakta zorluk yaşıyor musun?	**1**	**2**	**3**	**4**
4. Olayla ilgili kuvvetli duygu dalgalanmaları yaşıyor musun?	**1**	**2**	**3**	**4**
5. Olaydan önceki döneme kıyasla kendini daha gergin hissediyor, ya da daha kolay irkiliyor musun?	**1**	**2**	**3**	**4**
6. Olayı hatırlatacak şeylerden uzak duruyor musun? (Örneğin; olayın geçtiği yer veya durumlar.)	**1**	**2**	**3**	**4**
7. Olay hakkında konuşmamaya çalışıyor musun?	**1**	**2**	**3**	**4**
8. Olayla ilgili görüntüler birden zihninde beliriyor mu?	**1**	**2**	**3**	**4**
9.Başka şeyler o olayı aklına getiriyor mu?	**1**	**2**	**3**	**4**
10. O olayı düşünmeye çalışıyor musun?	**1**	**2**	**3**	**4**
11. Kolayca (çabucak) sinirleniyor musun?	**1**	**2**	**3**	**4**
12. Açık bir sebep olmadığı zamanlarda bile dikkatli ve tetikte (bir şey olacakmış gibi) oluyor musun?	**1**	**2**	**3**	**4**

13. Uyku problemi yaşıyor musun?	**1**	**2**	**3**	**4**

APPENDIX D: The Autobiographical Emotional Events Dialogue (AEED)

Yönerge:

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

Kartlardaki duygulara tek tek bakalım;

"Mutlu"
"Üzgün"
"Kızgın"
"Korkmuş"
"Güvende Hisseden"

Şimdi sizden _____ ile ilgili bir hikâye anlatmanızı ve bunu birlikte yapmanızı isteyeceğim.
___'nın mutlu hissettiği gerçek (yaşanmış) bir olay, üzgün hissettiği başka bir olay şeklinde bütün duygularla ilgili birer yaşanmış olay anlatacaksınız. Toplamda beş duyguyla ilgili beş farklı olay anlatmanız gerekiyor. Bu hikayeler her ikinizin içinde bulunduğu olaylarla ilgili de olabilir, sadece ___'nın içinde bulunduğu bir olayla (okulda, arkadaşlarıyla vb.) ilgili de olabilir.
Acele etmeden anlatın ve her duygu için anlattığınız hikâyede ne olduğunu ve ___'nın ne hissettiğini ne düşündüğünü ve ne yaptığını anlayabilelim.
İstediğiniz duyguyla başlayabilir ve istediğiniz sırayla devam edebilirsiniz, belirli bir sırayı takip etmeniz gerekmiyor, bütün duygularla ilgili hikâye anlatmış olmanız gerekiyor.
Hikâyeyi bitirdiğinizde bana haber verin ve anlatmak istediğiniz bir sonraki duyguyu söyleyin ki size o kartı gösterebileyim.
Sormak istediğiniz bir şey var mı?

ETHICS BOARD APPROVAL

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