ISTANBUL BILGI UNIVERSITY
INSTITUTE OF GRADUATE PROGRAMS
CLINICAL PSYCHOLOGY MASTER'S DEGREE PROGRAM

THERAPEUTIC ALLIANCE DEVELOPMENT AND STRAINS IN PSYCHODYNAMIC PSYCHOTHERAPY WITH YOUTH: COMPARING FACE-TO-FACE AND ONLINE PROCESSES

Ebru AÇIKGÖZLER
119637004

Asst. Prof. Sibel HALFON

İSTANBUL
2022

Therapeutic Alliance Development And Strains In Psychotherapeutic Allıance Development And Strains In Psychodynamic Psychotherapy With Youth: Comparing Face-To-Face And Online Processes

Ergen Psikodinamik Psikoterapisinde Terapötik İttifak Gelişimi ve Kırılmalar: Çevrimiçi ve Yüzyüze Süreçlerin Karşılaştırılması

Ebru Açıkgözler
119637004

Tez Danışmanı: Dr. Öğr. Üyesi Sibel Halfon İstanbul Bilgi Üniversitesi
Jüri Üyeleri: **Dr. Öğr. Üyesi Zeynep Maçkalı** İstanbul Bilgi Üniversitesi
Dr. Öğrt. Üyesi Nesteren GAZİOĞLU Maltepe Üniversitesi

Tezin Onaylandığı Tarih: 22.06.2022
Toplam Sayfa Sayısı : 129

Anahtar Kelimeler (Türkçe)
1) terapötik İttifak
2) çevrimiçi psikoterapi
3) ergenlik
4) pandemi
5) kırılma onarım

Anahtar Kelimeler (İngilizce)
1) therapeutic alliance
2) online psychotherapy
3) adolescence
4) pandemic
5) rupture resolution

ACKNOWLEDGEMENTS

First and foremost, I would like to thank my advisor Sibel Halfon for her guidance. I have always admired her intelligence and dedication to the psychology field. I am so glad to find an opportunity to work together on my thesis. It has been the most educatory year for me thanks to her. I also thank my thesis committee, Zeynep Maçkalı and Nesteren Gazioğlu for their contributions.

I would like to thank all clinical psychology students who contributed by giving their precious time and coding the sessions. This study could not be possible without them. I am a lucky person to have my thesis buddies Dilara, Nurşen, and Tuğçe with me whole year. They also showed their support whenever I needed it. They made my thesis year more bearable with their emotional encouragement. I am sure that we have connected so deeply and wish to have each other's backs for the rest of our lives. I am so glad to know my kind, and sincere friend Hazal. She has been always with me while struggling with my thesis and clinical practice. I wish she will always be my peer supervisor and encourage me to step forward. I would like to express my gratitude to Selin Ateş, she has always shown me the fun parts of life with her fun and joyful laughs. Begüm, Şule, Ece, Selin Tahmazoğlu, Zeynep and Serhan, I am so glad to know you and be friends with you.

This challenging year, I am lucky to have my soul mate, Kurtuluş with me. He always helped me to see the big picture and calmed me down with his love and care. Also, I would like to thank my cat Leyla who is my love, daughter, friend, and family. Even though she was not so careful about jumping on my computer and wrote several pages of “rrrr” on my work, she was a good night watcher while I had to work till morning. I want to thank my chosen family, Rabia and Merve to have my back forever. Lastly, I would like to thank my family for showing their support and believing in me. It means a lot to me.

This thesis was partially supported by thesis advisor Assistant Professor Dr. Sibel Halfon's TUBİTAK Project No: 215 K 18

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

ABSTRACT

The therapeutic alliance is the relationship between therapist and patient consisting of an emotional bond and collaboration on therapy work. It has been found highly related to the effectiveness of psychotherapy. Nevertheless, there is still limited knowledge about the therapeutic alliance in youth psychotherapy, especially in the online therapy setting during the pandemic. The necessity of research investigating online therapies has increased because of the high demand for them during the pandemic. This study aims to investigate therapeutic alliance strength and processes of online youth psychotherapies conducted during the pandemic and compares the strength and growth of therapeutic alliance with face-to-face sessions conducted before the pandemic. It was hypothesized that there was no significant difference between therapeutic alliance strength between therapy types. In the study, the psychotherapy processes of 57 adolescents between the ages of 10 and 14 were examined. Online and face-to-face sessions were coded via the Therapy Process Observational Coding System- Alliance scale (TPOCS-A) once in every ten sessions. The Multilevel Modeling approach was applied to analyze the data. Results showed that there was no significant difference in mean alliance strength between online and face-to-face therapies; however, therapeutic alliance decreased in online therapy while it increased in the sessions that were conducted face-to-face over the course of treatment. Descriptive analyses showed that ruptures in youth therapies occurred more frequently in face-to-face therapy group. Moreover, confrontational ruptures and therapists' contributions to ruptures were more impactful in the face-to-face group. Results indicate that therapeutic alliance can be formed at the beginning of both treatment types; however, the face-to-face group seems advantageous in terms of identifying and repairing alliance ruptures. Therefore, the therapeutic alliance may have increased over time in the face-to-face group. This study provides preliminary results on therapeutic alliance in both online and face-to-face psychodynamic youth therapies.

Keywords: therapeutic alliance, online psychotherapy, adolescence, pandemic, rupture resolutions

ÖZET

Terapötik ittifak, terapi çalışmasında duygusal bağ ve iş birliğinden oluşan terapist ve hasta arasındaki ilişkidir. Psikoterapinin etkinliği ile yüksek oranda ilişkili bulunmuştur. Bununla birlikte, özellikle pandemi dönemindeki çevrimiçi terapi ortamında, ergen psikoterapisinde terapötik ittifak hakkında hala sınırlı bilgi bulunmaktadır. Pandemi sırasında yüksek talep nedeniyle çevrimiçi terapileri araştıran araştırmaların gerekliliği ise artmaktadır. Bu çalışma, çevrimiçi ergen psikoterapilerinin pandemi sırasında ve pandemi öncesi yüz yüze oturumlarda ittifak gücü ve terapötik ittifak süreçlerini araştırmayı amaçlamaktadır. Yüz yüze ve çevrimiçi terapilerde ittifak gücünde anlamlı bir fark çıkmayacağı hipotez olarak sunulmuştur. Çalışmada 10 ile 15 yaş arasındaki 57 ergen katılımcının psikoterapi süreçleri incelenmiştir. Çevrimiçi ve yüz yüze seanslar Gözleme Dayalı Terapötik İttifak Aracı (TPOCS-A) ile her on seansta bir kodlanmıştır. Verileri analiz etmek için Çok Düzeyli Doğrusal Modelleme yaklaşımı uygulanmıştır. Sonuçlar, çevrimiçi ve yüz yüze terapiler arasında ortalama ittifak gücünde anlamlı bir fark olmadığını göstermiştir. Ancak, çevrimiçi terapi sürecinde terapötik ittifak azalırken, terapi süresince yüz yüze terapi grubunda artmıştır. Betimleyici analiz terapötik ittifaktaki kırılmaların yüz yüze terapi grubunda daha sık olduğunu göstermektedir. Ayrıca, konfrontasyonel kırılmalar ve terapistlerin kırılmalara olan katkısı yüz yüze terapi grubunda daha etkilidir. Sonuçlar, terapötik ittifakın her iki tedavi türünün başlangıcında da kurulabileceğini göstermektedir; ancak yüz yüze grup, ittifak kopukluklarını tespit etmek ve onarmak açısından avantajlı görünmektedir. Bu nedenle, terapötik ittifak yüz yüze grubunda zamanla artmış olabilir. Bu araştırma, hem çevrimiçi hem de yüz yüze psikodinamik ergen terapisindeki terapötik ittifak hakkında ön bulgular sunmaktadır.

Anahtar Kelimeler: terapötik ittifak, çevrimiçi psikoterapi, ergenlik, pandemi, kırılma onarılma

CHAPTER 1
INTRODUCTION

Teletherapy has been discussed for a long time among therapists in terms of benefits and limitations. One of the biggest concerns about online therapies is building a therapeutic alliance with patients because of limited bodily reactions, unable to read cues, and space between patient and therapist (Hanley, 2009). On the other hand, empirical studies show the effectiveness of online therapies as much as face-to-face therapies in terms of therapeutic alliance and outcome (Kaiser et al., 2021). The patient and therapist relationship has been essential in psychodynamic therapy from its beginning with Sigmund Freud. Following theoreticians developed the concept of therapeutic alliance, and studies proved its effectiveness on the outcome. Recently, therapeutic alliance studies have developed more via second-generation studies. Those researchers argue that there is an ongoing negotiation on the alliance, so these studies show that ruptures are frequent in sessions, as was predicted before, but ruptures could strengthen outcomes when they are resolved in session (Safran & Muran, 1996). Even though studies show the effectiveness of online therapies, teletherapies during the pandemic may cause changes in the therapeutic alliance because of changed dimensions like therapy settings, traumatic effects of the pandemic, etc. There is no evidence to examine the effects of changes in dynamics in psychotherapy with the Covid-19 pandemic on therapeutic alliance and outcome. There is insufficient research about online therapy processes during the pandemic; therefore, conducting discussions about the effectiveness of online youth therapy and the difference in therapeutic alliance development is impossible. During the Covid-19 pandemic, teletherapy has become the only option while it was a personal option for patients and therapists before. Hence, this unique age of psychotherapy necessitates investigating the differences between face-to-face therapy and teletherapy dynamics more in-depth.

Undoubtedly, the Covid-19 pandemic has been the biggest disaster of our times. Current statistics show that there are 528 million confirmed cases so far and 4 million deaths from the virus (Johns Hopkins Coronavirus Resource Center,

2022). Covid-19 is not the only pandemic in history, but it is unique in terms of the conditions of the era, such as increased use of social media, fast spread of news, and unfiltered resources from users (Cinelli et al., 2020). Therefore, the spread of news about viruses was faster than the virus itself (Horesh & Brown, 2020). Besides the physical danger of viruses, the psychological impacts of Covid- 19 are undeniable.

Statistics from different resources show increased anxiety and depression rates all over the world due to the pandemic. Especially, adolescents have been affected by the conditions of the pandemic because socialization has a vital role in the adolescence period because of the increased number of conflicts with parents in the process of building self-identity. Studies show an increase in screen time and a decrease in physical activity (Xiang et al., 2020), mental health disturbances like anxiety and depression (de Miranda et al., 2020), game addiction, and related sleep disturbances among adolescents (Fernandes et al., 2020). As a result, psychotherapy research has become more essential and needed for youth to increase its effectiveness in this novel era more than ever. On the other hand, precautions against the virus spread have prevented traditional face-to-face therapies for a longtime, which causes the psychotherapy process to be affected like many aspects of life. Many psychotherapists transformed to teletherapy, and many of them have stillbeen continuing online sessions.

In this present study, how therapeutic alliance changes in the therapy process will be investigated in both online and face-to-face treatments from a global alliance perspective. Thus, therapeutic alliance strength and growth for both therapy types will be compared. Additionally, low alliance sessions from both groups will be determined and analyzed via micro alliance measurement to reveal rupture and repair sequences in those sessions. Rupture and repair frequencies and impacts in low alliance sessions will also be compared between online and face-to-face treatment groups. In this way, differences in the therapeutic alliance process and low alliance sessions between online therapy and face-to-face therapy will be explored and discussed.

1.1 PSYCHODYNAMIC BACKGROUND OF THERAPEUTIC ALLIANCE

Therapeutic alliance has been an important and popular topic among therapy researchers for a long time because important results indicate a high correlation between outcome and therapeutic alliance (Flückiger et al., 2018). The theoretical background should be conceptualized to understand the importance of the therapeutic alliance in treatment.

Firstly, the therapeutic alliance was conceptualized in adult therapy, starting with Sigmund Freud. Freud (1912b), from the beginning of his theory, emphasized the importance of the relationship between the analyst and the patient because it is the primary tool to cure patients' neurosis. He claims that a patient's unconscious and unsatisfied part of the self (fantasies, wishes, internal objects, etc.) is directed to the analyst, which is also defined as transference neurosis, the most significant resistance in the analytical work (Kanzer, 1981). There is a two-sided interaction in the analysis; therefore, transference and countertransference concepts have been emphasized, and Freud (1912b) believed that this unconscious interaction between the patient and analyst should be brought to the consciousness to be able to cure a patient's neurosis. Mitchell (1993) states that both hopes and dreads that come from the unconscious, infantile fantasies are projected to the analytic situation, and they become consciousness via analytical work. To be able to sustain the analytical work, Freud (1912b) emphasizes the importance of realistic aspects of the relationship with the patient, which is defined as a "therapeutic pact," and he separates the real relationships from transference neurosis (Freud, 1912b). Freud and Breure (1893-1895) indicate that patients should be collaborators of the therapeutic work to apply the necessities of analysis, such as internalizing the therapist's interpretations, regularly attending, telling dreams, and using free associations, etc. (cited in Kanzer, 1981).

Then, Sterba (1934) was the first theoretician to use the term "ego alliance" defining alliance working with the ego's reality principle, and he indicates that for a successful therapy, the patient's ego should swing between experiencing and observing the ego (cited in Gaston, 1990). Then, Zetzel (1956) and Greenson (1965)

also highlight the importance of being an ally of the patients' observing part of the ego. Zetzel (1956) used the term *therapeutic alliance* for the first time, and she distinguished the transference from the transference neurosis. She argues that the transference neurosis to work, transference, or a "therapeutic alliance" should be established. According to Brenner (1979), Zetzel interpreted therapeutic alliance with referring to the very early relationship patterns between the mother and the infant. As much as the analytical work is deepened, the patient regresses to the early childhood conflicts between the mother and the infant, which are directed to the therapist (Zetzel, 1956). If the therapeutic alliance is not strong enough, transference neurosis could be complex because the patient cannot differentiate between inner conflicts and the real relationship with the therapist (Zetzel, 1956). The therapeutic alliance was conceptualized as the adequate ego strength by her, which enables the patient to differentiate between inner and outside experiences since it works by the reality principle (Zetzel, 1956).

Greenson (1965) divided the relationship into three categories: transference, real relationship, and the working alliance. He argues that all three concepts of the relationship are interrelated and affect each other. Even though his ideas are similar to that of Zetzel's, he prefers to use "working alliance" as a term because he would like to highlight the conscious and rational will of the patient to work with the therapist. He was the one who advocated that a working alliance should be a necessary part of the whole therapy process instead of building it only at the beginning for successful therapy (Greenson, 1965, 2008). He believes that an appropriate working environment to establish a working alliance could be sustained only with a therapist who has a steady, dependable, and "human" characteristics (Greenson, 1965).

A therapeutic alliance was a more quantifiable aspect to Bordin (1979). He was the one who conceptualized the therapeutic alliance categorically and described three aspects of it, which were the agreement on goals, collaboration on tasks, and development of the bond (Bordin, 1979). The goal is described as the agreement of both sides to work on the patient's psychological burdens as therapy goals; the task is described as a collaboration of both sides to follow the therapist's therapeutic

methods; the bond is described as the attachment between the patient and the therapist including deeper bonds of trust and acceptance (Bordin, 1979). Bordin created an inclusive model depending on previous theoreticians' alliance conceptualizations and measurable categories for research.

Later, Lubrosky (1984) conceptualized the developmental phases of the alliance by categorizing the alliance into two: type I alliance and type II alliance. Type I alliance refers to patients' perception of the therapist as warm, supportive, and helpful, and the therapy as effective, which happens in the early phase of therapy; type II alliance is the collaboration and mutual understanding of goals and tasks of the therapy (Lubrosky, 1984). He argues that an affectionate bond is built first in the therapy and a high affectionate bond sustains further alliance parts for goal and collaboration (Horvath & Luborsky, 1993).

1.1.1 Therapeutic Alliance in Child and Adolescent Psychotherapy

Affectionate bonds are seen as a vital part of the child and adolescent therapy. One of the pioneers of child and adolescent psychotherapists, Anna Freud (1946), emphasized the therapeutic alliance in youth therapies. She indicates that the therapeutic alliance is an emotional attachment between the child and the therapist, so it is necessary for the therapy, and it is the base for interpretation (A.Freud, 1946). Anna Freud (1946) conceptualized the therapeutic alliance by splitting it into two aspects; emotional bond and work task. She argues that emotional bond is a base of therapeutic work in youth therapy, so it can facilitate youth to get involved in therapeutic work (A. Freud, 1946). Since the bond is the fundamental aspect of youth therapy, her studies primarily focused on the emotional bond aspect of child therapy (Shirk, Karver & Brown, 2011).

Axline (1947), the founder of child-centered therapy, claims that the relationship between the child and the therapist is not the base of the therapy but the essence of the child therapy. Children can be free to discover their emotions and inner conflicts in a dependable therapist's existence (Shirk, Karver & Brown, 2011). She believes that a therapeutic relationship could be built in an environment of

acceptance, empathy, and caring with protective boundaries and limits (Moss & Hamlet, 2020). She puts relationships at the center of the therapy. In her principles of child-centered play therapy (Axline, 1969), she mentions firstly to "*Develop a warm, friendly rapport with the child as soon as possible*." and in the following statements, she highlights the importance of being respectful, being a follower of the child's lead, and acceptance (cited in Moss & Hamlet, 2020, p.1). Followers of the child-centered therapy also support being nonjudgemental and caring, and the supportive attitudes of the therapist are the base of change in the therapy (Shirk, Karver & Brown, 2011).

Carl Rogers (1957), the pioneer of client-centered therapy or Rogerian therapy, is another theoretician who supported putting the patient in the center of therapy with empathy, unconditional positive regard, and congruence. He believes that therapeutic change comes from these attitudes of the therapist. Even though Rogers mainly worked with adult patients, he influenced child counseling because of his humanistic approach. He valued humanity itself; therefore, having a respectful and open relationship with the patient was his only necessary tool for therapy. He also believed that child therapy could be successful if a supportive environment for children to grow could be created by therapists' acceptance, care, and empathy. He associates the care of a therapist for a child with a mother's love for her infant (Rogers, 1957).

Rogers (1957) was not the only one associating the therapist-patient relationship with the mother-infant relationship, and many theoreticians and psychotherapists defend that the therapeutic alliance between the therapist and the patient is the reflection of the early mother and child relationship (Bowlby, 1958; Chethik, 2002; Loewald, 1960; Mackie, 1981; Zetzel, 1965). Bowlby (1988) indicated that therapists are temporary attachment figures. Attachment theory developed by Bowlby (1958) and Ainstworth (1978) claims that infant and mother develop an attachment within the first 12 months of the infancy, and one takes this attachment style to every relationship lifelong because it is the first human relationship reference for the human being (Ainsworth et al., 1978; Bowlby 1958; Zilberstein, 2014). Therefore, it is possible to state that therapeutic alliance with the

patient includes mother-infant attachment styles. The attachment style or the internalized working model is activated when the one who has felt threatened or stressed seeks proximity, protection, and care, except for the ones who has a disorganized attachment (Zilberstein, 2014). Since young children are more vulnerable and dependent on attachment figures, their internal working model is activated often (Zilberstein, 2014). This may be because attachment and emotional bonds in child therapy are essential. With age and maturation, the vulnerability of the child decreases. Adolescents do not seek parents if they can handle it on their own because they are more independent to cope and able to use peer support (Zilberstein, 2014). However, insecure attachment to caregivers could affect relationship patterns in adolescence; therefore, psychotherapy aims to provide a secure attachment to patients to repair mother-infant relationship conflicts for better functioning in relationships, gaining affect regulation, and mentalization capacity (Fonagy & Target, 2002).

Kohut (1984) hypothesizes that at the core of psychopathology, there are repeated empathic failures in the early phases of the relationships between the child and caregiver, and these could be cured in the therapeutic relationship with an empathic attitude of the therapist (cited in Baker & Baker, 1987). Therefore, a therapeutic relationship must be positive, dependable, need-gratifying, and real. In this way, patients are able to attend therapeutic work and also develop a capacity to build secure relationships (Horvath & Luborsky, 1993). Winnicott (1971) also indicates that therapeutic growth can happen only by a “good enough” therapist who can attune to a child’s needs and create a holding environment to help the child find the true self. The therapist’s availability, sensitivity, and supportive and empathic attitudes create secure attachment and enable the child to explore safely his/her inner world (Zilberstein, 2014). In play therapy, the relationship between the therapist and the child is curative and necessary for growth (Shirk & Saiz, 1992).

Bibring (1937) argues that a therapeutic relationship is a “new-object relationship" in which a patient can establish a new way of relationship pattern differing from the early attachment to his/her caregiver (cited in Horvath & Luborsky, 1993). Chethick (2002) states that the therapeutic alliance is children’s

libidinal attachment to the therapist who provides an opportunity to fix his/her early relationship patterns. Chethick (2002) examined three sessions of three different clients from different developmental phases, such as a toddler, 6 year-old child, and a young adult. His paper shows that relatedness and the special communication between toddler and mother sessions are developed both in child and adult sessions. He claims that a playground is established both in the child and adult sessions, and the playground enables patients to be free and face their inner conflicts (Chethick, 2002). Building this playground depends on the quality of the early mother-child relationship. He indicates that "*the alliance coexisted with the transference*"; therefore, establishing the playground is possible with the alliance as well as transference (Chethick, 2003, p.18). Therefore, therapeutic relationships are in the gray area where reality and transference are blended. According to Murray (1974), to fix these attachment patterns, children use therapists as a transitional object which is defined as the object used and controlled by the child to soothe him/herself against separation from the external object (Winnicott 1971). In this sense, the transitional object belongs to both the real and fantasy of the child. So it is both subjective that belongs to the internal world of the child and objective belongs to reality at the same time. This creates a dual relationship with the therapist affecting each other. In this duality, therapeutic alliance holds the real base of the relationship to sustain dependability and secures the frame of the therapeutic work (Chethik, 2002).

This duality of relationship resembles Winnicott's (1971) emphasis on play. Winnicott (1971) claims that play is a transitional space between reality and the fantasy of children. Through play, children can separate the inner and outside world (Winnicott, 1971). In the play, children could give meaning to their inner conflict partly from outside and outside conflicts affecting the inner world (Winnicott, 1971). Also, play is a place where the therapist can be regressive, fun, and child-like, which helps to build a therapeutic alliance since the child is not the one who needs to be adult-like and understood by a playful adult (Gardner, 1993). Both verbal symbolization and defenses for direct communication are not adequate yet; play is the language of children until late latency or pre-adolescence (Sarnoff,

1987). Sarnoff (1987) explained that incredible improvement in language enables pre-adolescents to use language as a playground so they can stop playing. He named it as "*lucid demise*" because it is the era of the abandonment of symbolic play and transition to speech (p. 42). Latency-age speech and adolescent speech are also differentiated by the use of language as play in evacuative ways for adolescents (Dowling, 1994). Even though there are various types of adolescent and child therapy in terms of therapy technique, developmental features, and so on, there is less emphasis and research on adolescent psychotherapy in terms of different aspects of the therapeutic alliance.

Adolescence is a time to change both physically and psychologically and is known as the second individuation phase (Blos, 1967). Suppressed oedipal conflicts are awoken in the adolescent with the maturation in sexuality. Freud (1958) described this phase as retesting the internalized objects of pre-latency. Adolescence is divided into early, middle and late adolescence (Elliot & Feldman, 1990). Early adolescence is between 10 to 14 years old, and it is the time of changes in biological maturation and refocusing on the social interactions centered on the opposite sex (Elliot & Feldman, 1990). During this second individuation process, parents are devalued, and adults who are different from their parents are idealized (Everall & Paulson, L. 2002). They try to gain control over their lives and seek to become independent, so they may perceive therapists as authority figures. However, respect from the therapists and being on the same level with adolescents may encourage them to open themselves (Everall & Paulson, L. 2002). Even though it is hard to build a therapeutic alliance with adolescents, a high therapeutic alliance enables them to work their conflicts on a safe ground. Therapists in adolescent therapy can serve as a friend who is easy to talk to and has wisdom and experience (Everall & Paulson, L. 2002). In this research, early adolescents are chosen as a target group to understand their therapeutic alliance development and difference inthe two treatment types.

Shirk and Karver (2003) hypothesized that therapeutic alliance might have greater importance in youth than in adult patients. Especially, the emotional bond has been prioritized in child and adolescent psychotherapy (Shirk & Karver, 2003).

Emotional bond with the therapist causes children to collaborate with the therapist in tasks like playing, discovering inner conflicts, and following limits and rules (Chethik, 2003). Since youth are not mostly self-referred unlike adults, agreements on goals are not understood by youth because of less insight into the problems (Shirk, Karver & Brown, 2011). Therefore, the therapeutic alliance has been conceptualized in youth therapies only considering the collaboration and bond subscales of Bordin (Elvins & Green, 2008). On the other hand, DiGiuseppe, Linscott, & Jilton (1996) argued that neglect of the goal in the therapeutic alliance in youth therapies is against the nature of the social contract aspect of the therapy; therefore, they advocated that therapeutic alliance with children and adolescents is hard to establish. Therapy goals may differ for youth patients, parents, and therapists (Shirk & Brown, 2011). Even though there is no adequate study to show the effects of agreement of goals just with the parents in youth therapy, parents' involvement in the process of therapy shows a positive impact (Broggi & Sabatelli, 2010). Therefore, it can be said that youth therapy may be differentiated from adult therapy due to its nature (Shirk & Brown, 2011).

Empirical studies hypothesizing the goal as a component of therapeutic alliance in youth therapy, especially with older children and adolescents, failed to prove the three-factor model of Bordin (DiGiuseppe et al., 1996; Faw, et. al., 2005). Therefore, those researchers agreed that child and adolescent therapeutic alliances, due to developmental differences, may be differentiated from adult alliances (DiGiuseppe et al., 1996; Faw, et. al., 2005). Additionally, bonds and collaboration on tasks have been found to be correlated dimensions of youth therapy (Shirk & Saiz, 1992). So, bond and collaboration are the main aspects of therapeutic alliance in youth therapies. In this study, the therapeutic alliance has been operationally defined by the affectionate bond between the therapist and the youth and the collaboration on therapeutic tasks like playing, talking, or attending sessions (McLeod & Weisz, 2005).

1.1.2 Second Generation Therapeutic Alliance

Therapeutic alliance has been a controversial but rich topic in the psychotherapy literature. In the current knowledge on therapy relationships, the relational aspect of the alliance has been evaluated as "what the patient communicates to how the patients communicate and negotiates" (Dwyer Hall, 2021, p.13). Second-generation therapeutic alliance research focuses on relational aspects of the therapeutic alliance in terms of alliance development and rupture and resolution processes (Safran, Muran & Shaker, 2014). Safran & Muran (1996) claimed that the alliance is not established at once, but there is an ongoing negotiation between patients and therapists to sustain the safe ground. They state that "The alliance is a relational push-and-pull in the affectionate bond" (Safran, Muran, & Rothman, 2006, p.38); therefore, alliance ruptures are inevitable. Since the bond has vital importance in youth therapy, as it is mentioned before, it is necessary to understand ruptures in the alliance.

From the beginning of the psychotherapy, alliance ruptures have been indicated in many terms like "resistances" (Freud, 1958), "empathic failures" (Kohut, 1984), "therapeutic impasses" (Hill et al., 1996), "tears" (Bordin, 1994), "empathic strains" (Wilson & Lindy, 1994), "stucks" (Mellado et al., 2017), "transference-countertransference enactments" (Safran & Muran, 2006). All of these terms refer to a deterioration of the affectionate bond and non-collaboration on the therapy work. The operational definition of the alliance ruptures by second-generation researchers is "deterioration in the alliance, manifested by a lack of collaboration between patient and therapist on tasks or goals or a strain in the emotional bond." (Eubanks, Muran, & Safran, 2015, p.2).

Firstly, Freud (1958) drew attention to patients' non-collaborative and resistant attitudes, especially while working on important issues in the analysis. Freud's theory conceptualized these strains in the analysis as intra-psychic conflicts of the patient (Wong, 2021). Freudian theory neglects therapists' individual features affecting analysis (Mitchell, 1993). However, recent therapeutic alliance researchers investigating interpersonal dyads, interpret these

resistant behaviors as alliance ruptures having a mutual contribution of both the therapist and the patient (Safran & Muran, 2006; Wong, 2021). There is constant communication between the therapist and the patient on the level of both conscious and unconscious (Safran & Muran, 2006). The patient's maladaptive interpersonal schema is directed to the therapist, and if the therapist internalizes these projections unconsciously, alliance ruptures occur (Safran & Muran, 1996). In this way, the vicious cycle of the patient is repeated in the therapeutic relationship (Safran & Muran, 1996). For example, when a patient who has a hostile manner toward his/her therapist is responded by counter hostility, the patient's hostile understanding of others has been confirmed by the therapist's action (Safran & Muran, 1996). Since the alliance ruptures contain both sides' unconscious materials, they are obtained as transference and countertransference enactments (Safran & Muran, 2006). Enactments are the moments neither therapist nor patient can mentalize the current material, so the relationship could deteriorate (Safran &Muran, 2006). The relational perspective advocates that the therapy process is either an ongoing enactment moment or a big enactment moment (Safran & Muran, 2006). In this way, they highlight the frequency and inevitable aspects of the enactments in the therapy process.

As mentioned above, the psychotherapy process is the pull and push of the subjective beings in the relationship (Safran, Muran, & Rothman, 2006). This pull and push in the relationship originates from the mother-infant dyads (Tronick, 1989). Attachment researchers investigating the mother-infant relationship indicate that necessary rhythm in the relationship between mother and infant determines the security of the attachment; on the other hand, a high degree of misattunements in the mother-infant relationship shows insecure attachment (Bebee et al., 2010; Meins et al. 1998). When a mother is able to mentalize her child's mental states and hold his/her mind in her mind, the child feels secure, which is also related to the development of the theory of mind (Meins et al., 2002). It helps the child understand his/her feelings, behaviors, and uniqueness of his/her identity and others (Ensink & Mayes, 2010). However, the breakdowns in this mother-infant relationship are the core of psychopathology (Tronick, 1989).

Therefore, psychotherapy works on these breakdowns by building therapeutic alliances and finding a rhythm, which provides the patient a secure new object to repair dyadic ruptures in previous relationships (Feldman & Eidelman, 2007; Koole & Tschacher, 2016).

Resolution of ruptures provides a new and adaptive relational schema to the patient, and the patient could experience that the therapist is available even in the strains (Safran & Kraus, 2014). For this reason, capturing the rupture in the session and repairment in the session is the essence of therapeutic change (Safran et al., 2001). The therapist attempts to repair deteriorations in the relationship again and again, which causes to build secure attachment and high therapeutic alliance. Empirical studies also prove the theory that rupture resolutions have a significant impact on positive outcomes (Eubanks, Muran & Safran, 2018; Humer et al., 2021; Muran et al., 2009; Safran et al., 2001; Stiles et al., 2004; Strauss et al., 2006; Westra, Constantino & Aviram, 2011). Alliance ruptures could be observed either by patients' withdrawal or confrontational responses (Safran & Muran, 2000). Patients with withdrawal responses show disengagement from the therapist and therapy work (Safran, Muran, & Rothman, 2006). Withdrawal responses are identified as denial, minimal response, abstract communication, avoidant storytelling and/or shifting topic, deferential and appeasing attitude, content/affect split, self--criticism, and/or hopelessness (Eubanks, Muran, & Safran, 2015). Withdrawal ruptures could be toward satisfying the therapist; therefore, they are more hidden and type of psudoalliance (Safran, Muran & Rothman, 2006). In the confrontational ruptures, the patient's attitude toward the therapist or therapy work can be hostile; therefore, confrontational responses are easier to capture because of their nature (Eubanks, Muran, & Safran, 2015). Confrontation markers are identified as complaints or concerns about the therapist, and patient rejects therapist intervention, complaints or concerns about the activities of therapy (homework, e.g.), complaints or concerns about the parameters of therapy (like therapy room, e.g.), complaints or concerns about progress in therapy, patient defends self against the therapist, and make an effort to control or put pressure on the therapist.

Due to a higher emphasis on emotional bond and collaboration in youth psychotherapies, relational aspects of therapeutic relationships should be considered more. Adolescents are seen as the challenging population in psychotherapy in terms of building therapeutic alliances because they are not self-referred to the therapy (Di Giuseppe et al., 1996). Additionally, adolescence is an era of rapid growth and changes in their physical body, and they may feel like they are losing control in this turmoil (Waddell, 2002; Wong, 2021). On the other hand, they need to control their lives and establish their sense of identity by being a separate being from others, especially from their parents. Therefore, they may have several conflicts with their parents (Chen-Gaddini, 2012). Since adolescence is all about gaining autonomy and being "the one" by separating themself from the others, the therapy and establishing an alliance with an adult therapist and being "the two" with her/him could be challenging (Ogden, 1994; O'Keefe et al., 2020). Therefore, they may have difficulty engaging in the therapy, especially at the beginning of the process (Safran & Muran, 2000). Still, ruptures in youth therapy are vital for them to master separation and individuation actions and build self-identity (Blatt & Behrends, 1987).

Adolescents mostly show withdrawal behaviors to avoid their inner conflicts, to arrange proximity in the relationship with the therapist, and for their need for autonomy (Binder et al., 2008; Holly Dwyer, 2021; Wong, 2021). Empirical research also supports that adolescents show mostly withdrawal ruptures (Cirasola et al., 2022; Gersh et al., 2017; O'Keeffe et al., 2020; Schenk et al., 2019). Resistance to come to the therapy or engaging in therapy work by opening themselves originate from the need for autonomy or avoidance of difficult feelings (Holly Dwyer, 2021). By withdrawal responses, adolescents are able to master their autonomy and arrange their position in the relationship with the therapist (Coutinho, et al., 2011). The extreme form of withdrawal could end with the dropout, mainly when the ruptures are not resolved (O'Keeffe et al., 2020). On the other hand, some adolescents may reflect their inner aggression to the outside and show their dissatisfaction, leading the therapist to be a problem solver (Wong, 2021). Confrontational ruptures like controlling the therapist,

showing complaints towards the therapist, and therapy parameters may be felt by therapists as inadequacy, anger toward the patient, guilt, and shame (Wong, 2021). These teenagers attack the therapy relationship to control their difficult feelings like shame and guilt (Anastasopolous, 1997). It is also a reaction showing the patient's need for more proximity and more accurate understanding from the therapist (Coutinho et al., 2011).

Even though limited studies are investigating the rupture resolution process and its effects on the therapy process and outcome, empirical studies show that unresolved ruptures correlate with dropout and difficulty of engagement to therapy (Gersh et al., 2017; Holly Dwyer, 2021; O'Keeffe et al., 2020; Schenk et al., 2019). This present study is valuable in terms of researching the youth therapeutic alliance process in both online and face-to-face therapies through both the pan-theoretical approach of Bordin (1979) and the rupture-repair approach.

1.2 EMPIRICAL LITERATURE ON THERAPEUTIC ALLIANCE

Empirical studies about therapeutic alliance could be categorized into outcome and process studies. Even though this present research aims to investigate the strength and process of alliance development, it is essential to look at outcome studies since there are important indications. Then, the development of the alliance will be elaborated on in detail.

A great number of results show that therapeutic alliance correlates with good therapy outcomes. In literature concerned with adults, the most recent meta-analysis in adult psychotherapy proves that therapeutic alliance has high predictability on the outcome (Flückiger et al., 2018). In this meta-analysis, 295 studies were conducted between 1978 and 2017, including both face-to-face therapy and teletherapy. According to the results, both in teletherapy and face-to-face adult psychotherapies there is a correlation between outcome and therapeutic alliance (Flückiger et al., 2018). A recent meta-analysis conducted with adult patients that included 20 studies before February 2020 shows that there is no difference in treatment outcome between different mediums as oral (video, phone) or written (e-

mail, chat) (Kaiser, Hanschmidt, & Kersting, 2021). Overall, it has been proved that therapeutic alliance and outcome have a significant correlation in both face-to-face and teletherapy treatments in adult therapy (Kaiser, Hanschmidt, & Kersting, 2021).

The most recent meta-analysis of alliance and outcome in child and adolescent psychotherapy conducted by Karver and colleagues (2018) includes 28 studies and only the face-to-face therapies done between 1995 and 2017. The study has a small to medium effect size. It shows that there is an association between therapeutic alliance and outcome. In this study, while alliance outcome correlation is low for internalization, substance abuse, and eating disorders, it has a high correlation for outpatient and behavioral treatments. Also, meta-analysis shows that parents' alliance has high predictability of outcome than adolescents and children (Karver et al., 2018). However, in this study, Internet-based treatments are not included. In another meta-analysis (Shirk and Karver, 2003), 23 studies have been conducted in the years between 1973 and 2001. In this study, therapeutic alliance with externalizing children has shown a higher correlation with the outcome while age difference and type of treatment (behavioral or non-behavioral) show no statistically significant difference in association with outcome. Another meta-analysis of alliance and outcome in youth psychotherapies shows a small size of effect; therefore, the researcher discusses less the importance of the alliance and outcome association in youth therapies, but the development of the alliance is suggested to be examined in detail (McLeod, 2011).

Additionally, second-generation research of therapeutic alliance investigating rupture and resolution process and its effect on the outcome shows a high correlation. In the recent meta-analysis, 11 studies in adult literature have been included in the research on rupture repair episodes and treatment outcomes, and results indicate that there is a moderate relation between rupture-repair and positive outcomes (Eubanks, Muran & Safran, 2018). The research examining the correlation between rupture repair and outcome association indicates that low rupture intensity and high resolution are correlated with high outcomes (Muran et al., 2009).

Even though few studies investigate rupture-repair episodes' effect on

outcome in youth therapies, there are promising results. Daly and colleagues (2010) researched 86 borderline adolescents between 15 to 18 years old and receiving Cognitive Analytical Therapy (CAT). In the research, the global alliance has been measured at 3-time points, and low alliance sessions are selected by separating sessions as "poor" and "good" and then poor sessions are investigated by the researcher to identify unresolved ruptures (Daly et al., 2010). Results indicate that rupture resolution is related to treatment outcome and rupture resolution is a key element of psychotherapy with borderline adolescents. Schenk and colleagues (2019) have found an inverted U-shaped rupture repair trajectory with borderline adolescents. It also supports the argument that there are many ruptures in the process of psychotherapy, and if they are resolved, it affects the outcome positively (Schenk et al., 2019).

Dywer Hall (2021) explored rupture and resolution strategies in psychodynamic therapy with the depressed adolescent population and found ruptures and therapist contribution in the early phase of the therapy with adolescents more frequently. It was interpreted as adolescents' ambivalent feelings to bond with therapists while establishing the initial relationship (Dywer Hall, 2021). As it is also mentioned above, adolescents, as a developmental need, aspire to autonomy; therefore, being two with the therapist may evoke conflictual feelings (Ogden, 1994). This finding is supported by a single-case study in adolescent psychodynamic psychotherapy, which shows fewer resolution markers in the initial (Cirasola et al., 2022). Nevertheless, it increases in the middle and end phases, which causes a positive outcome (Cirasola et al., 2022). The therapeutic change is conceptualized by the therapists in this single-case study as "…*not only due to the development of new skills or new insights, but rather to the capacity of the therapeutic relationship to create a feeling of being understood, accepted, and thought about."* (Cirasola et al., 2022, p.15).

Moreover, Dywer Hall (2021) categorized the resolution markers of 3RS as Immediate Resolution and Expressive Resolutions. While immediate resolution means pursuing quick strategies like clarifying misunderstandings or validating defensive posture, expressive strategies aim to explore the rupture's relational

aspects like inviting patients to discuss feelings (Dywer Hall, 2021). Immediate strategies are used more at the beginning of the therapy to form initial alliance while expressive techniques are used in the middle and late phases of the therapy to work on unadaptive relational schema (Dywer Hall, 2021). Immediate responses to rupture is found to be related to a good outcome since therapeutic alliance is actively monitored by the therapist (Schenk et al., 2019). Schenk and colleagues (2019) also found that immediate response to confrontation ruptures; therefore, the collaboration between therapists and adolescents increased immediately after confrontation ruptures. It is because confrontational ruptures are more overt, and easy to identify than withdrawal ruptures (Schenk et al., 2019).

Unresolved ruptures have been found to be related with the dropout rate in the adolescent population (O'Keeffe et al., 2020). Researchers used the Rupture Repair Resolution (3RS) coding manual developed by Eubanks and colleagues (2014). Due to the results of this study, unresolved ruptures and high intensity of ruptures are associated with dissatisfied dropouts, and also there is more therapist contribution to rupture in the dissatisfied dropout group (O'Keeffe et al., 2020). They found more withdrawal ruptures in the treatment process (O'Keeffe et al., 2020). Adolescents may often show their dissatisfaction by withdrawing, and an increase in the confrontational ruptures through the process may indicate trustful relationships and improvement in depressive symptoms (Cirasola et al., 2022; Dywer Hall, 2021; Gersh et al., 2017; O'Keeffe et al., 2020).

To sum up, the resolutions of ruptures are an impactful signifier of good outcomes in youth psychotherapies. Moreover, the youth population may have characteristic features regarding specific rupture markers. Studies support that withdrawal ruptures occur more frequently. The current research will contribute to filling in the gap in the literature about rupture and repair in youth psychotherapy in both online and face-to-face therapy settings.

1.2.1 Development of Therapeutic Alliance

Building therapeutic alliance has been seen as a priority in both adult (Freud 1912; Zetzel, 1956; Greenson, 1965) and youth therapies (A.Freud 1946; Axline, 1947; Rogers, 1957), which is because the therapeutic alliance is seen as a necessity for therapeutic work. However, the therapeutic alliance is not static but a dynamic entity, necessitating negotiation during the whole therapy process (Safran & Muran, 2000). Therefore, process studies are needed to understand its development and relation to outcome.

Process research on therapeutic alliance mainly aims to find if there is a typical growth of the alliance associated with a good outcome and if a specific phase of the treatment predicts a good outcome (Stiles & Goldsmith, 2010). To obtain a growth trajectory, the alliance was measured at several time points in studies. Unfortunately, different studies have found different trajectories instead of one type of alliance growth trajectory for subgroups (Kivlighan & Shaughnessy, 1995; Patton et al., 1997). Then, Kivlighan and Shaughnessy (2000) conducted research analyzing the data with the cluster-analytic model to find alliance growth patterns. They claimed that there are three clusters of alliance development which are stable, linear, and quadratic growth or U-shaped growth (Kivlighan & Shaughnessy, 2000). U-shaped alliance growth has been found to be associated with more successful therapy in adult therapies (Kivlighan & Shaughnessy, 2000; Patton, Kivlighan, & Multon, 1997; Stiles et al., 2004). This trajectory has been seen as an indicator of good outcome therapy based on high alliance establishment at the initial sessions (Strauss et al., 2006) and the positive impact of rupture repair sequences on the outcome (Eubanks, Muran & Safran, 2018). Hovarth and Luborsky (1993) and Patton et al., (1997) also indicated that therapeutic alliance was formed at the beginning of the therapy in a U-shaped curve, and alliance ruptures occur in the middle phases where transference and countertransference are centered and neurotic patterns of the patient are worked. At the end of the therapy in successful therapy, ruptures are resolved, so the alliance increases again (Horvath & Luborsky, 1993; Patton et al., 1997). Therefore, there are fluctuations in the therapeutic

alliance in the treatment process as high-low-high. Several rupture repair studies also show that a good outcome has been associated with the resolution of the ruptures (see Eubanks, Muran & Safran, 2018 for review).

Halfon and colleagues (2019) conducted the process of research investigating typical growth alliance trajectories in psychodynamic child therapy. In this research, 89 children between 4 to 10 years old are included. They measured the alliance in every ten sessions randomly via observer-based alliance measurement TPOCS adapted in child therapy (McLeod & Weisz, 2005; Özsoy, 2018). They have found stable and U-shaped quadratic change (Halfon et al., 2019). This study result also indicates that effective therapy necessitates a good initial alliance with the patient. Depending on the initial alliance, psychotherapy work could be deepened in the middle phase and resolved afterward (Halfon et al., 2019).

However, researchers criticized Kivlighan and Shaughnessy (2000)'s studyresult because of the limitations of the research, like the small sample size and short therapy process, and implied more and more patterns are possible to be identified in-process research (Stevens et al., 2007). Besides, replication studies could not find U-shaped trajectories all the time in a good outcome therapy; therefore, it is impossible to consider one shape of growth trajectory all the time (Stiles & Goldsmith, 2010). Other researches show different alliance growth trajectories like stable alliance (e.g., Kramer et al., 2008; de Roten et al., 2004, Stiles et al.,1998), linear alliance growth (e.g., Hilsenroth, Peters, & Ackerman, 2004; de Roten et al.,2004), U-shaped alliance growth (e.g., Hilsenroth, Peters, & Ackerman, 2004), and V-shaped alliance growth (e.g., Strauss et al., 2006; Stiles et al., 2004). In youth studies, similar patterns have been found, like concave growth curve (Kendall et al.,2009), and gradual linear increase (Cirasola et al., 2021; Chu et al., 2014), negative linear slope (Hudson et al., 2014), and a U-Shaped pattern (Hurley et al., 2013; Halfon, Özsoy & Çavdar, 2019).

It is possible to interpret discrepancies as there are various different developments of alliance in the different samples, age groups, and patient diagnostic groups. For example, Kanninen and colleagues (2000) found an association between attachment style and alliance trajectory. The research shows

that secure and preoccupied patients have a U-shaped trajectory while avoidant patients have a stable one until mid-phase and a negative slope on the termination (Kanninen et al., 2000). The aim of the process research might be changed to assessing developments of alliance in the different samples in different settings instead of looking at a typical trajectory for all populations. These discrepancies might reflect the uniqueness of the development of the alliance depending on conditions. Therefore, the direction of research has turned to the global assessment of the therapeutic alliance to micro-process analysis, examining changes and strains or ruptures episodes within the session to understand what works in the therapy (Mellado et al., 2017; Safran, 2003). Safran (2003) indicates the importance of zooming in therapist-patient relationships because the alliance has been made up uniquely in every therapist and patient relationship.

The research design of the studies also needs to be considered in process research due to measurement informants, measurement tools, data analysis, treatment group, and size, because it might be affected by these variables (Bickman et al., 2012). Especially, the perspectives that alliance has been measured like youth, therapist, caregiver, or observer should be cautiously assessed (McLeod & Weisz, 2005). Since youth are not developmentally capable of the assessment relationship, self-report has been biased and unable to project real aspects of the relationship (Shirk & Karver, 2003; McLeod, 2011). McLeod and Weisz (2005) claimed that the source of object observers who assesses alliance might be more appropriate forthe youth population. In the present study, the Therapy Process Observational Coding System-Alliance scale (TPOCS-A; McLeod & Weisz, 2005) for global alliance measurement has been used because of its objective observer coding, easy coding to apply, strong psychometric properties, and because it is appropriate to youth alliance conceptualization so measures only bond and task aspects.

Trajectories could also show differences between treatment types. Cirasola and colleagues conducted (2021) a research to investigate the difference in mean alliance trajectory on three types of depressed adolescents; Cognitive behavioral therapy (CBT), brief psychological intervention (BPI), and short-term psychodynamic psychotherapy (STPP). In this study, it is more possible to identify

the development of alliance in the whole therapy process compared to the three treatment types. Results indicate that there is a lower alliance in the STPP sample but has a growth slope; on the other hand, BPI and CBT showed high but stable alliance patterns (Cirasola et al., 2021). It is possible to interpret that alliance ruptures have frequently occurred in psychodynamic treatments because the psychodynamic approach focuses on transference and countertransference occurrences. Therefore, the therapeutic alliance may have more meaning in this treatment type in terms of outcome. In another research, early alliance rupture and resolution process have been researched on the impact of outcome in three treatment types: Cognitive Behavioral Therapy (CBT), Brief relational therapy, and short-term dynamic therapy (STDP) (Muran et al., 2009). According to the result, low rupture intensity and high resolution are indicated to be high outcomes (Muran et al., 2009). Additionally, fewer ruptures have been stated by participants in CBT, which is interpreted as both relational and STDP treatments focusing on transference and counter-transference aspects of the relationship; therefore, there are more strains in these treatments (Muran et al., 2009). Researchers argued that there are different alliance trajectories even though they are similar in effectiveness; therefore, more research should be conducted to compare different treatment and patient groups (Cirasola et al., 2021).

The development of alliance in youth psychotherapy is a neglected area. A research finding shows no correlation between age and therapeutic alliance (Ozsoy, 2018). Since adolescents have a high need for autonomy due to the aforementioned developmental features, establishing alliances with adolescents is harder and occurs later than with children and adults (Abrishami & Warren, 2013; DiGiuseppe et al., 1996; Shirk et al., 2011). Statistics also show that adolescents are the most frequently dropped-out group in psychotherapy (de Haan et al., 2013; Midgley & Navridi, 2006). O'Keeffe and colleagues' (2020) study also shows that there are many ruptures in the alliance while working with adolescents, and unresolved ruptures are associated with dropouts. Therefore, the youth population should be considered more and the alliance concept in psychotherapy should be investigated to increase the efficacy of psychotherapies for this population.

There is no research either on adult or child and adolescent literature to show how therapeutic alliance develops in a teletherapy setting and its differences from traditional face-to-face therapies. Even though there is much research showing similarity in effectiveness with face-to-face therapies, as they are mentioned below, there might be differences in developing therapeutic alliances in a teletherapy setting. Dolev-Amit and colleagues (2020) claimed that online therapies might be different in terms of identifying ruptures, especially withdrawing responses because of the distance, but there is no empirical study proving that.

1.3. THERAPEUTIC ALLIANCE DURING THE COVID-19 PANDEMIC

1.3.1. COVID -19 Pandemic

1.3.1.1. COVID-19 Pandemic and Mental Health

Covid- 19 pandemic has been the most challenging life event nearly all over the world in this decade. Covid-19 is an infectious variant virus of SARS, which was first detected in December 2019 in China, and since then, its detrimental effects have continued (Wang et. al., 2020). This disease damages the lungs and respiratory system and causes cold, flu, or pneumonia in a range of severe to mild symptoms (Wang et. al., 2020). The World Health Organization (WHO) declared a pandemic on the 11th of March, 2020 (Cucinotta, D., & Vanelli, M., 2020), and until the increase in vaccination during 2021, solid attempts for prevention like social isolation, school closures, and lockdowns have been taken in many countries including Turkey. The pandemic's effect on mental health is, on the other hand, undeniable. It brought many uncertainties and challenges for people worldwide such as not knowing the cures for disease, conflicting authority messages, increased financial issues, unknown date of ending restrictions, and loss of loved ones (Pfefferbaum & North, 2020).

Since there are many dimensions of the pandemic all over the world, Horesh and Brown (2020) define Covid-19 epidemics as a mass trauma affecting every part of society worldwide. Therefore, the Covid-19 pandemic should be seen from the perspective of trauma. Traumatic events may affect people both psychologically

and physically, and the severity of trauma may differ with the type of trauma, such as cumulative, second hand (Kira et al., 2012), and resilience of victims (Center for Substance Abuse Treatment, 2014). Covid- 19 pandemic was also unexpected for people, and we all tried to survive by protecting ourselves by self-isolation, increasing hygiene, stocking food and supplies, etc. Since the pandemic has still been continuing, the post-traumatic effects of Covid-19 trauma are unknown.

During the pandemic, anxiety about getting infected by the virus, intrusive thoughts, and fear of uncertainty have been part of nearly all human beings but showed differences in severity. Increased communication via social media also increased the spread of news and anticipatory anxiety among people (Horesh & Brown, 2020). Since it has been hard times, increased mental health disturbances have also been proven by research. Literature concerning adults shows that the pandemic increased panic attacks, anxiety, and depression rates among adults in different places of the world (El-Zoghby et al. 2020; Généreux et al., 2021; Haider et al., 2020). In studies conducted by adults in Turkey, researchers primarily focused on the general effects of Covid-19 on mental health (Duran & Erkin, 2021; Morgül et al., 2021; Özdin & Bayrak Özdin, 2021). In a study, 23.6% of the population having depression and 45.1 % of the population having anxiety were found above the cut-off point (Özdin & Bayrak Özdin, 2021). Lockdown studies show an increase in depression symptoms and feelings of loneliness (Lee et al., 2020). A study comparing quarantined and unquarantined samples shows increased suicidal thoughts, self-harm, and emotional distress (Luo et al., 2020). Wilson and colleagues (2007) find that loneliness is a common factor in psychological disturbances like depression, anxiety, insomnia, and dementia. The feeling of loneliness might be the main traumatic factor of the Covid-19 pandemic.

Socialization in adolescence, on the other hand, has vital importance. Adolescence is the age of conflict with parents because they need to establish their sense of identity by overcoming their parents. Also, they tend to socialize more with their peers to locate themselves in their social circles (Viner et al., 2012). However, the pandemic prevented this by social isolation cautions and school disclosures. Therefore, parents and adolescents are together at home with increased tension of

the pandemic. Many studies are showing negative effects of school closures because it prevented meeting social needs, disrupted routines, and exposed them to conflicts at home (Huscsava et al.,2021; Lee, 2020; Panchal et al., 2021; Tang et al., 2021). An empirical study investigating the effect of school closures found increasing anxiety, depression, and stress factor (Tang et al., 2021). Lee (2020) indicates increased domestic abuse during the pandemic because of increased emotional and economical stress in families. In another research, 20 percent of adolescents indicate childhood adversities and physical violence at home (Huscsava et al., 2021). Another research also illustrates that not only school closures but also deterioration of parents' mental health and fear of viruses have contributed to a significant increase in the symptoms of anxiety and depression and low life satisfaction (Magson et al., 2021). Chung and colleagues' (2020) study about parental stress during the pandemic shows that it is associated with harsh parenting and less intimacy between parents and children. These worrying results show multiple detrimental dimensions of the Covid-19 pandemic on the mental health of youth.

There is no sufficient study on the psychological well-being of youth in Turkey during the pandemic. In a study with 745 adolescents investigating factors affecting anxiety levels during the lockdown, it is revealed that the anxiety level of adolescents was found to be accompanied by a high level of loneliness and was four times higher compared to the previous results (Kılınçel et al., 2021). Previous researchers argue that economic hardship, unemployment of parents, and effects of these financial issues on parents' mental health increase anxiety among adolescents; unfiltered information from TV about Covid19, school closure, and having a close family member having Covid-19 virus are factors affecting anxiety level of adolescents. In another study comparing the youth population (15–25 years-old) in Turkey and Australia, the Turkish population showed high mental health disturbances in terms of anxiety, depression, and general health (Akkaya-Kalaycı et al., 2020). Turkey's current financial conditions, mental health care policies, and more restricted precautions during pandemics might have a negative effect on youth living in Turkey (Akkaya-Kalaycı et al., 2020).

Since the stress level is high and the need for socialization is not met enough because of restrictions, screen time and social media use have increased during the pandemic among adolescents (Nagata et al., 2020). Also, previous researchers imply sleep disturbances and lower physical activity because of increased screentime. Therefore, adolescents are also affected psychologically by the Covid-19 pandemic (Zhou, 2020). One of the studies shows that older adolescents have more depression and anxiety symptoms than young children related to the pandemic (Zhou et al., 2020). A review paper investigating the effect of Covid-19 on children and adolescents finds anxiety and depression as common problems encountered and an increase in loneliness, anger, irritability, fear, and boredom (Panchal et al., 2021). Adolescents with previous mental health disturbances have mainly shown increased anxiety, feeling tense, and a decline in the mood, while a small percentageof them showed improvement in the mood and tension because of a decrease in school stress (Huscsava et al., 2021).

Gruber and colleagues (2020) identified three dimensions of the pandemic affecting mental health: uncertain end date, multidimensional effects such as individual, family, school, and government, and preventing protective factors like social meetings because of social isolation (Gruber et al., 2020). Increased stress and reduced number of protective factors caused collective collapses in mentalizing; therefore, increase in psychopathology, domestic violence, and pre-mentalizing acts like obsessive cleaning or excessive stocking of food and toilet paper (Lassri & Desatnik, 2020). Therefore, stressors increased, affecting mental health during the pandemic and necessitated innovative protective factors. Pandemic has been seen as an opportunity for some people to find new hobbies and mindfulness practices; on the other hand, it has been more struggling for some people. So, not all people have experienced this trauma at the same level because of changing risk and protective factors. According to a review paper, adolescents between 13 to 15 years old are more vulnerable than children (Panchal et al., 2021). It is explained that the transition from childhood to adolescence brings its depressive baggage, and prevention of socialization via restrictions during the pandemic also affects their well-being (Panchal et al., 2021). Therefore, mental

health acts for the youth population should be increased, and psychotherapy treatments should be improved by conducting more research specific to this population.

1.3.1.2 Covid 19- Trauma and Therapeutic Alliance

As it was mentioned above, the therapeutic alliance is the essence of youth therapy (Axline, 1947; A. Freud, 1946). Due to pandemic conditions, the psychological well-being of both patients and therapist have been affected (Ahlström et al., 2022; Ledesma & Fernandez, 2021). Therefore, therapeutic alliance during the pandemic should be examined by considering the effects of traumatic stress of Covid-19 and teletherapy conditions.

The Covid-19 pandemic causes anticipatory anxiety, losing or/and fear of losing loved ones, witnessing infected people's death or pain, the possibility of death, not knowing the cure, fast-spread of the virus, social isolation preventions, increased financial and societal issues, impossibility to know how the process will go on, hopelessness and contradictory authority messages are all traumatic factors of the Covid-19 (Gruber et al., 2020; Horesh & Brown, 2020). Therefore, it has been defined as a mass trauma since it has multi-dimensional effects on every part of society (Horesh & Brown, 2020).

In the case of trauma, as well as many parts of human capacity, emotion regulation capacity also collapses (Levine & Frederick, 1997); therefore, one is not able to regulate his/her feelings and understand the mental states neither of oneself or others. This phenomenon has been explained by mentalization researchers. Mentalization which is defined as an ability to think of oneself and others and is related to emotion regulation capacity, social learning, and epistemic trust, has collapsed or regressed to pre-mentalizing modes in the case of trauma (Lassri & Desatnik, 2020; Luyten & Fonagy 2019). Since traumatic events are hard to digest, hopelessness and a tendency to self-harm, alienation, or reenactment with traumatic experiences could increase. Depending on the severity of trauma and epistemic trust might be harmed, which causes interpersonal and psychological disturbances

(Luyten & Fonagy 2019).

Since the mentalization capacity of people has been affected due to pandemic stress, especially at the beginning of the pandemic, epistemic trust and therapeutic alliance also have expected to be affected by this trauma. Epistemic trust has been seen as vital in youth psychotherapies (Fonagy & Allison, 2014). It is because youth are not self-referred, so they are not capable of understanding what they are doing and why they are seeing the therapist, so this population needs to be mentalized and establish epistemic trust (Aisbitt, 2020; Fonagy & Allison, 2014). Additionally, youth are not fully capable of establishing confident relationships with adults, and their only references are their attachment relationships, which is the problem for the referral most of the time (Aisbitt, 2020; Fonagy & Allison, 2014). Also, Fonagy et al. (2015) claim that if there is no trust in the therapeutic relationship, patients' capacity to change does not develop. Even though no empirical studies examine the effects of Covid-19 trauma on epistemic trust, it is a possible factor that affects the epistemic trust of youth. The high increase in depression and anxiety rates among youth mentioned above from several studies during the pandemic may also indicate a damaged perception of a safe future and world; therefore, hope for change in the therapy and the epistemic trust of many youths might be negatively affected.

On the other hand, Covid-19 has mutual effects on both patients and therapists; therefore, it is a special time for therapists to share the same trauma with their patients (Ahlström et al., 2022; Ledesma & Fernandez, 2021). Making empathy with patients during the pandemic might have some benefits as well as difficulties. Similar problems with patients could be helpful for therapeutic change as therapists can understand the patient more (Ledesma & Fernandez, 2021). On the other hand, Geller (2021) advocates that it might cause countertransference problems. Wilson and Lindy (1994) explain that traumatized patients project their "*trauma-specific transferences*" to the therapist, which causes empathic strains in the therapy. It could be hard to stay close to traumatic materials especially when the therapeutic relationship has deepened; therefore, they introduce two types of empathic stains; type one is avoidance from the traumatic material like distancing,

detaching; type two is enmeshment with the patients' traumatic experiences. Therefore, psychotherapist might not able to work pandemic trauma related subjects (p.57).

As it was mentioned, the pandemic has not been a good time for mentalization, neither for patients nor therapists. Research conducted during the pandemic has the evidential value of previous theory and the result shows that therapists show vicarious traumatization during the pandemic because of trauma-related stress, tiredness, feeling less competent related to teletherapy, feeling less connected with the patients (Aafjes-van Doorn et al., 2020). Ledesma and Fernandez (2021) applied qualitative research examining the therapists' experiences during the pandemic, and therapists narrate their feelings at the beginning of the pandemic as "thrown up in the air" and hard to main their psychological well-being. Then, they expressed that they could "find a new rhythm"(Ledesma & Fernandez, 2021). Another research investigating therapists' experiences during the pandemic find that therapists felt lonely and anxious due to adapting new lifestyle of the pandemic and shifting from face-to-face to online setting (Ahlström et al., 2022).

1.3.2. Teletherapy in the pandemic

1.3.2.1. Comparision of online and face-to-face therapies

Like with many aspects of life, psychotherapy practices have also been affected by the Covid-19 pandemic. Because of the virus spreading, traditional face-to-face sessions have been canceled for a while. However, the uncertainty of the process, when the pandemic will end, and not knowing the cure have created a vicious cycle; all those dynamics have prevented psychotherapy appointments but patients with mental health problems are affected more by these pandemic dynamics. Therefore, many psychotherapists have continued their sessions as teletherapy through video conferencing applications or websites like Zoom, Skype, or Whatsapp (Gordon et al., 2021). Teletherapy is defined as psychotherapy conducted in real-time at a distance via videoconferencing, telephone calls, or email

and text-based communications (Kaplan, 1997).

Teletherapy started in the era of the Internet, and audio call technology increased in many parts of the world, especially with the pandemic. Difficulty in reaching mental health services due to geographical distance, affordability of telemental health, and its appropriateness to dynamics of some mental disturbances like agoraphobia and social isolation during the pandemic have always been advantages of the teletherapy; however, there has been reluctance to apply teletherapy because of the concerns for not being able to a therapeutic relationship and its effectiveness (Cook & Doyle, 2002). Therefore, researchers have started comparison studies of teletherapy and face-to-face therapy before the pandemic and still go on to fill the gap in the literature.

Most studies comparing both treatment types aim to investigate the effectiveness of teletherapy and have used therapeutic alliance as a predictor of the outcome because, in many face-to-face therapy types of research, the high therapeutic alliance has been found to be a predictor of the outcome (Horvath, et al., 2011). In a meta-analysis, researchers investigated comparison studies to understand whether or not therapeutic alliance is also meaningful in predicting the outcome of online therapies (Kaiser et al., 2021). Even though therapeutic alliance has been found less relevant for face-to-face therapies, it is still a strong predictor of outcomes for teletherapies (Kaiser et al., 2021). However, papers that have been used in the meta-analysis included only text-based (e-mail and chat) and audio call(telephone) therapies; therefore, it can be a limitation to understand the effects of therapeutic alliance in other communication types.

Some empirical studies suggest that there is no statistically significant difference between online and face-to-face therapies or even higher therapeutic alliance scores on some subscales in online therapy (Cook & Doyle, 2004; Ghosh et al., 1997; Holmes & Foster, 2012; Stiles-Shields et al., 2014). Cook & Doyle (2004) investigates whether or not working alliance levels are significantly different in the teletherapy group compared with face-to-face samples in previous research. In this research, there is a small sample size (n = 25) and most of them have taken text-based intervention. Participant-based alliance measurement Working Alliance

Inventory (WAI) has been applied to the participants at only one-time point (Cook & Doyle, 2004). Previous research results show that therapeutic alliance scores are even higher in online samples in composite and goal scores of WAI. Preschl and colleagues (2011) have also found similar results to the previous research. Firstly, they researched the randomized control trials to compare online (n = 25) and face-to-face (n = 28) Cognitive Behavioral Therapy for depressed adults in terms of the working alliance. Alliance has been measured in mid and post of treatment by participants and post for therapists via Working Alliance Inventory (WAI) in this research. They have applied t-test analysis to compare two treatments in the analysis, so the alliance growth slope has not been calculated. Working alliance of participants has been found comparable in both groups, and therapist measures have been found to be statistically higher in the task subscale in online groups. It is because the tasks of therapy were focused more on the online therapy (Preschl et al., 2011).

In other research, Holmes and Foster (2012) also conducted a comparison study of face-to-face (n = 37) and online counseling (n = 13) with adults based on general mental health, working alliance, and social presence. At one time point, the participant-based working alliance was measured via Working Alliance Inventory (WAI) in the study. According to the results, there is no difference in general mental health and social presence, but working alliance composite scores and goal subscale have been found statistically higher in the online group, which has also been interpreted as a precise setting of the goals on online counseling, especially with synchronous communication tools like videoconferencing (Holmes & Foster, 2012). A research investigating the perception of patients about the transition fromface-to-face to online therapy during the pandemic shows that patients have perceived therapy as another “job” that they need to attend (Werbart et al., 2022). For this reason, it seems that the therapeutic relationship has lost its emotional aspect a little, and its purpose has gained importance.

Stiles-Shields and colleagues (2014) conducted similar research to Preschl and colleagues' (2011) study. They applied a randomized control trial with a larger sample of adults having depressive symptoms; 162 for face-to-face and 163

participants for telephone-based CBT treatment (Stiles-Shields et al., 2014). Working Alliance Inventory has been applied in the fourth and fourteenth sessions for both the patients and therapists. Data were analyzed by t-test for two treatments. Results show that there is no statistical difference in the therapeutic alliance and the therapeutic alliance has been found to be related to the outcome but not depression severity (Stiles-Shields et al., 2014). It can be evaluated that larger samples could be more representative of the population, so higher scores on working alliance in teletherapy might be misleading. To understand differences in alliances, in-depth research looking at alliances in several time points might be needed. Additionally, since youth patients may not understand questions developmentally, observer coding could be more objective (McLeod & Weisz, 2005). Even though some studies are applied to compare these two treatments in terms of therapeutic alliance and outcome, there are some limitations for some of them, like small sample size and low comparability of sample due to size. Also, there is no study to work with pandemic samples; therefore, it is impossible to understand the pandemic's effect on online therapy. Additionally, although therapeutic alliance has been found similar in two treatments at different time points, studies are not sufficient to evaluate the growth speed of therapeutic alliance because of limited measurement time points and insufficient analysis.

King and colleagues (2020) conducted a comparison study on a brief alcohol intervention program for college students. Samples were randomly assigned to face-to-face and online programs. The research aimed to research changes in alcohol consumption in these two treatment groups. According to the results, both treatments have been found to be similar in effectiveness, and a working alliance has a significant impact on alcohol consumption (King et al., 2020). Therefore, the working alliance has also been found to be similarly increased in process in both groups.

While the literature concerning adults on the comparison of teletherapy and face-to-face therapy has been developing in terms of empirical studies, child and adolescent literature has still been limited. There is only one study comparing therapeutic alliance on child and adolescent psychotherapy. Anderson and

colleagues (2012) carried out a comparison study for adolescents who had different anxiety diagnoses and the sample was assigned to online or face-to-face treatment randomly. The therapeutic alliance was measured at one point in 3rdr session for both groups by WAI-S. Results indicated that there was no statistical significance between groups in the mean of therapeutic alliance among adolescents, but parentsimplied higher alliance in the face-to-face group.

Huscsava and colleagues (2021) have conducted a descriptive study investigating patients' symptom dynamics, adversities, and transition process of teletherapy with 30 adolescents between 12 to 18 years old. According to the results, most participants have evaluated teletherapy as beneficial due to social support and consistent regular meetings, but only a few who showed an increase in symptoms found it unbeneficial, which has been interpreted as the appropriateness of patient to teletherapy as an important factor for the effectiveness of teletherapy (Huscsava et al., 2021). Also, researchers indicate that a therapeutic alliance could be established with adolescents on teletherapy (Huscsava et al., 2021). In other research, researchers investigate the effectiveness of a 5-week online treatment program for depressed adolescents by comparing it to online-only group (n = 80), blended group (n = 81), and face-to-face group (n = 82), which are randomized to treatments (Lappalainen et al., 2021). Results show that online-only and blended groups showed significantly greater improvements in pre- and post-depression symptom measurements than the control groups (Lappalainen et al., 2021). This study shows that online treatments could affect symptom reduction more. The other research studies randomized control trial videoconferencing and face-to-face psychiatric assessment of children and adolescents 4 to 16 years old. Even though most children and adolescents (82%) like and 26 percent prefer online options, psychiatrists are mostly not satisfied with online options (Elfrod et al., 2000).

A qualitative study investigating perceptions of adult patients with anaclitic personality about shifting to online therapy during the pandemic found several themes (Werbart et al., 2022). From the perspective of patients, online therapy is experienced totally differently from face-to-face therapy (Werbart et al., 2022). Participants indicate loss of therapeutic rituals due to loss of therapy room, more

superficial therapy work, increased ruptures in the alliance, and feeling of therapists' lowered emotional receptivity (Werbart et al., 2022). On the other hand, they find online therapy more liberating, less demanding and convenient (Werbart et al., 2022). Because of distance and screen, most of them find online work felt like "*dehumanizing*" and "*That the screen becomes like a… threshold or a wall*" (Werbart et al., 2022, p.6). They express their need to communicate non-verbally like in-face treatment (Werbart et al., 2022).

Another research investigating therapist perception in transition during the pandemic indicated six themes that are similar to the previous study: concerns about technical problems and confidentiality, therapy frame, superficial therapy work, loss of therapy room, and body language (Ahlström et al., 2022). Most therapists in this research have stated that online therapy is hard to establish a therapeutic alliance and deepen therapeutic work due to technical interruptions and loss of bodily reactions (Ahlström et al., 2022). In addition, therapists stated that it is more difficult to interpret transference relationships due to technical and external interruptions; therefore, they stated that there should be more consideration of reality aspects in the online environment. (Ahlström et al., 2022).

To sum up, even though adult literature has shown that online therapy is as effective as face-to-face therapies and even higher in some therapeutic alliance sub-categories, qualitative studies conducted during the pandemic show some difficulty in terms of building the alliance. More research is needed to understand more deeply how the development of therapeutic alliance differentiates both types of therapy for youth, especially under the conditions of the pandemic.

1.3.2.2 Variables of Teletherapies

Because of the change in the therapy setting, there are different variables to consider while studying online therapies, which are therapy setting, confidentiality concerns, the competence of therapists in online therapy, and the trauma effect of pandemic on therapy work.

Teletherapy settings have had to be different because of pandemic

conditions in terms of therapy environment and communication tools like videoconferencing (Markowitz et al., 2021). Many therapists and patients have had to connect from their home setting; therefore, it might have some effects on therapeutic work due to increased elements of distraction and confidentiality concerns such as Internet connection problems, having a family member at home, knocking on doors, pets walking around, etc. (Ahlström et al., 2022; Markowitz et al., 2021). Therapy settings have been found essential for effective therapeutic work with the patient because they establish the frame of therapy (Gray, 2013) and create symbolic containers for patients (Waldburg, 2012). Therefore, a safe environment, both physically and psychologically, such as not being heard by other people, is key to digging into patients' material (Frank & Frank, 1993). Also, a therapeutic setting could help patients establish therapists' roles and prestige and increase the effectiveness of the work (Frank &Frank, 1993). A study that has been done to explore the importance of therapy rooms for both therapists and patients shows that the majority of participants think that rooms should be physically safe and comfortable, less destructive elements included, and soundproofed (Sinclair, 2021). However, it is nearly impossible to provide those conditions through online therapy. Both patients and therapists indicate the need to transition from their daily lives to the therapy room (Ahlström et al., 2022; Garcia et al., 2022; Werbart et al., 2022). On the other hand, for some therapists, home settings are perceived as an opportunity to know their patients better since it could provide extra information about patients' life that they do not even recognize or avoid telling their therapist (Ahlström et al., 2022; Markowitz et al., 2021).

Another and most discussed variable of online therapy is confidentiality. Confidentiality in online therapy has been seen as one of the critical problems to prefer online over face-to-face therapy. In traditional face-to-face therapy, confidentiality is the therapist's responsibility by providing soundproof therapy rooms, and locking therapy notes and records (Turkish Psychologists Association Ethical Codes, 2004). However, online therapy in terms of confidentiality creates some limitations because of therapy settings such as home settings for both parties and communication tools such as Zoom, Skype, and other video conferencing tools

(Anthony et al., 2015). Limitations due to confidentiality in online psychotherapy may affect some people to hinder self-disclosure (Roback & Shelton, 1995). This aspect is especially important for the youth population since they are developmentally in the separation and individuation phase; therefore, they construct their self-identity by hiding some features of themselves from their parents (Atzil-Slonim, 2019).

Competence is another variable to consider, and the competence of a therapist is an ethical necessity for conducting psychotherapy (Turkish Psychologists Association Ethical Codes, 2004). In the pandemic conditions, many psychotherapists have had to transfer to online therapy without taking extra training for online therapy (Hall et al., 2020). Therefore, different aspects of online therapy have been learned by experience in the sessions, which may cause some awkward moments, disruptions of the therapeutic frame, and deterioration in the relationship between patient and therapist. In a study investigating therapeutic skills in online therapy, therapy outcome has been found to be lower when therapists are not trained in teletherapy (Lin et al., 2021). Studies also show that therapists felt incompetent about online therapy at the beginning of the pandemic (Aafjes-van Doorn et al., 2020).

Working with youth on online platforms might also have some disadvantages because of the home environment setting (confidentiality concerns, family problems), more destruction (computer, internet, phone), and etc. However, there is also research showing that adolescents prefer online therapies over face-to-face therapies. A study shows that nearly 30% of Australian adolescents prefer online therapy over face-to-face therapy, and they found online therapy beneficial because of its accessibility and reduced stigmatization anxiety (Sweeney et al., 2019). Also, age has been an important variable in ineffectiveness, and children and adolescents benefit more from teletherapy. It is interpreted as online platforms are more meaningful in terms of socialization for adolescents and children (Barak & Sadovsky, 2008). Therefore, therapeutic settings could be beneficial or less effective in terms of therapeutic work while working with youth at a distance.

Empirical studies, as it is evaluated above, comparing therapeutic alliance

and outcome in online and face-to-face therapies are promising but literature is limited in terms of micro-alliance measurements and comparing Covid-19 online therapies, especially in the youth population. Teletherapy hinders reading bodily reactions, making eye contact, and proximity (Hanley, 2009; Markowitz et al., 2021; Rolnick & Ehrenreich, 2020); therefore, it might create a challenge for therapists to establish therapeutic alliances (Ahlström et al., 2022; Hanley, 2009; Werbart et al., 2022). It may be hard to reach and make emotional engagement at the moment especially with patients tending to dissociate or being emotionally avoidant (Markowitz et al., 2021). Also, there are more distractors in an online setting like notifications coming to the screen and in the home environment (Wong, 2021). Dolev-Amit and colleagues (2020) indicate the difficulty of capturing withdrawal ruptures (denial, minimal response, abstract communication, etc.) in online therapy because withdrawal ruptures are silent and detached emotional signs, so the therapist could also feel detached because of looking at a computer screen instead of capturing rupture remark.

Therapy is not only dependent on talking or playing but also on the synchronicity of head movement, bodily responses, and the pitch of the voice (Koole & Tschacher, 2016). Researches show that synchronicity is important to establishing a therapeutic alliance increasing emotion regulation capacity. As a result, positive effects on the outcome are observable (Feldman, 2007; Vacharkulksemsuk and Fredrickson, 2012). However, in online therapies, it could be challenging to synchronize with the patient because of the inability to see the whole body of the patient and connection disruptions (Rolnick & Ehrenreich, 2020). On the other hand, the distance makes patients feel more comfortable working in their homes (Werbart et al., 2022). An empirical study shows that patients show more effort to interact with the therapist, initiate more therapy works, and feel safer due to distance on online therapies to open themselves up (Day & Schneider, 2002; Simpson, 2005). Especially while working with youth patients, technology could be a "transitional space," and patients can show their digital identities to the therapists (Wong, 2021).

To sum up, teletherapy is a treatment type whose' efficacy has been proven

by many studies but it needs to be studied more due to the unique conditions of the pandemic and the insufficient research especially for youth patients.

1.4. PURPOSE OF THE STUDY

The purpose of this study is to compare therapeutic alliance growth and alliance strength between teletherapy done during the Covid-19 pandemic and traditional face-to-face psychodynamic therapies done before the pandemic with the youth population who are between 10 to 15 years old. Because of online therapy's different settings and the pandemic's traumatic effects on both patients and therapists, there might be a difference in the development of therapeutic alliance compared to traditional face-to-face therapies. Nevertheless, there is no empirical study to investigate the differences in the development of alliance across these treatment modalities. Therefore, no hypothesis could be built based on the literature.

On the other hand, studies examining the difference in the overall strength of the alliance between online and face-to-face therapies show that the strength of the alliance is either the same (Stiles-Shields et al., 2014) or even higher in online therapies, especially on the task subscale of the alliance construct (Cook & Doyle, 2004; Preschl et al., 2011; Holmes & Foster, 2012). Therefore, based on this literature, we expect that alliance strength would not differ between online and face-to-face treatments.

Also, this study aims to investigate low alliance sessions and identify strains in terms of withdrawal markers, confrontational markers, and therapists' resolution markers. Since second-generation researchers of alliance claim that alliance is an ongoing negotiation, it will be more meaningful to understand strains in both treatment modalities to understand the difference in the alliance process deeply (Muran & Safran, 2000). Since there is no research comparing online and face-to-face therapies in terms of strain qualities, there is no hypothesis that could be developed based on empirical studies; however, the theoretical discussion of Dolev-Amit and colleagues (2020) claimed that online sessions might be more challenging

than face-to-face ones in terms of capturing withdrawal markers so withdrawal markers may be higher in online sessions.

To sum up, this present study aims to examine whether (1) there is a difference in therapeutic alliance growth and alliance strength between online and face-to-face psychodynamic youth therapies: It was hypothesized that the strength of alliance would be the same between online and face to face therapy, (2) whether low alliance sessions differ in terms of descriptive features of withdrawal, confrontational and resolution markers in frequency and significance.

CHAPTER 2
METHOD

2.1. DATA

The current data was collected from Psychotherapy Research Laboratory at Istanbul Bilgi University. Psychotherapy studies have been conducted to evaluate the effectiveness of the psychotherapy mechanisms in this laboratory. Psychodynamic psychotherapy is offered to all participants who are between 10 to 14 years old by psychotherapists who are master-level clinical psychologists. Inclusion criteria for psychotherapy in the center include having no psychotic symptoms, no severe developmental delay or autism spectrum, no suicidal risk, and no substance abuse. Moreover, during the pandemic, all applications to the psychological counseling center were assessed by considering patients' availability for the online psychotherapy. Patients were asked if they had availability for the psychotherapy in terms of physical conditions such as Internet access, private room to attend sessions, and appropriate device for Internet connection. Patients were also asked to provide a private room in which they did not hesitate to be heard by family members and attend regularly from the same place as much as possible to protect the therapeutic frame. All clients who applied to receive psychotherapy treatment were offered to participate in the research. Their permissions were taken to use their psychotherapy process in the research and recording audio and/or video of the sessions. All confidentiality precautions were applied to protect the personal information of patients. Participation in the research was voluntary, and withdrawal from the research during the treatment was possible. Istanbul Bilgi University Ethics Committee also approved the data which has been used in the current study.

2.2. PARTICIPANTS

2.2.1. Youth

In this study, early adolescents who are 10 to 14 years olds were targeted (M_{online} = 11.40, M_{f2f} = 11.65). In the present study, 37 youth that took face-to-

face treatment (43% female, 57% male) and 20 youth took online treatment (60% female, 40% male) were included. Youth who took face-to-face treatment received psychotherapy between 2016 and 2019. Online clients took psychotherapy starting in 2020, and just 9 of them have terminated yet. Application reasons in both treatment were mostly defined by behavioral problems and learning/ school problems in both group. See Table 2.1 for detailed information.

Table 2.1

Demographic of Youth Patients

Variables	Categories	$N_{face\text{-}to\text{-}face}$	$\%_{face\text{-}to\text{-}face}$	N_{online}	$\%_{online}$
Gender	F	16	43.2	12	60.0
	M	21	56.8	8	40.0
Age	10-12	27	73.0	13	65.0
	13-14	10	27.0	7	35.0
Application Reasons	Anxiety	12	32.4	7	35.0
	School and Learning Problems	11	29.7	4	20.0
	Depression	1	2.7	1	5.0
	Relationship Problem	0	0.0	2	10.0

2.2.2. Therapists

There were 24 psychotherapists provided face-to-face (97% female, 3% male) and 13 online (90% female, 10 % male). Therapists of both treatment groups were of similar age between 23 to 33 (M_{f2f} = 25, M_{online} = 24) and nearly 90 % female in both groups. They were all master's students in the Clinical Psychology Master Program at İstanbul Bilgi University either in the first or second year of their internship. 95% of the therapists in both treatment groups had 1-year experience. In the first year of internship, three-hours of group supervision and one-hour of individual supervision were provided for all therapists weekly. For the second year of the internship, one-hour individual supervision per week was provided. All psychotherapists applied psychodynamic psychotherapy and

supervisors were also psychodynamic psychotherapists who are experienced with more than ten years inthe field.

2.3. TREATMENT

All clients who applied to Psychological Counseling Center received open-ended psychodynamic psychotherapy. Treatments are not manualized but both therapists and supervisors consider cases in terms of case-specific needs with detailed case formulations. Treatment offered in the center is open-ended and terminations are decided with the parents and youth by considering the need of the patient. Therapy duration for both treatment types in the current research is similar in terms of mean (M_{f2f} = 25.46, M_{online} = 29.60), and a minimum 7 and maximum of 60 sessions were included in the current data. In the present research, 16% percentof cases drop during face-to-face treatment, but there is no dropout case in online treatment. Sixty percent of the online groups have consisted of active cases continuing treatment.

Psychodynamic psychotherapy for youth aims to offer a safe and new relationship to express the inner world through play or speech, depending on the developmental aspect of the youth. Therapists engage with the patient's experiences by actively listening or playing and encouraging them to express their feelings, wishes, and needs by providing a safe space and linking their feelings and wishes with the play or speech themes. Psychodynamic psychotherapy depends on transference and countertransference relationships; therefore, the therapeutic relationship between the youth and the therapist has been actively explored during the treatment. Helping clients to link their relationship patterns with their previous relationships, unsatisfied needs, and unexpressed feelings and building a secure relationship with the therapists is aimed. Therefore, establishing a good enough therapeutic alliance with youth is essential for this treatment to be effective. The play was present in certain sessions, particularly among the research's younger participants. Because the target population is in a period of transition from play to speech therapy, the play was an important part of the therapy process in some cases

and a tool to develop a therapeutic relationship.

There is a standard procedure in the counseling center for assessing cases initially. Assessment sessions last approximately seven sessions. Therapists usually conduct a clinical interview with the parents and youth to learn about the cause for the referral, developmental history, and family history at the beginning. Then, therapists administer mother-child and father-child play observation sessions. For 10-year-old children in the current study, therapists arranged one-to-one meetings with them for free play assessment. For children older than ten years old, therapists scheduled one or two intake appointments with youth alone to discuss the cause for the referral. Additionally, in separate sessions, therapists conduct Parent Developmental Interviews (PDI; Slade et al., 2004) with both parents. Lastly, the therapist arranges a feedback session with parents and, in some cases, youth to describe how the therapist conceptualized symptoms and therapeutic requirements. A weekly program for youth and a monthly session for parents was usually offered. Except for the location where the therapy was provided, there was no change in the content of the evaluation sessions between the face-to-face and online groups.

While face-to-face sessions were held at the psychological center at Istanbul Bilgi University, sessions for online cases were held on Zoom, Skype, or Whatsapp Videocall because of pandemic restrictions. Since online therapy takes place in a different setting than traditional therapy, the psychotherapy frame was also established differently. In a traditional therapy frame, patients were required to attend sessions on the same day and in the same therapy room. Also, the confidentiality of clients is protected by therapists. Patients were required to inform their absence before 24 hours of the scheduled therapy time; otherwise, the session fee would be charged. After three unnoticed absences, patients were terminated. Because of the pandemic's extraordinary circumstances, a more adaptable online therapy framework had to be established. In the online setting, patients also had more control over therapy settings and parameters such as the therapy room and therapy instruments. Most of the time, patients were allowed to attend sessions from other rooms. Due to Internet issues and/or device limitations, sessions could be conducted over the phone rather than video chatting. In online therapy, therapy

schedules were more fluid, and patients were rarely expected to pay session fees if they did not inform their absence before 24 hours. There were also some issues that arose from the therapeutic framework. For example, patients sometimes attended from inappropriate places in terms of privacy. There were more technical issues such as internet disconnections and device malfunctions. Also, during the meetings, the privacy of the room was sometimes violated by a family member.

2.4. MEASURES

2.4.1. Demographic Information Form

Pre-meetings were done with patients applied to the center with the center's psychologist to assess whether the client was appropriate for the treatment center offered. The demographic information form was fulfilled in the pre-meeting session and intake sessions by the psychologists.

2.4.2. Therapy Process Observational Coding System- Alliance Scale

Global alliance in the therapy process is measured by the Therapy Process Observational Coding System- Alliance scale (TPOCS-A; McLeod & Weisz, 2005). This measurement is used to measure the quality of therapeutic alliance between therapists and youth patients. Therapy sessions were codded after watching the entire session, and two independent coders rated the 9-item scale in terms of frequency and/or intensity of each item. Each item is rated in a 6-point Likert scale between 0 (not at all) to 5 (great deal). The items are, (1) the patient feels understood and supported by the therapist, (2) the patient behaves in a hostile manner to the therapist, (3) the patient shows positive affect to the therapist, (4) how much the patient shares experiences with the therapist, (5) patient seems to be annoyed or anxious to interact with the therapist, (6) both the therapist and the patient seem to be annoyed and anxious to interact, (7) the patient shows some changes his/her life due to the therapy gains, (8) the patient do not follow therapeutic tasks, and (9) both the therapist and the patient apply therapeutic tasks and work equally together

(McLeod, 2005; See Appendix A).

TPOCS-A is user-friendly and objective due to the observational aspect, and retroactive measurement. McLeod and Weisz (2005) developed the measurement tool for assessing the alliance in youth therapies and applied their work to youth who are 8 to 14 years old. It has also excellent internal consistency ($\alpha = 0.95$) and inter-rater reliability of the measurement is acceptable (ICC > 0.40; $M = 0.59$, $SD = 0.10$; McLeod & Weisz, 2005). The convergent validity of the measurement is 0.53 within the correlation to TASC (McLeod & Weisz, 2005). TPOCS-A measurement scale was adapted to the Turkish child population who are 4 to 10 years old by Sibel Halfon, Özsoy, Kara, and Çavdar (2020) with the consultation of Bryce D. McLeod, Ph.D. In this adaptation study, there is a good internal consistency ($\alpha = 0.73$) except the item 7 (i.e., "child uses therapeutic tasks to make changes outside the session"). It is because the dynamic of psychodynamic psychotherapy does not offer homework or assignments so much compared to behavioral treatments (Halfon et al., 2020). Adaptation of the measurement to youth older than ten years old in the Turkish population has not been made yet; however, the measurement tool has been developed for the age group (8 to 14 years old) in the original study, and this population is intercepted with the current study population (McLeod & Weisz, 2005). Additionally, the adaptation study also shows good internal consistency with the Turkish population (Halfon et al., 2020).

For the present study, ten clinical psychology graduate students were trained to code TPOCS-A by Sibel Halfon, Ph.D., and her research team, who were also master's students in clinical psychology. Pilot sessions ($N = 8$) were coded separately by all raters, and then consultations were given by the research team. Raters achieved adequate interrater reliability (ICC = 0.70). Then, the current data was started to be coded. One from every ten sessions for each case from the data was randomly assigned for coding interdependently to two raters who were blind to thestudy except for the author and three coders. Sessions that were not adequate due to interrater reliability (ICC < 0.70) were resolved by pair discussions. Interrater reliability of rated sessions for the present study is between ICCs 0.70 to 1 ($M = 0.93$,$SD = 0.04$). The items showed good internal consistency ($\alpha = 0.81$).

2.4.3. Rupture Resolution Rating Scale

The Rupture Resolution System or 3RS (Eubanks et al., 2015) was used to code low alliance sessions for micro alliance analysis. The Rupture Resolution System (3RS) was chosen for this study because it is an observational, user-friendly, and retroactive measuring system.

Ruptures are defined as a deterioration in alliance, lack of collaboration, and/or emotional strains between the patient and the therapist (Eubanks et al., 2015). There are two categories of ruptures: withdrawal and confrontation. Withdrawal rupture is defined as a patient's act of moving away from the therapist and/or the therapy work (Eubanks et al., 2014). Withdrawal rupture markers consist of seven markers and those are described in Table 2.2.

Table 2.2

Description of Withdrawal Rupture Markers

Withdrawal Rupture Markers	*Description*
(1) Denial	The patient denies the obvious feelings and/or therapy work by withdrawing.
(2) Minimal Response	The patient goes silent or makes minimal response to the therapist's questions or interpretations, which prevents the deepening of the discussion.
(3) Abstract Communication	The patient uses abstract or vogue language to avoid genuine feelings.
(4) Avoidant Storytelling and/or Shifting Topic	The patient either tells irrelevant stories from the present topic and/or shifts the topic or plays to avoid genuine feelings.
(5) Deferential and Appeasing	The patient becomes overly obedient and conforms to the therapist to hide true feelings or avoid conflict with the therapist.
(6) Content/Affect Split	The patient shows affect that does not fit the content or plays for hiding true feelings
(7) Self-criticism and/or hopelessness	The patient shows self-criticism or hopelessness to keep the therapist away and closes her/himself to therapy gain.

Confrontation rupture is defined as a patient's act toward the therapist and/or the therapy work in a hostile manner, and there is a sensible tension during these ruptures (Eubanks et al., 2014). Confrontation markers consists of 7 markers and those are demonstrated in Table 2.3.

Table 2.3

Description of Confrontation Markers

Confrontation Rupture Markers	*Description*
(1) Complaints/concerns about the therapist	The patient shows negative feelings toward to therapist, either verbally or physically.
(2) Patient rejects therapist intervention	The patients show rejection to the therapist's intervention in a hostile manner.
(3) Complaints/ concerns about the activities of therapy	The patient shows dissatisfaction or discomfort with a therapy activity.
(4) Complaints/ concerns about the parameters of therapy	The patient shows dissatisfaction or discomfort with therapy parameters such as therapy room, toys, therapy time, etc.
(5) Complaints/ concerns about progress in therapy	The patient shows concerns, doubtful feelings, or dissatisfaction with therapy progress or works.
(6) Patient defends self against the therapist	The patient defends his/her actions, thoughts, or feelings towards the therapist's interpretations in a hostile manner.
(7) Efforts to control/pressure the therapist	The patient tries to control the therapist by commanding or pressuring him/her.

Resolution is defined as strategies of therapists use to repair ruptures (Eubanks et al., 2014). These markers consist of 10 items illustrated in Table X. Additionally, the effectiveness of resolution was measured by the marker (1)" to what degree were ruptures resolved over the course of the session?". Moreover, the scale measures the therapist's contribution by (2) "Did the therapist cause or exacerbate ruptures in the session?" on a 5-point Likert scale as 1 means "No" and 5 means "Yes, mostly". Detailed examples of each rupture and resolution marker were provided in Appendix B.

Table 2.4

Description of Resolution Markers

Resolution Markers	*Description*
(1) Therapist clarifies a misunderstanding	The therapist gives an explanation to clarify the misunderstanding to resolve the rupture.
(2 Therapist changes tasks or goals	The therapist responds to ruptures that originate from the therapy task or goal by changing it.
(3) Therapist illustrates tasks or provides a rationale for treatment	The therapist provides a rational explanation for the therapy work or goal.
(4)Invites to discuss thoughts or feelings	The therapist invites patients to understand thoughts or feelings when a rupture occurs.
(5) Acknowledges his/her contribution to a rupture	The therapist accepts the contribution to the rupture and which ways s/he frustrates the patient.
(6) Discloses his/her internal experience	The therapist responds to rupture by disclosing his/her true feelings and internal experiences about it.
(7) Links the rupture to larger interpersonal patterns between the patient and the therapist	The therapist links the rupture to previous ruptures to highlight similarities.
(8) Links the rupture to larger interpersonal patterns in the patient's other relationships	The therapist links the rupture to the patient's relationship with others.
(9) Validates the patient's defensive posture	The therapist validates the patient's defensive posture by understanding its adaptiveness without challenging him/her.
(10) Redirecting or refocusing	The therapist redirects the patient when s/he moves away from the therapy work or true feelings or shifts the topic.

Sessions were coded in terms of the frequency of markers while watching the session. Every marker was coded if it was observed in every 5 minutes time points. The frequency of the markers was coded only once in each 5-point sequence without recording each incident of markers in that 5-minutes time interval. Therefore, the maximum frequency could be 10 for a 50-minute session for each marker. If the coders were not sure if the marker fully represents the situation coded as half (0.50), which is called check minute minus in the manual (Eubanks et al., 2014). After watching the entire session, the significance rating, which is a 5-points

Likert scale from 1 (no significance) to 5 (high significance) was coded to assess the significance of that rupture or resolution marker for the therapeutic alliance. Additionally, questions for (1) efficacy of resolution markers and (2) therapist contribution to ruptures were coded at the end like significance rating on a 5-points Likert scale.

This measurement has been developed for adult patients; nevertheless, it has been used in adolescent populations in some studies recently (Cirasola et al., 2022; Dywer Hall, 2021; Gersh et al., 2017; O'Keeffe et al., 2020), and the results have been found appropriate for the literature. Nevertheless, some adjustments were made when it was applied to the youth population in this study. Firstly, patients' shifts in the play were coded as (4) avoidant storytelling and/or shifting topics in the case of showing moving away from the therapist and/or therapy work. Additionally, complaints about toys, board games, and online therapy parameters that have been used in youth therapy were coded as (4) complaints and/or concerns about the parameters of the therapy marker.

Eubanks and colleagues (2019) have conducted a reliability and validation study for this measurement for the population aged between 21 to 78 (M = 39.48, SD = 16.06). Interrater reliability was measured differently for withdrawal, confrontation, and resolution in terms of frequency and significance (Eubanks et al., 2019). Interrater reliability of frequencies in all markers are between ICC (1,2) = 0 .85 to 0.98 while significance are between ICC (1,2) = 0.81 to 0.93 (Eubanks et.al., 2019). Convergent validity with Structural Analysis of Social Behavior (SASB) failed to find significance between SASB and 3RS (Eubanks et al., 2019). Further self-report analysis of the therapist and the patient to correlate ruptures in 3RS to find convergent validity was also moderate in withdrawal frequency (r = −0.27, p = .11) and significant correlation with confrontation frequency (r = −0.50, p = .002; Eubanks et al., 2019). It was interpreted that withdrawal ruptures' nature is subtle and hard to recognize for therapist, patient, and observer, while confrontationmarkers are more overt (Eubanks et al., 2019).

For the current study, four clinical psychology students, including the author, were trained by Sibel Halfon, Ph.D. with the consultation of Catherine F.

Eubanks-Carter, Ph.D., and J. Christopher Muran, Ph.D. for Rupture Repair Resolution System (3RS). Coders started to learn coding 3RS by adult patients' session videos (N = 8) which have been coded before by Dr. Eubanks and her team. Regular meetings and discussions were held with Dr. Halfon to discuss training videos and markers to be evaluated in youth sessions. Coders succeeded in good interrater reliability to excellence (ICC = 0.70-1) of youth sessions (N = 5). Then, coder pairs were assigned with random sessions to code interdependently. Since coders were the therapists of some cases in the online group, those patients' sessions were deliberately assigned to other coders to eliminate bias. Interrater reliability of sessions from the data was good to excellence (ICC = 0.72 to 0.99; M = 0.89, SD = 0.075).

2.5. PROCEDURE

Permission was taken from each youth's parents for recording the sessions and participation in the research. Each participant was assigned a research number to protect personal information. Every session of the youth in the data was videotaped and/or audiotaped. In total, 181 sessions were coded via TPOCS-A. Each case from the data has been measured by TPOCS-A once every 10 sessions, 1-10, 11-20, 21-30, 31-40, 41-50, 51-60 chosen randomly. Chosen sessions were randomly assigned to two coders to code independently with TPOCS-A. After coding global alliance, online and face-to-face data was analyzed and also low alliance sessions called "residuals" were determined, which have been explained in the analysis section in detail. Low alliance sessions were randomly coded via Rupture Resolution Rating Scale (3RS) by four graduate students who were not blind to the study questions. Then, a descriptive analysis of the rupture and repair was made to understand the difference in both treatment types.

CHAPTER 3
RESULTS

3.1. DATA ANALYSIS

To be able to understand the first research question which is whether there is a difference in therapeutic alliance strength and growth slope between online and face-to-face psychodynamic youth therapies, the multilevel modeling (MLM) approach was taken. MLM analyses were conducted with MLWin Version 3.05 (Rasbash, et.al., 2020). Therapy type was dummy coded as online therapy as 1, and face-to-face therapy as 2. It was investigated if there was a significant difference in the overall strength (mean) and growth of the therapeutic alliance according to therapy type. In the model, the effect of age, gender and baseline problem levels were controlled.

The second research question explored the different kinds of ruptures (their frequencies and significance) in "low alliance" sessions. For this purpose, in order to determine the low alliance sessions, an empty multilevel model was constructed where the therapeutic alliance was the dependent variable with no predictors. The latent intercept and residuals were calculated. The residuals represent each child's individual deviation from the grand mean intercept. Sessions that deviated from the mean by -1 SD were selected and coded with Rupture Resolution Rating Scale (3RS). Rupture and repair frequencies in low alliance sessions were calculated using SPSS Version 22 (IBM Corp., 2015).

3.2. RESULTS

3.2.1. Comparison of Online and Teletherapy Therapeutic Alliance Development Slopes

Descriptive Statistics

The means, standard deviations and bivariate correlations of the gender, age, pre-treatment CBCL total score, aggregated therapeutic alliance and therapy type were illustrated in Table 3.1. It implicated that females showed higher therapeutic

alliance than males (p = .013).

Table 3.1

Descriptive statistics and Bivariate Correlation between Gender, Age, Pre-Treatment CBCLTotal Score, Therapeutic Alliance Total Score, and Therapy Types

Variables	*M*	*SD*	1	2	3	4	5
(1) Gender	0.51	0.50	-				
(2) Age	11.56	1.50	-0.24	-			
(3) Pre CBCL Total	61.17	8.61	0.13	-0.03	-		
(4) Therapeutic Alliance	28.88	4.37	-0.33*	0.01	-0.16	-	
(5) Therapy Type	1.35	0.48	-0.16	-0.08	0.12	0.00	-

Notes: Gender was dummy coded as "0" = female, "1" = male. Therapy type was also dummycoded as "1" = Face-to-Face, "2" = Online.
$**p < .01$.
$*p < .05$.

Multilevel Modeling Analyses

Psychotherapy sessions (N = 181) were nested within patients (N = 57) who were nested within the therapist (N = 37). The degree of interdependency due to therapists were examined because multiple patients were treated by the same therapists. Two-level (sessions nested within patients) and three-level (sessions nested within patients nested within therapists) "empty" multilevel models were constructed, where the therapeutic alliance was entered as the dependent variable with no predictor variables. The therapist level ICC was 0.00 ns., which indicated that 0 % of the variance in the therapeutic alliance originated from the therapists, suggesting that the variance in the session measures is not attributable to differences between therapists. On the other hand, the between patient ICC was 0.38, p < .01, accounting for 38 % of the variance in the therapeutic alliance, which implies that a two-level model is appropriate because not all variance is attributable to session-level variables. Therefore, only two-level models were used.

Afterward, an MLM analysis was applied to examine the difference in the strength of mean and growth slope of the therapeutic alliance due to therapy type. An interaction term between time and therapy type was generated to see if there was a difference in the growth of therapeutic alliance in therapy duration. Results indicated that there was a significant difference in alliance growth according to therapy type (See Table 3.2 and Figure 3.1). It showed that therapeutic alliance decreased over the course of the therapy in online treatment; however, it increased in face-to-face treatment ($p = .02$). There was no significant difference in the overall mean strength of the therapeutic alliance between therapy types ($p = .57$).

Table 3.2

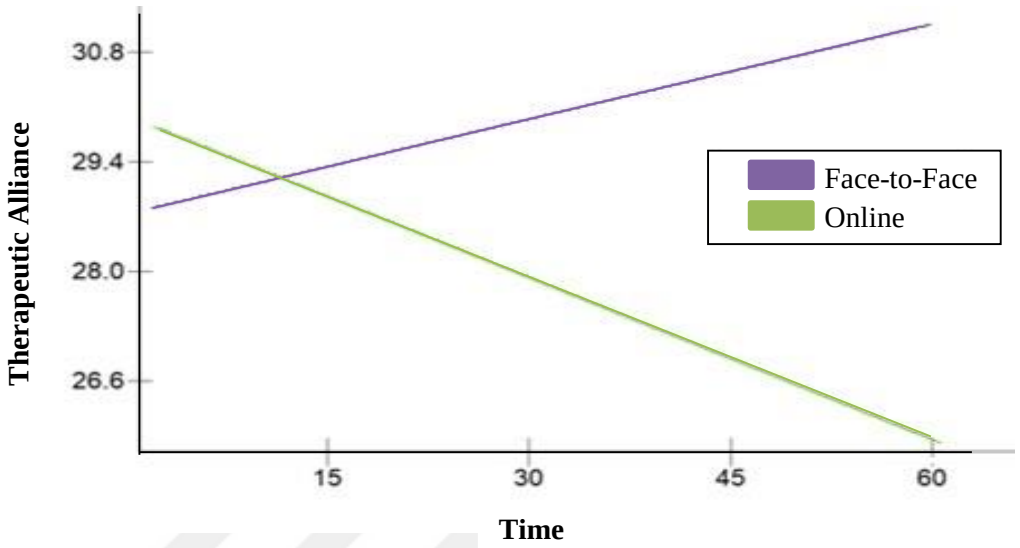
Summary of Multilevel Model Predicting Therapeutic Alliance by Age, Gender and Therapy Type and Time in Treatment

	Model: Therapeutic Alliance		
Intercept and Predictors	*β*	*SE*	*t* -ratio
Intercept (β_{00})	30.07	0.83	36.22
Therapy Type (β_{01})	-0.57	1.03	-0.55
Time (β_{10})	0.04	0.03	1.33
Therapy Type *Time (β_{11})	-0.11	0.05	2.20*
Gender (β_{02})	-2.92	1.02	-2.86*
Age (β_{03})	-0.25	0.34	-0.73
Pre-treatment problem level (β_{04})	-0.02	0.05	0.40

$**p < .01$.
$*p < .05$.

Figure 3.1

Linear Growth Trajectory of Therapeutic Alliance over Time When Controlled for Gender, Age,Pre-Treatment CBCL and Treatment Type



3.2.2. Exploring the Low Alliance Sessions

Sessions that deviated by 1 *SD* below from the sample means were selected for further analysis. 16 sessions from face-to-face therapy and 13 sessions from online therapy were identified to be 1 *SD* below the overall mean.

Since the sample size was not appropriate for the inferential statistical analysis, only results of descriptive statistics were presented. It was demonstrated that the frequency of total ruptures was observed less in the online group. However, for the face-to-face group, it was observed that confrontation ruptures occurred more frequently. The significance of resolutions, that is, how well the ruptures were resolved, was similar in both types of therapy. However, the frequency of resolution attempts was higher in face-to-face therapy. Also, the therapist's contributed more to ruptures in the face-to-face group compared to the online group.

Table 3.3

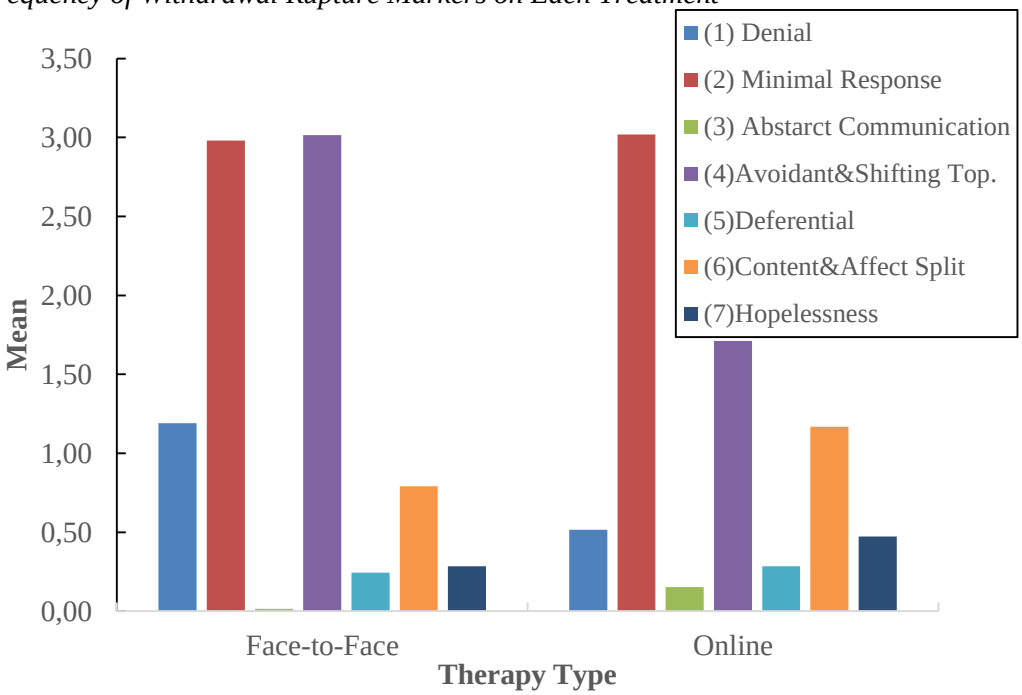
Descriptives of Each Category Comparing with Treatment Groups

	Therapy Type			
	Face-to-Face		Online	
	M	*SD*	*M*	*SD*
Withdrawal (Significance)	2.71	0.94	2.32	0.47
Withdrawal (Frequency)	8.53	4.51	7.33	4.07
Confrontation (Significance)	1.64	0.99	1.12	0.24
Confrontation (Frequency)	3.31	4.63	1.26	0.90
Resolution (Significance)	2.69	0.89	2.69	0.65
Resolution (Frequency)	3.20	3.98	2.49	1.75
Total Rupture Frequency	11.84	5.29	8.59	4.31
Therapist Contribution (Signficance)	2.01	0.73	1.64	0.50

Figure 3.2 illustrates the frequency of withdrawal rupture markers' differences between treatment groups. (2) minimal response and (4) avoidant storytelling & shifting topic rupture markers were found higher in frequency for both groups. Nevertheless, avoidant shifting topic happened more frequently in face-to-face therapy (See Figure 3.2 For more detail).

Figure 3.2

Frequency of Withdrawal Rupture Markers on Each Treatment

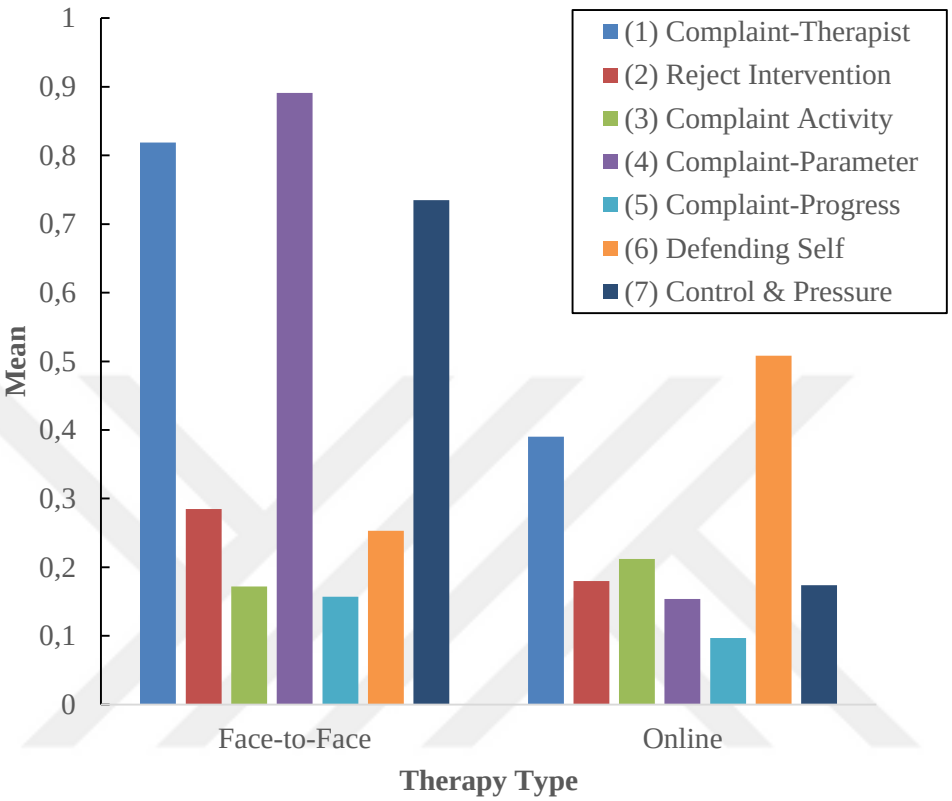


*Note.*The means of each withdrawal marker are illustrated for therapy type.

Secondly, as it was illustrated in Figure 3.3, (1) complaints about the therapist, (4) complaints about parameters, and (7) controlling the therapist markers mostly occurred in the face-to-face group. Considering the online group, the most occurred confrontational rupture marker was (1) complaint about the therapist, compared to the markers in this group.

Figure 3.3

Frequency of Confrontation Markers on Each Treatment

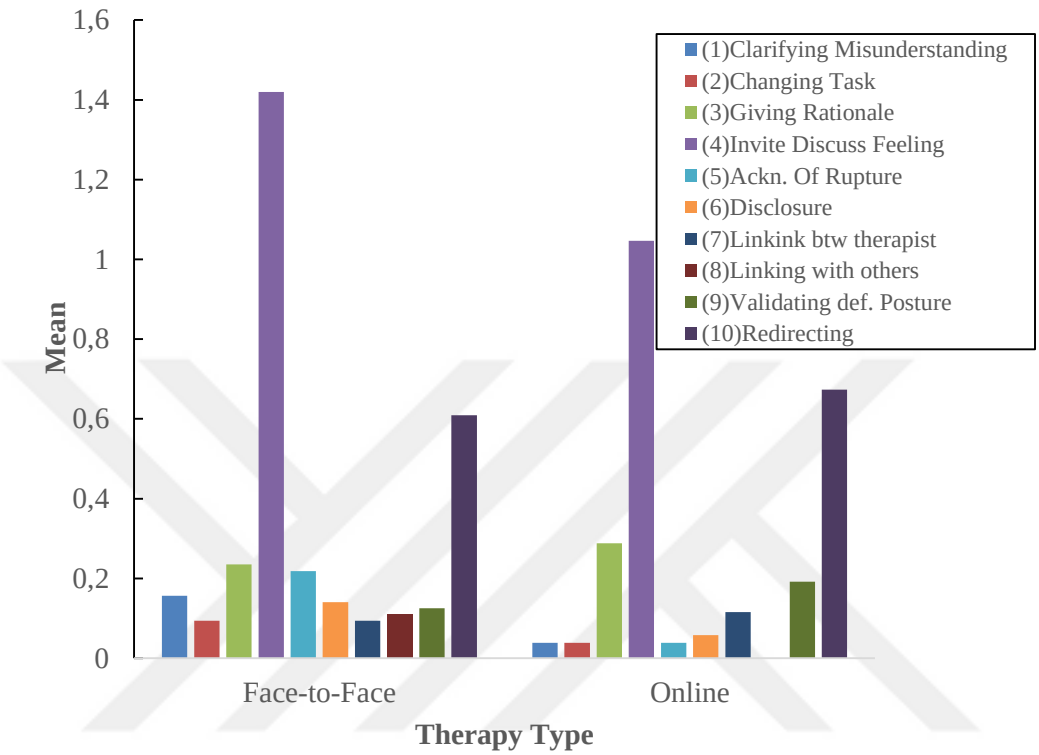


Note. The means of each confrontation marker are illustrated for therapy type.

Lastly, (4) invite to discuss feelings and (10) redirecting resolution markers frequently occurred in both groups within all markers. However, (4) invite to discuss feelings marker occurred more frequently in the face-to-face group. The marker (8) linking rupture to the interpersonal relationship with others was not coded in the online group at all (See Figure 3.4 for more detail).

Figure 3.4

Frequency of Resolution Markers on Each Treatment



Note. The means of each resolution marker are illustrated for the therapy type.

Additionally, in session examples of rupture markers for both therapy groups were provided in Appendix B.

CHAPTER 4
DISCUSSION

This study aimed to compare the differences in the mean alliance strength and alliance growth between online and face-to-face youth psychodynamic psychotherapies. According to the results, there was no significant difference in the mean alliance strength. The first hypothesis was supported. However, the therapeutic alliance increased in face-to-face while it decreased in online therapy during the therapy process. Additionally, this study aimed to explore low alliance sessions in terms of rupture and resolution characteristics by comparing both treatment groups. The results showed that there were more rupture and resolution frequencies in face-to-face therapy sessions. Especially, confrontational ruptures occurred more frequently, and therapists' contribution to ruptures impacted the alliance more in face-to-face therapy.

4.1. RESEARCH QUESTIONS

4.1.1. Therapeutic Alliance Process Comparison in Two Treatment Types

Firstly, the mean alliance strength was compared, and there was no significant difference between therapy types. Previous research comparing therapeutic alliance between online and face-to-face psychotherapy also found similar mean alliance strength between online and face-to-face treatments for both adult and adolescent psychotherapies (Anderson et al., 2012; Cook & Doyle, 2004; Ghosh et al., 1997; Holmes & Foster, 2012; Kaiser et al., 2021; Stiles-Shields et al., 2014). There were some limitations in those studies, such as a small sample size, measuring alliance at a single time point, and statistical analysis techniques that did not account for the multi-level structure of the data. This study was conducted with longitudinal data, including up to six time points within the treatments. The analyses were conducted with repeated measurements across the therapy sessions, taking patient and therapist effects into account using multi-level modeling analyses.

Therefore, these results support previous studies but also add to the literature with a stronger methodology.

The findings suggest that the unusual pandemic conditions and the different therapy frames of teletherapy did not significantly affect the mean alliance strength compared to face-to-face therapy. However, it would be misleading to evaluate the alliance only by mean alliance strength. Even though some researchers indicated that the alliance is stable after the third session (Eathon et al., 1988; Horowitz et al., 1984; Luborsky, 1976), the alliance is now considered to be a dynamic entity that changes over the course of therapy (Safran, Muran & Rothman, 2006). In line with these considerations, we also found a difference in the overall alliance growth. The therapeutic alliance increased in face-to-face treatment from the beginning to the end of the treatment, while it decreased in online therapy over the course of treatment. Since there are several uncontrolled variables in this study design, it is not fully appropriate to compare these two treatments with each other. Future studies that design their research as randomized control trials would provide richer and more consistent results.

At the beginning of the therapy, both online and face-to-face therapies had a similar mean alliance in the current study. This may imply that the alliance can be established in the initial phase in both groups. Previous studies also suggest that patients show more cooperation in therapy work and warm feelings to the therapist in the initial phase (Kabcenell, 1993). However, therapeutic alliance went into opposite directions in the middle phase, where the therapeutic relationship was expected to be deepened, and non-adaptive relational schemas and deeper emotional materials were expected to be uncovered (Everall & Paulson; Horvath, 2000; Özsoy, 2018). In face-to-face treatment, these difficult feelings could probably be addressed and possible alliance ruptures could be resolved. Therefore, patients may have felt emotionally contained and worked in cooperation with therapists, which may have caused the therapeutic alliance to grow over time. On the other hand, working on the difficult feelings of patients and addressing alliance ruptures in online therapy may not have been as possible as in face-to-face therapy.

This may have originated from the distance, different therapy settings, and pandemic conditions. Since these feelings could not be adequately worked in therapy, they may have been reflected in the real relationship with the therapist and therapy work so the alliance reduced over time (Everall & Paulson, 2002; Horvath, 2000).

Previous studies also show that there is a quadratic change in the therapeutic alliance, which implies that there are more alliance ruptures in the middle phase (Halfon et al., 2019; Kivlighan & Shaughnessy, 2000; Patton, Kivlighan, Multon, 1997; Schenk et al., 2019; Stiles et al., 2004). After the initial alliance is formed as secure enough, patients' non-adaptive relational schema and deeper emotional materials come out in the transference relationship, which causes ruptures in the alliance in the middle phase of the therapy (Eubanks, Muran & Safran, 2018). It is because emotional arousal heightens as the therapy work deepens; therefore, negative feelings are projected to the therapist (Axelman, 2006). It causes that the alliance decreases in the middle phase in the U-shaped alliance trajectory. When alliance ruptures are able to be resolved, the alliance increases again nearly after 25th session (Özsoy, 2018). Studies suggest that therapeutic change is possible when alliance ruptures are resolved (Eubanks, Muran & Safran, 2018; Humer et al., 2021; Muran et al., 2009; Safran et al., 2001; Stiles et al., 2004; Strauss et al., 2006; Westra, Constantino & Aviram, 2011). When the current study findings are considered in line with the previous studies, it can be evaluated that while the alliance was strengthened by repairing ruptures in face-to-face therapy, ruptures might have caused deterioration of the alliance in the online group.

To be able to understand the difference in alliance growth between therapy types in the current study, pandemic conditions and different therapy settings might need to be elaborated to understand their possible effects on the alliance. At first, therapy sessions have done under the conditions of the pandemic for the online group. Therefore, there were a lot of stressors related to the pandemic, such as fear of getting the infection, fear of losing a loved one, social isolation, restrictions etc. (Gruber et al., 2020; Horesh & Brown, 2020). These stressors might have affected

therapeutic alliance in the online group negatively. Because of pandemic stressors, therapists might not be able to mentalize their patients enough when therapy work was supposed to be deepened, and ruptures might not be realized or addressed sufficiently. As elaborated in detail in the literature, the pandemic has affected many dimensions of society. That is why it has been perceived as a mass trauma (Horesh & Brown, 2020). Mentalization studies show that trauma affects one's ability to mentalize others since social learning, emotion regulation, attention regulation capacities, and epistemic trust decrease with the effects of trauma (Lassri & Desatnik, 2020; Luyten & Fonagy, 2019). Since mentalization necessitates flexibility and interest, but these entities diminish during the crisis, the Covid-19 pandemic has not been a good time to mentalize patients for therapists. So, therapists' capacity for mentalization might also have decreased during the pandemic (Grignoli et al., 2021). Studies conducted in the pandemic also showed that vicarious traumatization, tiredness, less connection with their patients, and feeling less competent about online therapy were seen among therapists (Aafjes-van Doorn et al., 2020; Ledesma & Fernandez, 2021; Zuppardi, 2020).

On the other hand, the need for patients to be mentalized might have increased during the pandemic. Studies show that youth patients have suffered from anxiety and depression more than ever (Huscsava et al., 2021; Lee, 2020; Panchal et al., 2021; Tang et al., 2021). Also, the traumatic effects of the pandemic may have caused more hypervigilance or hypovigilance moods among youths (Perrotta, 2021); therefore, attention regulation and emotion regulation interventions may have been needed more during the pandemic. When the patient brings the deep emotional materials to the transference relationship, emotional arousal could be heightened; therefore, attention and emotion regulation could be broken, and mentalization capacity could be restricted (Fonagy et al., 2015; Muller & Midgley, 2015). When patients encounter those non-mentalized feelings during the treatment, they can regress to the previous steps of mentalization (Muller & Midgley, 2015). The psychotherapist helps to reconstruct mentalization capacity step by step, which is called "building blocks" in mentalization treatment (Bate & Malberg, 2020; Muller & Midgley, 2015). Therefore, psychotherapy offers

help to stay withpatients' emotional pain by regulating their attention and emotion by coming closerto the patient's mental state and helping to regulate attention and emotion of the patient (Bateman & Fonagy, 2005). These building block interventions help patients to build epistemic trust, which was found to be correlated with the therapeutic alliance positively (Aisbitt, 2020). When the setting of the treatments isconsidered, those interventions may have been more possible to apply in the face- to-face setting due to the therapy setting and lack of pandemic's traumatic effects on therapists; on the other hand, online therapy had many hindrances such as distance.

As the therapy work deepens, emotional arousal heightens; therefore the need for proximity and emotional closeness are probably needed for patients. Online therapy was probably more disadvantageous in that sense. It is because physical distance hindered many non-verbal cues and authentic moments, which probably caused emotional distance compared to face-to-face practice. This may be another reason for the decrease in the alliance in the online group. On the other hand, to be able to deepen the therapy work, the emotional bond is highlighted due to its necessity for this population in the literature (A. Freud, 1946; Axline, 1947; Rogers, 1957; Shirk, Karver, Brown, 2011). The therapist-patient relationship takesits roots in the relationship with the attachment figures (Bowlby, 1958; Chethik, 2002; Mackie, 1981; Loewald, 1960; Zetzel, 1965). A secure attachment could be possible by finding a rhythm or synchronicity with the child, starting with bodily movements (Beebe et al., 2010). As a new secure object, therapists also need to find a rhythm with the patients, which helps patients to increase emotion regulation capacity (Feldman, 2007; Vacharkulksemsuk & Fredrickson, 2012). However, research conducted with adult patients indicate that bodily synchronicity was not sopossible in the online therapy due to distance, and they felt less embodied and morestagnation during the online sessions (Garcia et al., 2022; Werbart et al., 2022). Also, studies show that both therapists and patients experience distance and distraction in the online setting as an impairment in alliance (Ahlström et al., 2022;Werbart et al., 2022).

Although both therapy settings seem sufficient to form an initial alliance,

itwas probably harder to find the rhythm again and again when ruptures occurred in the online setting in the middle phase due to lack of bodily interaction. In the current study, both youths and therapists mostly arranged their cameras to show only theirfaces and shoulders; therefore, it was impossible to see bodily movements mutually. Therefore, online therapy during the pandemic might not have been good enough to build a solid emotional bond with the youth as much as face-to-face therapy. There were more obstacles preventing reciprocality in the online therapy. Physical distance, inability to read all bodily reactions, inability to make eye contact and more technical interruptions might be the reason for the prevention of recatching the rhythm. On the other hand, ongoing bodily interaction in the face-to-face treatment may have made it easier for mutual regulation and finding the rhythm again. Mirroring bodily movements, managing the proximity, and up and down voice volume help patients regulate their attention and affect and regain their mentalization capacity (Kramer & Pascual-Leone, 2018; Muller & Midgley, 2015). Patients might feel contained by this mutual regulation because it was probably good enough to resolve alliance ruptures.

As it was mentioned above, finding a rhythm might be necessary when the therapeutic relationship deepens. However, there were more distractions from the technical setting in the online therapy, which probably made it hard to find a rhythm again and again. In the current study, online sessions were mostly held on Zoom, and any online platforms such as social media, online games, and websites were allowed to be used during therapy. There are contradictory opinions about using online platforms during therapy in the literature. Some advocates that online platforms are more meaningful for the youth population because they also have a presence on those platforms; therefore, online therapies could be more effective to work on (Barak & Sadovsky, 2008). Therapists could also have more opportunities to understand their patients' presence on online platforms (Barak & Sadovsky, 2008). Since online platforms may be more meaningful for youths, they might promote therapeutic alliance at the beginning of online therapy.

On the other hand, those platforms may also cause interruptions by application notifications, internet connection problems, etc. (Garcia et. al., 2021;

Hanley, 2021; Wong, 2021). Both therapists and patients could feel detached and disconnected from the main subject due to these interruptions (Ahlström et al., 2022; Werbart et al., 2022; Zuppardi et al., 2020). It also could function as an escape from difficult feelings for that population (Zuppardi et al., 2020). In our online sample, interruptions from the technical setting were observed, such as closing cam, frequent internet problems, calls during the session, overfocusing the online games or videos by ignoring the therapist, and so on. When emotional arousal heightened in the middle phase, it was probably more difficult to apply attention regulation and emotion regulation interventions in the online group because of that. It may have caused deterioration in the alliance during the process. Thus, therapists might need to be more active in monitoring patients' escapes and applying more interventions like redirecting their patients to the online therapy with youth patients.

Next, the physical therapy settings of the online sessions were one of the different aspects from the face-to-face therapy. During the pandemic, both patients and therapists were connected from their homes. The therapy room could create a psychic container besides its physical aspect, where the patient could unpack their emotional burden (Waldburg, 2012). The therapy room might be thought of as a container where difficult feelings are transferred, and the patient can find some distance after therapy. The transition from home to the therapy room in the face-to-face setting seems to enable patients to put their daily lives away and get ready for therapy sessions emotionally (Garcia et al., 2022; Werbart et al., 2022). The transition of place probably functions as an emotion regulator. However, the home had many functions as a workplace, living space, school, and therapy space during the pandemic. Since patients have not been able to become distant from the emotional burdens of the therapy due to physical limitations, they could have been more avoidant of unpacking their feelings. At the same time, therapists have also experienced the limitations of the space and the complexity of the multifunctional aspects of their homes during the pandemic. A qualitative study illustrated that therapists also need therapy rooms to feel prepared for therapy emotionally during the pandemic (Garcia et al., 2022). Therefore, therapists' function in containing the patients' emotions may have also

been lower in the online setting during the pandemic.

As it is mentioned above, the therapy room could function as a container that keeps patients safe, secure, and away from others' interruptions (Frank & Frank, 1993; Sinclair, 2021; Waldburg, 2012). In face-to-face treatment, patients come to the therapist's place, which was designed to fulfill therapeutic needs such as privacy. On the other hand, privacy was probably harder to sustain for most of the youth patients during the pandemic conditions, while the whole family had to be at home due to lockdowns and social isolation. Attending sessions from their family homes could have created worries to be heard by their families or neighbors for youths. Therefore, youth patients may not have felt privacy enough to deepen the therapy work in the middle phase by avoiding critical issues like family conflicts, romantic relationships, unsupported experiences by parents, sexual experiences, etc. Youth may have withdrawn in the case of difficult subjects for them, which may have caused a decrease in therapeutic alliance (Cirasola et al., 2022). Privacy is an important factor for this age group (Wisniewski et al., 2022). It is because they need to establish their self-identity and import new values and experiences, which sometimes conflict with their parents' perspectives; however, this conflictual experiences and values make them feel more autonomous (Atzil-Slonim, 2019). Studies investigating adolescents' stance toward online therapy also found that youth care about the privacy setting of the therapy conditions (King et al., 2020; Sweeney et al., 2019). Therapists also state that they felt insecure about deepening their interpretations and opening up difficult subjects by considering the privacy of their patients (Ahlström et al., 2022). This may be one of the reasons leading to a decrease in the alliance. Since youth patients might not have felt privacy, they might not have worked in collaboration for therapy work as much as face-to-face patients. For that reason, the privacy settings of the therapy room should be more carefully considered in online therapy.

In the current study, the therapy frame was another dimension that was quite different between therapy types. The standard and consistent therapy frame was able to be applied in the face-to-face setting. On the other hand, the more flexible therapy frame was applied in online therapy because of the therapy setting and the

pandemic conditions. For example, therapists accepted to change the scheduled therapy time more often or charged the fee rarely when they canceled the appointment within 24 hours. Therapists mostly accepted to do sessions when patients attended from different places during the pandemic. The flexible therapy frame may not have been an issue at the beginning of online therapy; on the contrary, this flexibility may have seemed to support patients. However, when difficult emotions arose, and a transference relationship was established, the therapeutic framework of online therapy may not have been sufficient to make patients feel emotionally contained because patients could show their aggression or difficult feelings by sabotaging the therapy frame (Goldberg, 1989). Therefore, the therapy frame should be consistent to be able to work on a deeper level in the transference relationship (Gray, 2013). Moreover, the consistent therapy frame ensures a secure environment for patients to discover their difficult feelings (Sayers, 2021). It might not have been easy to realize and/or address violations of the therapy frame for online therapists due to the flexible frame. Therefore, patients' resistance and aggressive feelings might be less highlighted and interpreted in the online therapy. This may result in a boost in those feelings and violations of the therapy frame in the online therapy. So the therapeutic alliance might get lowered when those feelings increase. Therefore, an online therapist should consider their therapy frame carefully to apply it consistently to create a safe space.

4.1.2. Rupture and Repair Differences in Low Alliance Sessions

In the current study, "low alliance" sessions were estimated and investigated by the rupture and repair approach. Descriptive analysis was applied to see the differences in rupture and resolution markers due to frequency and significance. The findings showed that ruptures and resolution occurred more frequently in the face-to-face group than in the online group. Especially, confrontational ruptures occurred more in face-to-face therapy. On the other hand, resolution attempts impacted the alliance similarly for both groups. Even though only low alliance sessions were observed from the perspective of rupture and resolution, it might also

reflect some insights for the rest of the therapy sessions. Those results will be discussed belove.

Firstly, the findings of this study showed that there are ruptures in the youth psychotherapies, as supported by other research (Daly et al., 2010; Dywer Hall, 2021; Gersh et al., 2016; O'Keeffe et al., 2020; Muran et al., 2009; Schenk et al., 2019). Also, the findings support that different therapy types could have different rupture and repair frequencies (Gersh et al., 2016). In the current study, it was found that low alliance sessions of face-to-face therapy had more ruptures. Safran and colleagues (2001) argue that ruptures could be an opportunity to work on patients' non-adaptive relational schema. Therefore, a higher frequency of rupture and resolution markers in the face-to-face therapy may indicate that this treatment had more opportunity to deepen therapy work (Daly et al., 2010; Safran et al., 2001). Previous studies also investigating rupture and repair processes with adolescents showed that as long as ruptures are resolved effectively, the dropout rate decreases and the effectiveness of therapy increases (Daly et al., 2010; Gersh et al., 2016; O'Keeffe et al., 2020; Schenk et al., 2019). When positive linear growth of the alliance is considered in the face-to-face group, it can be said that therapy work might be deepened and ruptures resolved in this group. Therefore, a secure and new relationship might have been established in this treatment (Safran & Kraus, 2014). On the other hand, online therapy might not deepen the therapy work in the middle phase because of the reasons mentioned above. Thus, fewer ruptures occurred in the low alliance sessions, which could reflect insights about the rest of the process. Another reason for higher rupture frequency in face-to-face treatment compared to the online group might be the difficulty of catching ruptures from an online setting. Dolev-Amit and colleagues (2020) advocate that distance work might hinder alliance ruptures, especially withdrawal ruptures. Therefore, there might be more alliance ruptures that online treatment could not identify by both coders and therapists. These misidentified ruptures might also affect the alliance in a negative way in online treatment.

Moreover, withdrawal rupture frequency was found to be higher than confrontation ruptures for both groups, which was also supported by previous

findings (Gersh et al., 2017; O'Keeffe et al., 2020; Schenk et al., 2019). It seems that youths are more prone to show their dissatisfaction by withdrawal (Cirasola et al., 2022). Safran and Muran (2000) argue that withdrawal ruptures function to arrange proximity with the therapist; therefore, withdrawal ruptures may occur more in this age group to resist too much closeness. Withdrawal ruptures are more introverted and subtle in their nature, so they might be hard to recognize, especially in the online setting, because of the aforementioned features of online therapy (Dolev-Amit et al., 2020; Eubanks et al., 2019). Therefore, there might have been more withdrawal ruptures missed by coders as well as therapists in the online group. There were probably more withdrawal ruptures in the middle phase of online therapy because difficult subjects arose. When those ruptures could not be noticed and resolved, therapy work could not be deepened because unresolved ruptures probably caused deterioration in the alliance, as it is supported by studies (Daly et al., 2010; Dywer Hall, 2021; O'Keeffe et al., 2020; Schenk et al., 2019).

When each withdrawal marker was considered, it could be stated that this age group tends to show mostly (2) minimal response (Cirasola et al., 2022; Schenk et al., 2019). Research conducted with the adolescents to analyze silences in the therapy showed that silences are mostly referred to as concerning due to the therapeutic relationship, and therapists should more actively try to attune with this population to decrease the number of silent moments (Zimmerman et al., 2021). Moreover, in the findings of this study, it was also found that (4) avoidant storytelling and shifting the topic was the second most used withdrawal marker. There was only a small difference between therapy types in (4) avoidant storytelling & shifting topic marker, which was higher in the face-to-face setting. As it was mentioned above, there are more disruptions in the online setting (Garcia et al., 2021; Hanley, 2021; Wong, 2021). However, that technical interruptions or interruptions from outside in the online setting could have been manipulated by patients easily; therefore, it would be more hidden and harder to interpret those ruptures as avoidant and shifting topic ruptures. For example, closing the camera after a therapist's interpretation might sometimes imply a patient's effort to shift the topic. Therefore, online therapists should be more actively seeking youth's

withdrawal responses in the therapy, especially the minimal response, and avoidant & shifting topic ruptures.

Also, results showed that confrontation ruptures occurred less compared to withdrawal ruptures, which supported previous studies for this age group (Cirasola et al., 2022; Eubanks et al., 2018; O'Keeffe et al., 2020). So, it seems that youth patients tend to show their dissatisfaction less and/or indirect ways (Eubanks et al., 2018; Farber et al., 2003; O'Keeffe et al., 2020). While withdrawal responses function to arrange proximity and put distance with the therapist, confrontation ruptures are attacks on the therapist for misunderstandings of the therapist and the need for more proximity (Coutinho et al., 2011; Safran & Muran, 2000). In the current study, face-to-face sessions had more confrontation ruptures compared to the online group. Even though confrontation ruptures have been found to be related to dissatisfaction with the therapy and dropout rate (O'Keeffe et al., 2020), another perspective found that these ruptures are significant due to their implications for the effectiveness of therapy, especially for youth with internalizing problems (Dywer Hall, 2021). It shows that youth patients feel freer to show their dissatisfaction with the therapy process directly, which necessitates a secure enough relationship (Dywer Hall, 2021). Since the therapeutic alliance trajectory for the face-to-face group was positive linear, the second perspective seems more appropriate for this study. When the adolescent population is considered, they need to build their self-identity by separating themselves from others and being autonomous (Atzil-Slonim, 2019). So, youth needs to confront others in the relationship when they need to put their unique identities in the relationship (Erikson, 1968). Therefore, the study findings might imply that youth's confrontational needs and aggressive feelings could have been worked in face-to-face therapy. These aggressive attitudes and feelings might also show that therapy work could get deepened in the face-to-face setting compared to online. As the therapeutic work deepened, patients may have needed more to be understood and proximity to the therapist. So, confrontational ruptures have been found higher in this treatment. Nevertheless, confrontational ruptures should be handled carefully since they could impact the alliance more (O'Keeffe et al., 2020).

When each confrontational marker was compared, (1) complaints about the therapist, (4) complaints about the parameters of therapy, and (7) attempting to control therapist markers frequently occurred in face-to-face therapy. (1), and (7) compared to the other markers, may require more proximity to the therapist. It is because complaining about the therapist and controlling the therapist markers are directed toward the therapist's stance in the relationship (Coutinho et al., 2011; Eubanks-Carter et al., 2014). It may also show a higher opportunity to work on the transference of the patient in psychodynamic therapy. From the psychodynamic approach, when aggressive feelings can work on transference relationships, patients' neurosis could be cured (Freud, 1912b). On the other hand, the complaint about the therapy parameters is a way to show aggression less directly. For example, a patient showed her dissatisfaction with the therapy by complaining about the security at the campus where the therapy was held in the study. Considering that, the youth had more control over the online parameters such as therapy room, toys or games, and screen control. Therefore, this marker may not be an efficient way of showing aggression to the therapist in the online setting. For example, when a patient complained about an online game he was asked to play in the online therapy, it was not coded as a complaint about the parameter. On the other hand, if the patient complained about the toys in the face-to-face setting, it was considered a ruptıre which reflects aggression towards therapy work and/or the therapist.

In the study, the frequency of resolution markers was found higher in the face-to-face sessions, so there were more attempts to resolve ruptures. Even though the frequency of resolution was higher in the face-to-face group, its impact on the alliance was quite similar in both groups. Since only low alliance sessions were taken into the analysis, this might indicate that ruptures were not resolved, which caused the alliance to decrease. Results of resolution attempts and their impacts were probably lower than good alliance sessions. Nevertheless, low alliance sessions may have shown some clues about the rest of the therapy sessions. As mentioned above, resolutions of ruptures have been found to be significantly impactful for effective therapy in the literature (Eubanks et al., 2018; Humer et al., 2021; Muran et al., 2009; Safran et al., 2001; Stiles et al., 2004; Strauss et al., 2006;

Westra et al., 2011). Especially, immediate responses to the ruptures were found to correlate with a positive impact on collaboration in the alliance (Schenk et al., 2019). Therapists in the face-to-face group might be advantageous in terms of identifying ruptures due to proximity and addressing the ruptures immediately. Therefore, the alliance may have been strengthened. On the other hand, online therapists might have missed the ruptures because of the technical disruptions and distance, and the resolution attempts were fewer. Eventually, it might have affected the alliance in the process. Moreover, results showed that two major resolution strategies in psychodynamic therapy for this population were (4) inviting to discuss feelings and (10) redirecting the patient. Previous findings also support it for this age group (Cirasola et al., 2022; Dywer Hall, 2021). Psychodynamic psychotherapy aims to explore feelings that cause strains in the transference relationship (Atzil-Slonim, 2019). Defenses toward the difficult feelings are also addressed by actively redirecting patients to these feelings (Atzil-Slonim, 2019). Therefore, a higher frequency of these resolution strategies might be because they are the primary interventions of psychodynamic psychotherapy.

Lastly, the therapist's contribution to rupture was found in this study as consistent with the literature (O'Keeffe et al., 2020). In the current study, it was found that both confrontational and therapist contributions were higher in the face-to-face group. In the literature, the therapist's contribution was also found to be more in the group that showed more confrontational ruptures (O'Keeffe et al., 2020). It may be the result of higher proximity in the therapy relationship. Since there was more proximity in the face-to-face group, confrontational ruptures increased. The transference relationship might be developed as well as countertransference. Tishby & Wiseman (2022) found that negative countertransference is related to ruptures. It could be stated that more proximity and confrontational attitudes of patients may have caused negative countertransference, which increased therapists' contribution to rupture. On the other hand, the face-to-face group might have had more chance to respond to rupture immediately, as discussed above, which may have caused an increase in alliance overall in the therapy process. On the other hand, distance in online therapy may affect the

therapy, including less transference and countertransference enactments. It may also refer to the less deepening therapy work in online treatment. Also, the therapist's contribution could be more in those low alliance sessions in both groups than in good alliance sessions. So proximity of face-to-face therapy setting might increase transference and countertransference enactments, which causes the therapist's contribution to rupture. It might be another important implication for therapists.

4.2. CLINICAL IMPLICATIONS

Current study results show that there is no significant difference in the mean alliance strength between the online during the pandemic and face-to-face therapy before the pandemic, which supports previous findings (Anderson et al., 2012; Cook & Doyle, 2004; Ghosh et al., 1997; Holmes & Foster, 2012; Kaiser et al., 2021; Stiles-Shields et al., 2014). This implies that therapeutic alliance could be established both through face-to-face sessions before the pandemic and online sessions during the pandemic.

However, the alliance trajectories go in opposite directions throughout the process. This finding implies that therapeutic alliance is a dynamic entity that changes over time (Safran & Muran, 2000). Therefore, ongoing negotiation in the therapeutic alliance should be considered by therapists. Our findings show that therapeutic alliance in online groups declined over time of treatment. This preliminary finding may imply that even though therapeutic alliance could be established at the beginning, online therapy should be strengthened in front of increased ruptures when therapy work deepens. It may be because face-to-face treatment was applied at a proximate distance, so it was probably easier to come closer to patients' emotional temperature and disturbances, so it was more probable address them. Since literature strongly suggests that therapeutic change comes from resolving ruptures and strong therapeutic alliance, it could be essential to acknowledge the handicaps of online therapy and design a "*holding environment*" (Winnicott, 1971, p.151).

As Winnicott (1971) states that good enough mothering in a holding environment helps the child to establish a healthy and creative self. Psychotherapy, in that sense, aims to create a holding environment for the patient to feel safe and free to discover their deep feelings (Winnicott, 1960). On the other hand, online therapy is a newly developing area, so it has not been studied enough to understand the effect of the online therapy environment on therapeutic alliance yet. Nevertheless, deterioration of alliance in online therapy should also be considered from the perspective of the therapy environment. Firstly, it seems that attunement both emotionally and physically creates a rhythm and emotional bond (Bateman & Fonagy, 2005; Feldman, 2007; Kramer & Pascual-Leone, 2018; Muller & Midgley, 2015). Especially in the middle phase, where ruptures increase and therapy work deepens, therapists should be aware of their patient's rupture responses and find the rhythm again and again after ruptures. To be able to attune to bodily responses, both therapists and patients should arrange camera angles to show their whole bodies in the online setting. This way, it would be more possible to mirror and notice bodily gestures. Also, withdrawal ruptures might be more observable in the body movement, and resolution attempts might increase. When the therapeutic work deepens and the ruptures occur, emotion regulation intervention would be more likely to be applied by mirroring the patient with a greater camera angle.

Next, privacy is an important entity that needs to be carefully considered in both therapies for this age group but especially in online treatment (King et al., 2020; Sweeney et al., 2019; Wisniewski et al., 2022). Youth patients show their privacy concerns in online therapy (King et al., 2020; Sweeney et al., 2019). Online therapists should consider the therapy room's privacy settings more diligently to provide them safe and confidential space.

Psychotherapy needs to be dependable and strong holding environment in front of patients' aggressive feelings due to heightened emotions. So, a consistent and secure therapy frame may be needed for online therapy (Goldberg, 1989; Gray, 2013; Sayers, 2021). Since online therapy has more distance between therapist and patient, aggressive feelings might be directed to the therapy frame. In the current online sample, a flexible therapy frame was adapted due to the pandemic conditions.

However, future online therapies might need to consider a more strict therapy frame to hold the therapeutic relationship strong. By protecting the stability of the therapy setting and frame, more difficult feelings like aggression could be worked in the transference relationship more effectively. With the establishment of a consistent and secure therapy frame, it would be more likely to address patients' resistance in the case of violations of the frame. Especially when emotional arousal heightens with the deepening therapeutic relationship, the therapy frame should prevent the escape of the patient.

The study support that ruptures, especially withdrawal ruptures, occur in the psychotherapy with youth population (Daly et al., 2010; Dywer Hall, 2021; Gersh et al., 2016; Muran et al., 2009; O'Keeffe et al., 2020; Schenk et al., 2019). Therefore, it implies that youth patients show their dissatisfaction or disturbances by withdrawing their emotional investment. However, literature shows that if ruptures are not addressed and resolved enough, it causes deterioration in the alliance or even dropouts (Gersh et al., 2017; Holly Dwyer, 2021; O'Keeffe et al., 2020; Schenk et al., 2019). Therefore, psychotherapists should monitor patients' responses more actively and address these ruptures because it is an effective way to increase alliance as well as therapy outcome (Eubanks et al., 2018; Humer et al., 2021; Muran et al., 2009; Safran et al., 2001; Stiles et al., 2004; Strauss et al., 2006; Westra et al., 2011). Minimal responses and avoidant & shifting topic ruptures were seen frequently in both therapy types (Cirasola et al., 2022; Schenk et al., 2019). Therefore, psychodynamic youth therapies need to consider those ruptures more. Especially, online therapy might be disadvantageous to catch those ruptures due to distance and uncontrolled parameters (Dolev-Amit et al., 2020).

Face-to-face therapy seems to be able to construct positive linear alliances and repair alliance ruptures; therefore, it has increased through time. As it was discussed, it seems that transference relationships could develop more intensely in the face-to-face setting, so enactments happen. In the current study, therapist contribution to rupture was found more significant in the face-to-face setting as well as the confrontation rupture of patients. This result may imply that therapists should be aware of their positive and negative countertransference to patients, which was

found to be correlated with ruptures in the literature (Tishby & Wiseman, 2022).

Lastly, online data was collected from the sessions held during the pandemic conditions. Therefore, it was aimed to continue providing therapy despite the negative effects of the pandemics. However, it has not been the best time for either patients or therapists to keep the mentalization process online (Grignoli et al., 2021). It has been traumatic for both parties. Our findings imply that therapeutic alliances in psychotherapy that are conducted under the pandemic circumstances might tend to be more fragile due to the aforementioned features of the pandemic. Therefore, patients might need more supportive therapeutic interventions during the traumatic times. Therapists may also needed to take therapy themselves to eliminatethe emotional strains of the shared trauma of the pandemic.

4.3. LIMITATIONS AND RECOMMENDATIONS FOR FUTURE RESEARCH

There are some strengths of this study, such as longitudinal design, and investigating online and face-to-face sessions from both macro and micro therapeutic alliance perspectives. Even though this study has some strengths to enhance the literature, it has several limitations that are needed to be considered. Firstly, the sample size of both therapy types was relatively small. So, its generalizability is limited. Low alliance sessions could not be analyzed by inferential statistics due to the small sample size. To improve methodology, a greater and similar sample size for each group should be used.

In this study, therapist features and patient features were similar, and the sample was chosen from the same center, which increased the comparability of treatment groups while decreasing the generalizability of the findings. Moreover, therapies were not applied at the same time, and patients were not randomized; therefore, there was no control group in the study. The face-to-face therapy group had more patients than the online group, which also limited comparability. The effects of the pandemic, therapists' features, patient features, and relationship features between them could not be controlled. So, this study is limited due to

internal validity, limiting the interpretation of the results. Future studies must design a randomized control trial with a greater and comparable sample size in which treatments are to be applied at the same time by controlling more variables.

In the current study, the therapeutic alliance was estimated to be linear and results implied a difference between online and face-to-face therapies. This preliminary finding probably addressed ruptures in the middle phase of treatment. To be able to interpret findings more consistently, quadratic change of therapeutic alliance for both treatment types should be estimated. Future studies can enhance literature by investigating quadratic alliance process.

Thirdly, since the current study only measured low alliance sessions by rupture and repair approach, it was not possible to interpret the rest of the therapy durations. Moreover, literature could be strengthened by applying the rupture and repair approach in a longitudinal design to understand rupture trajectories in that population. It would give more insight into the differences between therapy types in rupture and repair characteristics. Moreover, future studies could also investigate the correlation between youth characteristics and rupture characteristics and the difference between the therapy types to provide richer clinical implications.

Next, the result could be supported by outcome measures such as the Child Behavioural Checklist (CBCL; Achenbach, 1991). In this way, measuring the effectiveness of the treatment types would be possible. However, in the current study, it was not aimed because treatments were not the controlled groups for each other. Secondly, future studies could measure the mentalization adherence difference between online and face-to-face treatments. This way, it would be possible to interpret the therapist's mentalization adherence differences accurately. Thirdly, measuring vicarious traumatization of therapists during the pandemic via Vicarious Trauma Scale (VTS; Vrklevski & Franklin, 2008) would enhance the study. Lastly, both TPOCS-A and 3RS were observer-based alliance measurements, and future studies could strengthen their findings by adding more perspectives such as perspectives of youths, parents, and therapists (van Benthem et al., 2020).

The global alliance was measured by TPOCS-A which Halfon and colleagues (2020) adapted into Turkish with a population under 10 years old.

However, this measure has not been adapted yet for the youth population. Nevertheless, this current study was also supervised by Dr. Halfon, and no changes or adaptation in markers was suggested for the youth population. Rupture Repair Rating System (3RS) has not also been adapted either to the youth population or the Turkish sample. 3RS has been used for adolescents between 11-18 years old without adaptation in other research, and findings were supported mainly by literature (Dywer Hall, 2021; O'Keeffee et al., 2020). Moreover, coders of 3RS were not blind to the study questions. Coders were not also trained to code 3RS but only supervised when they needed it. Therefore, rupture and repair results could be interpreted tentatively.

Therapeutic alliance has been an area worked on by many researchers; nevertheless, youth population and online therapy have not been adequately worked on yet. There is no study comparing online sessions that have been done during the pandemic with face-to-face therapies yet. That is why interpreting the differences between growth alliance trajectories has depended on basic theories instead of empirical studies. Since it is a mostly unknown area, it would also be meaningful to design a qualitative study comparing online and face-to-face sessions. In this way, these treatments could be understood in-depth for this population.

CONCLUSION

This study aims to investigate the difference in the mean alliance strength and growth alliance trajectory between online treatment during the pandemic and face-to-face treatment before the pandemic in psychodynamic youth therapy. The research showed that mean alliance strength did not differ between therapy types. However, growth alliance trajectories were found to be significantly different, which shows that therapeutic alliance increased in the face-to-face group while decreasing in online therapy. Different therapy conditions, settings, and frames are discussed to understand this difference in the alliance trajectories. Additionally, this research investigates low alliance sessions with a rupture and repair approach. Descriptive results of low alliance sessions indicate that ruptures, especially confrontational ones, occurred more frequently in face-to-face treatment. This study provides significant results for clinical implications and enriches limited literature on youth and online psychotherapies.

REFERENCES

Aafjes-van Doorn, K., Békés, V., Prout, T. A., & Hoffman, L. (2020). Psychotherapists' vicarious traumatization during the COVID-19 pandemic. *Psychological Trauma:Theory, Research, Practice, and Policy*, Mit. 12(S1), S148.

Abrishami, G. F., & Warren, J. S. (2013). Therapeutic alliance and outcomes in children and adolescents served in a community mental health system. *J Child AdolescentBehavior*, 1(2). 16-22.

Achenbach, T. M., & Rescorla, L. A. (2000). *Mental health practitioners' guide for theAchenbach System of Empirically Based Assessment (ASEBA)*. Burlington: University of Vermont, Department of Psychiatry.

Ahlström, K., von Below, C., Forsström, D. & Werbart, A. (2022). Therapeutic encounters at the onset of the COVID-19 pandemic: psychodynamic therapists' experiences of transition to remote psychotherapy, *Psychoanalytic Psychotherapy.* 1(2). 1-19.

Ainsworth, M. D., Blehar, M., Waters, E., & Wall, S. (1978). *Patterns of attachment*. 1(1). 416.

Ainsworth, M. D. S. (1978). The bowlby-ainsworth attachment theory. *Behavioral and Brain Sciences*, *1*(3), 436-438.

Aisbitt, G. M. (2020). *Epistemic trust and mentalizing in adolescent therapeutic alliances.* [Doctoral dissertation, UCL (University College London)].

Akkaya-Kalayci, T., Kothgassner, O. D., Wenzel, T., Goreis, A., Chen, A., Ceri, V., & Özlü-Erkilic, Z. (2020). The impact of the COVID-19 pandemic on mental healthand psychological well-being of young people living in Austria and Turkey: a multicenter study. *International Journal of Environmental Research and Public Health,* 17(23), 9111.

Anastasopoulos, D. (1997). Shame in psychotherapy with adolescents. *Journal of ChildPsychotherapy*, 23(1), 103-123.

Anderson, R. E., Spence, S. H., Donovan, C. L., March, S., Prosser, S., & Kenardy, J.(2012). Working alliance in online cognitive behavior therapy for anxiety disorders in youth: comparison with clinic delivery and its role in predicting outcome. *Journal of Medical Internet Research,* 14(3), e1848.

Anthony, K. (2015). *Psychoanalysis online: mental health, teletherapy, and training*. 43(1), 171-182.

Atzil-Slonim, D. (2019). Psychodynamic psychotherapy for adolescents. In Contemporary psychodynamic psychotherapy. Academic Press. 1(1), 253-266.

Axelman, M. (2006). Making "use" of aggression in child psychotherapy. *Journal ofInfant, Child and Adolescent Psychotherapy,* 5, 196-205.

Axline, V. (1947). *Play therapy*. Boston: Houghton Mifflin

Baker, H. S., & Baker, M. N. (1987). Heinz Kohut's self psychology: An overview. *American Journal of Psychiatry*, 144(1), 1-9.

Barak, A., & Sadovsky, Y. (2008). Internet use and personal empowerment of hearing-impaired adolescents. *Computers in Human Behavior*, 24(5), 1802-1815.

Bate, J., & Malberg, N. (2020). Containing the anxieties of children, parents and familiesfrom a distance during the coronavirus pandemic. *Journal of Contemporary Psychotherapy*, 50(4), 285-294.

Bateman, A. W., & Fonagy, P. (2004). Mentalization-based treatment of BPD. *Journal OfPersonality Disorders*, 18(1), 36-51.

Beebe, B., Jaffe, J., Markese, S., Buck, K., Chen, H., Cohen, P., ... & Feldstein, S. (2010). The origins of 12-month attachment: A microanalysis of 4-month mother–infant interaction. *Attachment & Human Development*, 12(1-2), 3-141.

Bickman, L., De Andrade, A. R. V., Athay, M. M., Chen, J. I., De Nadai, A. S., Jordan- Arthur, B. L., & Karver, M. S. (2012). The relationship between change in therapeutic alliance ratings and improvement in youth symptom severity: whose ratings matter the most?. *Administration and Policy in*

Mental Health and MentalHealth Services Research, 39(1), 78-89.

Binder, P.-E., Holgersen, H., & H∅ stmark Nielsen, G. (2008). Re-establishing contact:A qualitative exploration of how therapists work with alliance ruptures in adolescent psychotherapy. *Counselling and Psychotherapy Research*, 8(4), 239–245.

Blatt, S. J., & Behrends, R. S. (1987). Internalization, separation-individuation, and the nature of therapeutic action. *The International Journal of Psychoanalysis*, 68(2),279–297.

Blos, P. (1967). The second individuation process of adolescence. *The PsychoanalyticStudy of the Child*, 22(1), 162-186.

Bordin, E. S. (1979). The generalizability of the psychoanalytic concept of the workingalliance. *Psychotherapy: Theory, Research & Practice*, 16(3), 252.

Bordin, E. S. (1994). Theory and research on the therapeutic working alliance: Newdirections. *The Working Alliance: Theory, Research, and Practice*, 13–37.

Bowlby, J. (1958). The nature of the child's tie to his mother. *International Journal ofPsycho-Analysis*, 39, 350-373.

Bowlby, J. (1988). Developmental psychiatry comes of age. *The American Journal of Psychiatry*. 145(1), 1–10.

Brenner, C. (1979). Working alliance, therapeutic alliance, and transference. *Journal ofthe American Psychoanalytic Association*, 27(1), 137-157.

Broggi, M. B., & Sabatelli, R. (2010). Parental perceptions of the parent-therapist relationship: Effects on outcomes of early intervention. *Physical & OccupationalTherapy in Pediatrics*, 30(3), 234-247.

Center for Substance Abuse Treatment. (2014). Understanding the impact of trauma. In Trauma-informed care in behavioral health services. *Substance Abuse and MentalHealth Services Administration* (US).

Chen-Gaddini, M. (2012). Chinese mothers and adolescents' views of authority and autonomy: a study of parent-adolescent conflict in urban and rural China. *Child Development*, 83(6), 1846-1852.

Chethik, M. (2002). The play relationship and the therapeutic alliance. PsychoanalyticSocial Work, 8(3-4), 9-20.

Chethik, M. (2003). *Techniques of child therapy (2nd ed.)*. New York, NY: GuilfordPress.

Chu, B. C., Skriner, L. C., & Zandberg, L. J. (2014). Trajectory and predictors of alliancein cognitive behavioral therapy for youth anxiety. *Journal of Clinical Child & Adolescent Psychology*, 43(5), 721-734.

Chung, G., Lanier, P. & Wong, P.Y.J. (2020). *Mediating effects of parental stress onharsh parenting and parent-child relationship during coronavirus (covid-19)pandemic in Singapore*. J Fam Viol. 37(1), 801-812.

Cinelli, M., Quattrociocchi, W., Galeazzi, A., Valensise, C. M., Brugnoli, E., Schmidt, A.L. & Scala, A. (2020). The COVID-19 social media infodemic. *Scientific Reports*, *10*(1), 1-10.

Cirasola, A., Midgley, N., Fonagy, P., Martin, P., & IMPACT Consortium. (2021). The therapeutic alliance in psychotherapy for adolescent depression: Differences between treatment types and change over time. *Journal of Psychotherapy Integration*. 1573-3696.

Cirasola, A., Midgley, N., Fonagy, P., Impact Consortium, & Martin, P. (2021). The factor structure of the Working Alliance Inventory short-form in youth psychotherapy: An empirical investigation. *Psychotherapy Research*, 31(4), 535-547.

Cirasola, A., Martin, P., Fonagy, P., Eubanks, C., Muran, J. C., & Midgley, N. (2022). Alliance ruptures and resolutions in short-term psychoanalytic psychotherapy foradolescent depression: An empirical case study. *Psychotherapy Research*, 1-18.

Cook, J. E., & Doyle, C. (2002). Working alliance in online therapy as compared to face-to-face therapy: Preliminary results. *Cyber Psychology & Behavior*, 5(2), 95-105.

Coutinho, J., Ribeiro, E., Hill, C., & Safran, J. (2011). Therapists' and clients' experiencesof alliance ruptures: A qualitative study. *Psychotherapy Research*, 21(5), 525-540.

Cucinotta, D., & Vanelli, M. (2020). WHO Declares COVID-19 a Pandemic. *Acta bio-medica: Atenei Parmensis*, 91(1), 157–160.

Daly, A. M., Llewelyn, S., McDougall, E., & Chanen, A. M. (2010). Rupture resolution in cognitive analytic therapy for adolescents with borderline personality disorder.*Psychology and Psychotherapy: Theory, Research and Practi*ce, 83(3), 273-288.

Day, S. X., & Schneider, P. L. (2002). Psychotherapy using distance technology: A comparison of face-to-face, video, and audio treatment. *Journal of CounselingPsychology*, 49(4), 499.

de Haan, A. M., Boon, A. E., de Jong, J. T. V. M., Hoeve, M., & Vermeiren, R. R. J. M.(2013). A meta-analytic review on treatment dropout in child and adolescent outpatient mental health care. *Clinical Psychology Review*, 33, 698–711.

de Miranda, D. M., da Silva Athanasio, B., de Sena Oliveira, A. C., & Silva, A. C. S.(2020). How is COVID-19 pandemic impacting mental health of children andadolescents?. *International Journal of Disaster Risk Reduction*, 101845.

de Roten, Y., Fischer, M., Drapeau, M., Beretta, V., Kramer, U., Favre, N., & Despland, J.-N. (2004). Is one assessment enough?: Patterns of helping alliance development and outcome. *Clinical Psychology and Psychotherapy*, 11, 324-331.

DiGiuseppe, R., Linscott, J., & Jilton, R. (1996). Developing the therapeutic alliance inchild—adolescent psychotherapy. *Applied and Preventive Psychology*, 5(2), 85-100.

Dolev-Amit, T., Leibovich, L., & Zilcha-Mano, S. (2020). Repairing alliance rupturesusing supportive techniques in telepsychotherapy during the COVID-19 pandemic. *Counselling Psychology Quarterly*, 1-14.

Dowling, S. (1994). Book Reviews: Psychotherapeutic Strategies in Late Latency throughEarly Adolescence. *Journal of the American Psychoanalytic Association*, 42(1), 243-247.

Duran, S., & Erkin, Ö. (2021). Psychologic distress and sleep quality among

adults in Turkey during the COVID-19 pandemic. *Progress in Neuro-Psychopharmacologyand Biological Psychiatry*, 107, 110254.

Dwyer Hall, H. (2021). *Exploring Alliance Rupture Resolution Processes in Psychotherapy with Adolescents* [Doctoral dissertation, UCL (University CollegeLondon)].

Eaton, T. T., Abeles, N., & Gutfreund, M. J. (1988). Therapeutic alliance and outcome:Impact of treatment length and pretreatment symptomatology. *Psychotherapy: Theory, Research, Practice, Training*, 25(4), 536–542.

Elford, R., White, H., Bowering, R., Ghandi, A., Maddiggan, B., & John, K. S. (2000). Arandomized, controlled trial of child psychiatric assessments conducted using videoconferencing. *Journal of Telemedicine and Telecare*, 6(2), 73-82.

Elliott, G. R., & Feldman, S. S. (1990). Capturing the adolescent experience. In S. S. Feldman & G. R. Elliott (Eds.), *At the threshold: the developing adolescent*. Cambridge, Mass.: Harvard University Press. 642.

Elvins, R., & Green, J. (2008). The conceptualization and measurement of therapeuticalliance: An empirical review. *Clinical Psychology Review*, 28(7), 1167-1187.

El-Zoghby, S. M., Soltan, E. M., & Salama, H. M. (2020). Impact of the COVID-19 pandemic on mental health and social support among adult Egyptians. *Journal ofcommunity health*, 45(4), 689-695.

Ensink, K., & Mayes, L. C. (2010). The development of mentalisation in children from atheory of mind perspective. *Psychoanalytic Inquiry*, 30(4), 301-337.

Erikson, E. H. (1968). *Identity: Youth and crisis (No. 7).* WW Norton & company.

Eubanks-Carter, C. F., Muran, J. C., & Safran, J. D. (2014). *Rupture resolution ratingsystem (3RS): Manual*.

Eubanks, C. F., Muran, J. C., & Safran, J. D. (2015). *Rupture resolution rating system(3RS): Manual [Unpublished manuscript]*. Mount Sinai-Beth Israel Medical Center, New York.

Eubanks, C. F., Muran, J. C., & Safran, J. D. (2018). Alliance rupture repair: A meta-analysis. *Psychotherapy*, 55(4), 508.

Eubanks, C. F., Lubitz, J., Muran, J. C., & Safran, J. D. (2019). Rupture resolution ratingsystem (3RS): Development and validation. *Psychotherapy Research*, 29(3), 306-319.

Everall, R. D., & Paulson, B. L. (2002). The therapeutic alliance: Adolescent perspectives. *Counselling and Psychotheraphy Research*, 2(2), 78-87.

Farber, B. A. (2003). Patient self-disclosure: A review of the research. *Journal of ClinicalPsychology*, 59, 589–600.

Faw, L., Hogue, A., Johnson, S., Diamond, G. M., & Liddle, H. A. (2005). The Adolescent Therapeutic Alliance Scale (ATAS): Initial psychometrics and prediction of outcome in family-based substance abuse prevention counseling.*Psychotherapy Research*, 15(1-2), 141-154.

Feldman, R., and Eidelman, A. I. (2007). Maternal postpartum behavior and the emergence of infant–mother and infant–father synchrony in preterm and full-terminfants: the role of neonatal vagal tone. *Developmental psychobiology*. 49, 290– 302.

Fernandes, B., Biswas, U. N., Mansukhani, R. T., Casarín, A. V., & Essau, C. A. (2020).The impact of COVID-19 lockdown on internet use and escapism in adolescents.*Revista de psicología clínica con niños y adolescente*s, 7(3), 59-65.

Flückiger, C., Del Re, A. C., Wampold, B. E., & Horvath, A. O. (2018). The alliance inadult psychotherapy: A meta-analytic synthesis. *Psychotherapy*, 55(4), 316.

Fonagy, P., & Target, M. (2002). Early intervention and the development of self-regulation. *Psychoanalytic Inquiry*, 22(3), 307-335.

Fonagy, P., & Allison, E. (2014). The role of mentalizing and epistemic trust in thetherapeutic relationship. *Psychotherapy*, 51(3), 372.

Fonagy, P., Luyten, P., & Bateman, A. (2015). Translation: Mentalizing as treatmenttarget in borderline personality disorder. *Personality Disorders: Theory, Research, and Treatment*, 6(4), 380.

Fonagy, P. (2015). The effectiveness of psychodynamic psychotherapies: An update. *World Psychiatry*, 14(2), 137-150.

Frank, J. D., & Frank, J. B. (1993). *Persuasion and healing: A comparative study ofpsychotherapy* (3rd ed.). Johns Hopkins University Press.

Freud, S. (1912).The Dynamics of Transference. *The Standard Edition of the CompletePsychological Works of Sigmund Freud*. 12(1), 97-108.

Freud, A. (1946). *The psycho-analytical treatment of children.*

Freud, S., & Breuer, J. (1955). Preface to the first edition of studies on hysteria. In *TheStandard Edition of the Complete Psychological Works of Sigmund Freud* (Volume II) (1893-1895): Studies on Hysteria (pp. XXIX-XXX).

Freud, S. (1958). On beginning the treatment (further recommendations on the techniqueof psycho-analysis I). In *The Standard Edition of the Complete Psychological Works of Sigmund Freud,* (Volume XII) (1911-1913): The Case of Schreber, Papers on Technique and Other Works (pp. 121-144).

García, E., Di Paolo, E. A., & De Jaegher, H. (2022). Embodiment in online psychotherapy: A qualitative study. *Psychology and Psychotherapy: Theory,Research and Practice*, 95(1), 191-211.

Gardner, R. A. (1993). *Psychotherapy with children*. Northvale, NJ: Jason Aronson Inc.

Gaston, L. (1990). The concept of the alliance and its role in psychotherapy: Theoreticaland empirical considerations. *Psychotherapy: Theory, Research, Practice, Training*, 27(2), 143.

Geller, S. (2021). Cultivating online therapeutic presence: Strengthening therapeutic relationships in teletherapy sessions. *Counselling Psychology Quarterly*, 34(3-4),687-703.

Gersh, E., Hulbert, C. A., McKechnie, B., Ramadan, R., Worotniuk, T., & Chanen, A. M.(2017). Alliance rupture and repair processes and therapeutic change in youth with borderline personality disorder. *Psychology and Psychotherapy: Theory, Research and Practice*, 90(1), 84-104.

Généreux, M., Schluter, P. J., Landaverde, E., Hung, K. K., Wong, C. S., Mok, C. P. Y., ... & Roy, M. (2021). The evolution in anxiety and depression with the progression of the pandemic in adult populations from eight countries

and four continents. *International Journal of Environmental Research and Public Health*,18(9), 4845.

Ghosh, G. J., McLaren, P. M., & Watson, J. P. (1997). Evaluating the alliance in videolink teletherapy. *Journal of Telemedicine and Telecare*, 3(1_suppl), 33-35.

Goldberg, P. (1989). Actively seeking the holding environment: Conscious and unconscious elements in the building of a therapeutic framework. *ContemporaryPsychoanalysis*, 25(3), 448-476.

Gordon, R. M., Shi, Z., Scharff, D. E., Fishkin, R. E., & Shelby, R. D. (2021). An International Survey of the Concept of Effective Psychodynamic Treatment During the Pandemic. *Psychodynamic Psychiatry*, 49(3), 453-462.

Gray, A. (2013). *An introduction to the therapeutic frame*. Routledge.

Grignoli, N., Arnaboldi, P., & Antonini, M. (2021). Therapeutic alliance in covid-19 eraremote psychotherapy delivered to physically ill patients with disturbed body image. *Frontiers in Psychology*, 12.

Greenson, R. R. (2008). The working alliance and the transference neurosis. *The Psychoanalytic Quarterly*, 77(1), 77-102.

Greenson, R. (1965). The problem of working through. *Drives, affects, behavior*, 2, 277-314.

Gruber, J., Prinstein, M. J., Clark, L. A., Rottenberg, J., Abramowitz, J. S., Albano, A. M., & Weinstock, L. M. (2020). Mental health and clinical psychological sciencein the time of COVID-19: Challenges, opportunities, and a call to action. *American Psychologist*. 76(3), 409–426.

Haider, I. I., Tiwana, F., & Tahir, S. M. (2020). Impact of the COVID-19 pandemic on adult mental health. *Pakistan Journal of Medical Sciences*, 36(COVID19-S4), 90.

Halfon, S., Özsoy, D., & Çavdar, A. (2019). Therapeutic alliance trajectories and associations with outcome in psychodynamic child psychotherapy. *Journal of Consulting and Clinical Psychology*, 87(7), 603.

Halfon, S., Özsoy, D., Kara, D., & Çavdar, A. (2020). The psychometric

properties of theTurkish form of the therapeutic alliance observational coding system (TPOCS-A).*Türk Psikoloji Yazıları*, 23(46), 69-71.

Hall, A. K., Nousiainen, M. T., Campisi, P., Dagnone, J. D., Frank, J. R., Kroeker, K. I.,& Oswald, A. (2020). Training disrupted: Practical tips for supporting competency-based medical education during the COVID-19 pandemic. *Medical Teacher*, 42(7), 756-761.

Hanley, T. (2009). The working alliance in online therapy with young people: Preliminary findings. *British Journal of Guidance & Counselling*, 37(3), 257-269.

Hill, C. E., Nutt-Williams, E., Heaton, K. J., Thompson, B. J., & Rhodes, R. H. (1996). Therapist retrospective recall impasses in long-term psychotherapy: A qualitativeanalysis. *Journal of Counseling Psychology*, 43(2), 207.

Hilsenroth, M. J., Peters, E. J., & Ackerman, S. J. (2004). The development of therapeuticalliance during psychological assessment: Patient and therapist perspectives. *Journal of Personality Assessment*, 83, 332-344

Holmes, C., & Foster, V. (2012). A preliminary comparison study of online and face-to-face counseling: Client perceptions of three factors. *Journal of Technology in Human Services*, 30(1), 14-31.

Horesh, D., & Brown, A. D. (2020). Traumatic stress in the age of COVID-19: A call toclose critical gaps and adapt to new realities. *Psychological Trauma: Theory, Research, Practice, and Policy*, 12(4), 331.

Horowitz, M. J., Marmar, C, Weiss, D. S., Dewitt, K. N. & Rosenbaum, R. (1984). Briefpsychotherapy of bereavement reactions. *Archives of General Psychiatry*, 41, 438- 448.

Horvath, A. O, & Symonds, B. D. (1991). Relation between working alliance and outcome in psychotherapy: A meta-analysis. *Journal of Counseling Psychology*,38,139-149.

Horvath, A. O., & Luborsky, L. (1993). The role of the therapeutic alliance in psychotherapy. *Journal of Consulting And Clinical Psychology*, 61(4), 561.

Horvath, A. O. (2000). The therapeutic relationship: From transference to alliance. Journal of clinical psychology, 56(2), 163-173.

Horvath, A. O., Del Re, A. C., Flückiger, C., & Symonds, D. (2011). Alliance in individual psychotherapy. Psychotherapy, 48(1), 9-16.

Hudson, J. L., Kendall, P. C., Chu, B. C., Gosch, E., Martin, E., Taylor, A., & Knight, A.(2014). Child involvement, alliance, and therapist flexibility: Process variables incognitive-behavioural therapy for anxiety disorders in childhood. *Behaviour research and therapy*, 52, 1-8.

Humer, E., Schramm, E., Klein, J. P., Härter, M., Hautzinger, M., Pieh, C., & Probst, T.(2021). Effects of alliance ruptures and repairs on outcomes. *Psychotherapy Research*, 31(8), 977-987.

Hurley, K. D., Lambert, M. C., Ryzin, M. V., Sullivan, J., & Stevens, A. (2013). Therapeutic alliance between youth and staff in residential group care: Psychometrics of the therapeutic alliance quality scale. *Children and Youth Services Review*, 35(1), 56-64.

Huscsava, M. M., Scharinger, C., Plener, P. L., & Kothgassner, O. D. (2021). 'The worldsomehow stopped moving': impact of the COVID-19 pandemic on adolescent psychiatric outpatients and the implementation of teletherapy. *Child and Adolescent Mental Health*.

IBM Corp. (2015). IBM SPSS Statistics for Macintosh, version 23.0. Armonk, NY: Author.

Johns Hopkins Coronavirus Resource Center. (2022). *COVID-19 Map*. Retrieved 29 May2022, from: https://coronavirus.jhu.edu/map.html

Kabcenell, R. J. (1993). Some aspects of the "treatment alliance" in child analysis. Journal of Clinical Psychoanalysis, 2(1), 27-41.

Kaiser, J., Hanschmidt, F., & Kersting, A. (2021). The association between therapeuticalliance and outcome in internet-based psychological interventions: a meta- analysis. *Computers in Human Behavior*, 114, 106512.

Kanninen, K., Salo, J., & Punamaki, R. L. (2000). Attachment patterns and workingalliance in trauma therapy for victims of political violence.

Psychotherapy Research, 10(4), 435-449.

Kanzer, M. (1981). Freud's" Analytic Pact*: The Standard Therapeutic Alliance. *Journalof the American Psychoanalytic Association*, 29(1), 69-87

Kaplan, E. H. (1997). Telepsychotherapy: Psychotherapy by telephone, videophone and computer videoconferencing. *Journal of Psychotherapy Practice and Research*, 6,227–237.

Karver, M. S., De Nadai, A. S., Monahan, M., & Shirk, S. R. (2018). Meta-analysis of theprospective relation between alliance and outcome in child and adolescent psychotherapy. *Psychotherapy*, 55(4), 341.

Kendall, P. C., Comer, J. S., Marker, C. D., Creed, T. A., Puliafico, A. C., Hughes, A. A.,Hudson, J. (2009). In-session exposure tasks and therapeutic alliance across the treatment of childhood anxiety disorders. *Journal of Consulting and Clinical Psychology*, 77(3), 517-525.

Kılınçel, Ş., Kılınçel, O., Muratdağı, G., Aydın, A., & Usta, M. B. (2021). Factors affecting the anxiety levels of adolescents in home-quarantine during COVID-19pandemic in Turkey. *Asia-Pacific Psychiatry,* 13(2), e12406.

King, R., Bambling, M., Lloyd, C., Gomurra, R., Smith, S., Reid, W., & Wegner, K. (2006). Online counselling: The motives and experiences of young people who choose the Internet instead of face to face or telephone counselling. *Counsellingand Psychotherapy Research*, 6(3), 169-174.

King, S. C., Richner, K. A., Tuliao, A. P., Kennedy, J. L., & McChargue, D. E. (2020). Acomparison between telehealth and face-to-face delivery of a brief alcohol intervention for college students. *Substance Abuse*, 41(4), 501-509.

Kira, I., Lewandowski, L., Somers, C. L., Yoon, J. S., & Chiodo, L. (2012). The effects oftrauma types, cumulative trauma, and PTSD on IQ in two highly traumatized adolescent groups. *Psychological Trauma: Theory, Research, Practice, and Policy*, 4(1), 128.

Kivlighan, D. M., & Shaughnessy, P. (1995). Analysis of the development of the workingalliance using hierarchical linear modeling. *Journal of Counseling Psychology*, 42(3), 338.

Kivlighan, D. M., & Shaughnessy, P. (2000). Patterns of working alliance development:A typology of working alliance ratings. *Journal of Counseling Psychology*, 47, 362–371.

Kohut, H. (1984). How does analysis cure? Chicago: University of Chicago Press

Koole, S. L., & Tschacher, W. (2016). Synchrony in psychotherapy: A review and anintegrative framework for the therapeutic alliance. *Frontiers in Psychology*, 7,862.

Kramer, U., de Roten, Y., Beretta, V., Michel, L., & Despland, J.-N. (2008). Patient's andtherapist's views of early alliance building in dynamic psychotherapy: Patterns and relation to outcome. *Journal of Counseling Psychology*, 55, 89-95.

Kramer, U., & Pascual-Leone, A. (2018). Self-knowledge in personality disorders: an emotion-focused perspective. *Journal of Personality Disorders*, 32(3), 329-350.

Lappalainen, R., Lappalainen, P., Puolakanaho, A., Hirvonen, R., Eklund, K., Ahonen, T.,& Kiuru, N. (2021). The Youth Compass-the effectiveness of an online acceptance and commitment therapy program to promote adolescent mental health: A randomized controlled trial. *Journal of Contextual Behavioral Science*, 20, 1-12.

Lassri, D., & Desatnik, A. (2020). Losing and regaining reflective functioning in the times of COVID-19: Clinical risks and opportunities from a mentalizing approach.*Psychological Trauma: Theory, Research, Practice, and Policy*, 12(1), S38.

Ledesma, D. A. S., & Fernandez, K. T. G. (2021). 'If I am not well, I can't do sessions well': An analysis of the narratives of Filipino Therapists during the COVID-19Pandemic. *Counselling and Psychotherapy Research.* 22(2), 524-533.

Lee, C. M., Cadigan, J. M., & Rhew, I. C. (2020). Increases in loneliness among youngadults during the COVID-19 pandemic and association with increases in mentalhealth problems. *Journal of Adolescent Health*, 67(5), 714-717.

Lee, J. (2020). Mental health effects of school closures during COVID-19. *The LancetChild & Adolescent Health*, 4(6), 421.

Levine, R. S. (1997). Martin Delany, Frederick Douglass, and the politics of representative identity. Univ of North Carolina Press.

Lin, T., Stone, S. J., Heckman, T. G., & Anderson, T. (2021). Zoom-in to zone-out:Therapists report less therapeutic skill in telepsychology versus face-to-facetherapy during the COVID-19 pandemic. *Psychotherapy,* 58(4), 449.

Loewald, H. (1960). On the therapeutic action of psychoanalysis. *International Journal ofPsychoanalysis*, 41:16-27.

Luborsky, L. L. (1976). Helping alliances in psychotherapy. In J. L. Claghorn (Ed.), *Successful Psychotherapy* New York: Brunner/Mazel. 92- 116

Luborsky, L. (1984). *Principles of psychoanalytic psychotherapy: A manual for supportive-expressive treatment.* New York: Basic Books.

Luo, X., Estill, J., Wang, Q., Lv, M., Liu, Y., Liu, E., & Chen, Y. (2020). The psychological impact of quarantine on coronavirus disease 2019 (COVID-19).*Psychiatry Research*, 291, 113193.

Luyten, P., & Fonagy, P. (2019). Mentalizing and trauma. *Handbook of Mentalizing InMental Health Practice*, 79-99.

Mackie, A. J. (1981). Attachment theory: Its relevance to the therapeutic alliance. *BritishJournal of Medical Psychology*, 54(3), 203-212.

Magson, N. R., Freeman, J. Y., Rapee, R. M., Richardson, C. E., Oar, E. L., & Fardouly,J. (2021). Risk and protective factors for prospective changes in adolescent mentalhealth during the COVID-19 pandemic. *Journal of Youth and Adolescence*, 50(1), 44-57.

Markowitz, J. C., Milrod, B., Heckman, T. G., Bergman, M., Amsalem, D., Zalman, H., & Neria, Y. (2021). Psychotherapy at a distance. *American Journal of Psychiatry*,178(3), 240-246.

McLeod, B. D., & Weisz, J. R. (2005). The therapy process observational coding system-alliance scale: measure characteristics and prediction of outcome in usual clinical practice. *Journal of Consulting and Clinical Psychology*,

73(2), 323.

McLeod, B. D. (2011). Relation of the alliance with outcomes in youth psychotherapy: Ameta-analysis. *Clinical Psychology Review*, 31(4), 603-616.

Meins, E., Fernyhough, C., Russell, J., & Clark-Carter, D. (1998). Security of attachmentas a predictor of symbolic and mentalising abilities: A longitudinal study. *Social Development*, 7(1), 1-24.

Meins, E., Fernyhough, C., Wainwright, R., Das Gupta, M., Fradley, E., & Tuckey, M.(2002). Maternal mind–mindedness and attachment security as predictors of theory of mind understanding. *Child Development*, 73(6), 1715-1726.

Mellado, A., Suárez, N., Altimir, C., Martínez, C., Pérez, J., Krause, M., & Horvath, A. (2017). Disentangling the change–alliance relationship: Observational assessmentof the therapeutic alliance during change and stuck episodes. *Psychotherapy Research*, 27(5), 595-607.

Midgley, N., & Navridi, E. (2006). An exploratory study of premature termination in child analysis. *Journal of Infant, Child, and Adolescent Psychotherapy*, 5(4), 437–458.

Mitchell, S. A. (1993). *Hope and dread in psychoanalysis.* Basic Books.

Morgül, E., Bener, A., Atak, M., Akyel, S., Aktaş, S., Bhugra, D. & Jordan, T. R. (2021). COVID-19 pandemic and psychological fatigue in Turkey. *The International Journal of Social Psychiatry*, 67(2), 128.

Moss, L., Hamlet, H. S., & Singer, J. *An Introduction to Child-Centered Play Therapy.*

Muller, N., & Midgley, N. (2015). Approaches to assessment in time-limited Mentalization-Based Therapy for Children (MBT-C*). Frontiers in Psychology*, 6,1063.

Muran, J. C., Safran, J. D., Gorman, B. S., Samstag, L. W., Eubanks-Carter, C., & Winston, A. (2009). The relationship of early alliance ruptures and their resolutionto process and outcome in three time-limited psychotherapies for personality disorders. *Psychotherapy: Theory, Research, Practice,*

Training, 46(2), 233.

Murray, M. E. (1974). The therapist as a transitional object. *The American Journal ofPsychoanalysis*, 34(2), 123-127.

Nagata, Jason M., Hoda S. Abdel Magid, and Kelley Pettee Gabriel. Screen time for children and adolescents during the coronavirus disease 2019 pandemic. *Obesity28.9* (2020): 1582-1583.

O'Keeffe, S., Martin, P., & Midgley, N. (2020). When adolescents stop psychological therapy: Rupture–repair in the therapeutic alliance and association with therapyending. *Psychotherapy*, 57(4), 471.

Ogden, T. H. (1994). The analytic third: Working with intersubjective clinical facts. *International Journal of Psycho-Analysis*, 75, 3-19.

Özdin, S., & Bayrak Özdin, Ş. (2020). Levels and predictors of anxiety, depression and health anxiety during COVID-19 pandemic in Turkish society: The importance ofgender. *International Journal of Social Psychiatry*, 66(5), 504-511.

Özsoy, D. (2018). *Therapeutic alliance in psychodynamic child psychotherapy: Growthtrajectories and relations with outcome.* [Master's thesis, İstanbul Bilgi Üniversitesi].

Panchal, N., Kamal, R., Orgera, K., Cox, C., Garfield, R., Hamel, L., & Chidambaram, P.(2020). The implications of COVID-19 for mental health and substance use. *Kaiser Family Foundation*, 21.

Panchal, U., Salazar de Pablo, G., Franco, M., Moreno, C., Parellada, M., Arango, C., &Fusar-Poli, P. (2021). The impact of COVID-19 lockdown on child and adolescent mental health: Systematic review. *European Child & Adolescent Psychiatry*, 1-27.

Patton, M. J., Kivlighan, D. M., Jr., & Multon, K. D. (1997). The Missouri psychoanalytic counseling research project: relations of changes in counselingprocess to client outcomes. *Journal of Counseling Psychology*, 44, 189–208.

Perrotta, G. (2021). Parental Alienation Syndrome (PAS): Definition, humanistic profilesand clinical hypothesis of absorption with “adaptation disorder”.

Open Journal ofPediatrics and Child Health, 6(1), 036-042.

Pfefferbaum, B., & North, C. S. (2020). Mental health and the Covid-19 pandemic. *NewEngland Journal of Medicine*, 383(6), 510-512.

Preschl, B., Maercker, A., & Wagner, B. (2011). The working alliance in a randomizedcontrolled trial comparing online with face-to-face cognitive-behavioral therapyfor depression. *BMC Psychiatry*, 11(1), 1-10.

Rasbash, J., Browne, W. J., Healy, M., Cameron, B., & Charlton, C. (2020). *MLwiNversion 2.02. 2005*. Institute of Education: London.

Roback, H. B., & Shelton, M. (1995). Effects of confidentiality limitations on the psychotherapeutic process. *The Journal of Psychotherapy Practice and Research*,4(3), 185.

Rogers, C. R. (1957). The necessary and sufficient conditions of therapeutic personalitychange. *Journal of Consulting Psychology*, 21(2), 95.

Rolnick, A., & Ehrenreich, Y. (2020). Can you feel my heart (via your camera and sensors)? The role of the body, its absence, and its measurement in online videopsychotherapy. *Biofeedback (Online)*, 48(1), 20-23.

Safran, J. D., & Muran, J. C. (1996). The resolution of ruptures in the therapeutic alliance. *Journal of Consulting and Clinical Psychology*, 64(3), 447.

Safran, J. D., & Muran, J. C. (2000). Resolving therapeutic alliance ruptures: Diversityand integration. *Journal of Clinical Psychology*, 56(2), 233-243.

Safran, J. D., Muran, J. C., Samstag, L. W., & Stevens, C. (2001). Repairing allianceruptures. *Psychotherapy: Theory, Research, Practice, Training*, 38(4), 406.

Safran, J. D. (2003). The relational turn, the therapeutic alliance, and psychotherapyresearch: Strange bedfellows or postmodern marriage? *Contemporary Psychoanalysis*, 39, 449–475.

Safran, J. D., & Muran, J. C. (2006). Has the concept of the therapeutic alliance outlivedits usefulness?. *Psychotherapy: Theory, Research, Practice, Training*. 43(3), 286.

Safran, J. D., Muran, J. C., & Rothman, M. (2006). The therapeutic alliance: Cultivating and negotiating the therapeutic relationship. In *Clinical*

strategies for becoming amaster psychotherapist. Academic Press. 37-54.

Safran, J. D., & Kraus, J. (2014). Alliance ruptures, impasses, and enactments: A relational perspective. *Psychotherapy*, 51(3), 381.

Safran, J. D., Muran, J. C., & Shaker, A. (2014). Research on therapeutic impasses and ruptures in the therapeutic alliance. *Contemporary Psychoanalysis*, 50(1-2), 211-232.

Sarnoff, C. A. (1987). *Psychotherapeutic strategies in the latency years.* Jason Aronson.

Sayers, J. (2021). Online psychotherapy: Transference and countertransference issues. *British Journal of Psychotherapy*, 37(2), 223-233.

Schenk, N., Zimmermann, R., Fürer, L., Krause, M., Weise, S., Kaess, M., & Schmeck, K. (2019). Trajectories of alliance ruptures in the psychotherapy of adolescentswith borderline personality pathology: timing, typology, and significance. *Research in Psychotherapy: Psychopathology, Process, and Outcome*, 22(2), 348.

Shirk, S. R., & Saiz, C. C. (1992). Clinical, empirical, and developmental perspectives onthe therapeutic relationship in child psychotherapy. *Development and Psychopathology*, 4(4), 713-728.

Shirk, S. R., & Karver, M. (2003). Prediction of treatment outcome from relationshipvariables in child and adolescent therapy: A meta-analytic review. *Journal of Consulting and Clinical Psychology*, 71, 452– 464.

Shirk, S. R., Karver, M. S., & Brown, R. (2011). The alliance in child and adolescentpsychotherapy. *Psychotherapy*, 48(1), 17.

Simpson, S. (2005). Videoconferencing and technological advances in the treatment ofeating disorders. In P. Swain, (Ed.). *Eating Disorders: New Research.* 7, 38-43.

Sinclair, T. (2021). What's in a therapy room?—A mixed-methods study exploring clients' and therapists' views and experiences of the physical environment of thetherapy room. *Counselling and Psychotherapy Research*, 21(1), 118-129.

Slade, A., Bernbach, E., Grienenberger, J., Levy, D. W., and Locker, A. (2004).

The Parent Development Interview and the Pregnancy Interview: Manuals for Scoring.New Haven, CT: City College of New York and Yale Child Study Center.

Stevens, C. L., Muran, J. C., Safran, J. D., Gorman, B. S., & Winston, A. (2007). Levelsand patterns of the therapeutic alliance in brief psychotherapy. *American Journal of Psychotherapy,* 61(2), 109-129.

Stiles, W. B., Agnew-Davies, R., Hardy, G. E., Barkham, M., & Shapiro, D. A. (1998). Relations of the alliance with psychotherapy outcome: Findings in the Second Sheffield Psychotherapy Project. *Journal of Consulting and Clinical Psychology*,66, 791-802.

Stiles, W. B., Glick, M. J., Osatuke, K., Hardy, G. E., Shapiro, D. A., & Agnew-Davies, R. (2004). Patterns of alliance development and the rupture-repair hypothesis: areproductive relationships U-shaped or Vshaped?. *Journal of Counseling Psychology*, 51(1), 81–92.

Stiles, W. B., & Goldsmith, J. Z. (2010). The alliance over time. *The Therapeutic Alliance: An Evidence-Based Guide to Practice*, 44-62.

Stiles-Shields, C., Kwasny, M. J., Cai, X., & Mohr, D. C. (2014). Therapeutic alliance inface-to-face and telephone-administered cognitive behavioral therapy. *Journal ofConsulting and Clinical Psychology*, 82(2), 349.

Strauss, J. L., Hayes, A. M., Johnson, S. L., Newman, C. F., Brown, G. K., Barber, J. P.,... & Beck, A. T. (2006). Early alliance, alliance ruptures, and symptom change ina nonrandomized trial of cognitive therapy for avoidant and obsessive-compulsivepersonality disorders. *Journal of Consulting and Clinical Psychology*, 74(2), 337.

Sweeney, G. M., Donovan, C. L., March, S., & Forbes, Y. (2019). Logging into therapy:Adolescent perceptions of online therapies for mental health problems. *Internet Interventions*, 15, 93-99.

Tang, S., Xiang, M., Cheung, T., & Xiang, Y. T. (2021). Mental health and its correlatesamong children and adolescents during COVID-19 school closure: The importance of parent-child discussion. *Journal of Affective Disorders*, 279, 353- 360.

Tishby, O., & Wiseman, H. (2022). Countertransference types and their relation to rupture and repair in the alliance. *Psychotherapy Research*, 32(1), 16-31.

Tronick, E. Z. (1989). Emotions and emotional communication in infants. *AmericanPsychologist*, 44(2), 112.

Turkish Psychologists Association Ethical Codes, (2004) Retrieved from: https://www.psikolog.org.tr/tr/files/folder/etik-yonetmeligi-x389.pdf.

Vacharkulksemsuk, T., and Fredrickson, B. L. (2012). Strangers in sync: achieving embodied rapport through shared movements. *Journal of Experimental SocialPsychology.* 48, 399–402.

van Benthem, P., Spijkerman, R., Blanken, P., Kleinjan, M., Vermeiren, R. R., & Hendriks, V. M. (2020). A dual perspective on first-session therapeutic alliance:strong predictor of youth mental health and addiction treatment outcome. *European Child & Adolescent Psychiatry*, 29(11), 1593-1601.

Viner, R. M., Russell, S. J., Croker, H., Packer, J., Ward, J., Stansfield, C., Mytton, O.,Bonell, C., Booy, R. (2020). School closure and management practices during coronavirus outbreaks including COVID-19: A rapid systematic review. *The Lancet Child & Adolescent Health*, 4(5), 397–404.

Vrklevski, L. P., & Franklin, J. (2008). Vicarious trauma:The impact on solicitors ofexposure to traumaticmaterial. Traumatology, 14(1), 106–118.

Waddell, M. (2002). *Inside Lives: Psychoanalysis and the Growth of the Personality* (Rev. ed.). Karnac.

Waldburg, C. (2012). Preparing the room. In L. French, & R. Klein (Eds.), *Therapeuticpractice in schools: Working with the child within: A clinical workbook for counsellors, psychotherapists and arts therapists.* Routledge. 79-80.

Wang, L. Q., Zhang, M., Liu, G. M., Nan, S. Y., Li, T., Xu, L., & Liu, F. (2020). Psychological impact of coronavirus disease (2019)(COVID-19) epidemic onmedical staff in different posts in China: A multicenter study. *Journal of Psychiatric Research*, 129, 198-205.

Werbart, A., Byléhn, L., Jansson, T. M., & Philips, B. (2022). Loss of Rituals, Boundaries, and Relationship: Patient Experiences of Transition to

Telepsychotherapy Following the Onset of COVID-19 Pandemic. *Frontiers inPsychology*, 13, 835214-835214.

Westra, H. A., Constantino, M. J., & Aviram, A. (2011). The impact of alliance ruptureson client outcome expectations in cognitive behavioral therapy. *Psychotherapy Research,* 21(4), 472-481.

Wilson, J. P., & Lindy, J. D. (Eds.). (1994). *Countertransference in the treatment ofPTSD*. Guilford Press.

Winnicott, D. W. (1971). *The use of an object and relating through identifications:Playing and reality*. London: Tavistock Publications, pp. 86-94.

Winnicott, D. W. (1960). The theory of the parent-infant relationship. *InternationalJournal of Psycho-Analysis*, 41, 585-595.

Wisniewski, P. J., Vitak, J., & Hartikainen, H. (2022). Privacy in Adolescence. In *Modern Socio-Technical Perspectives on Privacy.* Springer, Cham. 315-336.

World Health Organization (2021). Turkey Country Overview. Retrieved 2 January 2022,from https://www.who.int/countries/tur/

Wong, K. (2021). I*t takes two. Ruptures and repairs In the therapeutic relationship withadolescents: A hermeneutic literature review* [Doctoral dissertation, Auckland University of Technology].

Xiang, M., Zhang, Z., & Kuwahara, K. (2020). *Impact of COVID-19 pandemic on children and adolescents' lifestyle behavior larger than expected. Progress incardiovascular diseases*, 63(4), 531.

Zetzel, E. R. (1956). *Current Concepts of Transference. Essential Papers on Transference*, 15, 136.

Zhou, S. J., Zhang, L. G., Wang, L. L., Guo, Z. C., Wang, J. Q., Chen, J. C., ... & Chen, J. X. (2020). Prevalence and socio-demographic correlates of psychological healthproblems in Chinese adolescents during the outbreak of COVID-19. *European Child & Adolescent Psychiatry,* 29(6), 749-758.

Zilberstein, K. (2014). The use and limitations of attachment theory in child psychotherapy. *Psychotherapy*, 51(1), 93.

Zimmermann, R., Fürer, L., Schenk, N., Koenig, J., Roth, V., Schlüter-Müller, S., & Schmeck, K. (2021). Silence in the psychotherapy of adolescents with borderlinepersonality pathology. *Personality Disorders: Theory, Research, and Treatment*,12(2), 160.

Zuppardi, S. (2020). 'Only connect': reflections on technology and transference. *Journalof Child Psychotherapy*, 46(3), 312-320.

APPENDICES

APPENDIX A: Scoring Sheet for the Therapy Process Observational Coding System-Alliance Scale (TPOCS-A)

A. Bağ Alt Ölçeği

Aşağıdaki ölçeği kullanarak, lütfen çocuk ve terapistin bu seanstaki bağlarına dair değerlendirmenizi belirtin. Bu ölçekte bağ, çocuk ile terapistin ilişkisinde ne kadar olumlu duygulanım (örn. sevmek, anlamak, önemsemek) ve karşılıklı güven olduğudur. Lütfen aşağıdaki her puanlamayı tüm seansı düşünerek yapın. İlgili numarayı sorunun yanında bırakılan boşluğa yazın.

0	1	2	3	4	5
Hiç			Biraz		Çok

1. Çocuk ne sıklıkta/yoğunlukta terapistin anlayışlı ve destekleyici olduğunu belirtti? ___

2. Çocuk ne sıklıkta/yoğunlukta terapiste düşmanca, eleştirel veya savunmacı bir tutumla davrandı? ___

3. Çocuk ne sıklıkta/yoğunlukta terapiste olumlu duygular ifade etti? ___

4. Çocuk ne sıklıkta deneyimini terapist ile paylaştı? ___

5. Çocuk ne sıklıkta terapist ile etkileşiminde rahatsız görünüyordu? ___

6. Çocuk ve terapist ne sıklıkta birbirleriyle etkileşim halindeyken huzursuz veya rahatsız görünüyorlardı? ___

B. Görev Alt Ölçeği

Aşağıdaki ölçeği kullanarak, lütfen bu seanstaki terapötik görevlere dair değerlendirmenizi belirtin. Bu ölçekte terapötik görev; terapist tarafından uygulanan terapötik müdahaleler (yorum yapmak, soru sormak, terapötik sınır koymak, vb.) ve çocuğun terapötik müdahaleleri kullanma ve takip etmeye dair (oyun oynamak, duygu ve düşüncelerini ifade etmek, terapistin söylediğini detaylandırmak, konulan sınıra uymak, vb.) istekliliği ölüçülmektedir. Lütfen aşağıdaki her puanlamayı tüm seansı düşünerek yapın. İlgili numarayı sorunun yanına yazın.

0	1	2	3	4	5
Hiç			Biraz		Çok

7. Çocuk ne sıklıkta/yoğunlukta terapötik görevleri seans dışında, hayatında değişiklik yapmak için kullandı? ___

8. Çocuk ne sıklıkta/yoğunlukta terapötik görevlere uyum göstermedi? ___

9. Çocuk ve terapist ne sıklıkta/yoğunlukta terapötik görevler üzerinde beraber, eşit bir şekilde çalıştılar? ___

Appendix B

Examples for Ruptures, Confrontation and Resolution Markers for both Therapy Group

A. Face to Face

Withdrawal Markers

1. **Denial**

a. (*Öncesinde danışan espriler yapmaktadır, terapist de kendisini güldürmeye çalıştığını söyler, danışanın yüzü düşmüş ve kaçıngan davranmaktadır*)

T: Ç acaba burada anlattığı şeyler canımı sıktı falan diye mi düşündün? (Invite Discuss Feelings)

Ç: Yoo. (Denial & Minimal Response)

b. *(Öncesinde danışan köpek almak istediğini, hırsızlar gelince onu koruyacağını anlatmaktadır*).

T: Hırsız girebilir. Sen köpek almak istiyorsun, seni hırsızdan korusun diye. Hırsız senin için bayağı korkutucu bir şey galiba.

Ç: Cık. (Denial & Minimal Response)

2. **Minimal Response**

a.

T: A., geçen hafta konuşmuştuk ya belki resim yaparız diye. Ben bugün sana resim malzemeleri getirdim.

Ç: Hımm. (Minimal Response)

b. (*Danışan terapiste espri yapmaktadır, terapist buna dair hislerini anlamaya çalışır*.

T: Beni de burda güldürüyorsun bazen.

Ç: Bilmem. (minimal response)

3. **Avoidant Storytelling & Shifting Topic**

a.

Ç: Onu cehennemdeki gibi acıtacaksın

T: Cehennemde nasıl acıtıyorlar acaba?

Ç: Yakıyorlar. Neyse bu konuyu değiştirelim de. (Shifting Topic)

T: Hmm hoşlanmadın bir anda bu konudan

b. (*Terapist danışana önceden konuştukları bir aktiviteyi önermektedir*)

T: Bakmak istersen, ilgilenirsen yapabilirsin.

Ç: Ben onu teyzemde başlıycaktım, unuttum ama. Dün akşam çok geç yattık. Dün zaten tatlı krizine giriyordum az daha. Teyzem, dayım, ben tatlı krizine giriyorduk az daha. Şey bi üçümüze de bir tane aile boyu paket puding. Kinder, bir tane daha çikolatayı hepsine bandıra bandıra yedik. En sonunda dün akşam saat 10-11'de yiyebildik ancak onları eritebildik. (Avoidant storytelling & Shifting topic)

c. (*Hırsızla ilgili konuşulmaktadır, danışan hırsızdan korkmadığını söylemektedir.)*

T: Hı köpeğin olunca köpeğini vermeyeceksin.

Ç: Hadi oyun oynayalım. (Shifting Topic)

T: Sıkıldın yine konuşmaktan. (Gülüyor) Bu kadar konuşmak yeter

4. **Deferential & Appeasing**

a. (*Terapistin sorularına danışan kısa kısa cevap verir, çekinir bir tavrı vardır.*)

T: Pek bir şey yok gibi geliyor. Yapmayı tercih ettiğin bir şey var mı burada?

Ç: Yani fark etmez.

T: İstersen burada da oturabiliriz, bir şeyler çizmek istersen.

Ç: Yani şey fark etmez. Siz ne isterseniz (Deferential & Appeasing)

b. (*Terapist, danışanın babasıyla görüşmesi hakkındaki düşüncelerini sorar, danışan rahatsız olmuş gibidir.)*

T: Hıı senin istemeyeceğin bir şey bu.

Ç: Siz bilirsiniz. İsterseniz ama. (Deferential & Appeasing)

5. Content - Affect Split

(*Danışan danışmanlık merkezinin güvenli olup olmadığını sorgulamakta ve hırsız girebileceğini anlatmaktadır.*)

T: Hırsız gelirse ne yaparsın? Hiç hırsız girdi mi sizin evinize?

Ç: Cık. Ama arkadaşlarımın evine. Bir tane arkadaşımın evine tam beşşş kere girmiş. (Gülerek) (Content / Affect Split)

T: Beş kere! Offff! Seni çok eğlendirdi bu.

Ç: Yooo. (Denial)

6. Self Criticism & Hopelessness

(*Danışan dizi anlatır, terapist diziyle ilgili sorular sorar*.)

Ç: Pek iyi anlatamadım özür dilerim, ama şey. (Self-criticism)

T: Hmm, iyi anlatamıyorsun gibi geldi aslında anladım ben. Yani anladım bir fikrim oldu, çok bilmiyorum yani diziyi bilmiyorum ben, bu diziyi bilmiyorum. Merak ettim neler oldu. Bu sonra devam etti mi dizi anne öldükten sonra? (Disclosure & Clarifies a misunderstanding)

Confrontation Markers

1. Complaint About Therapist

a. (*Danışan seans odasına girmek istememektedir*.)

T: Of bu odaya girmek de çok zor oldu. (Possible Validate Defensive Posture)

Ç: Anlat hadii. Öf puf bunu yapmak zor, şunu demek zor. Tam konuşuyoruz. Oturunca mı konuşmuş oluyoruz? (Complaint about the therapist ve reject intervention)

b.

T: Seni en çok sinirlendiren nedir burada? (Invite discuss feelings)

Ç: Yani öf be kıt mısın anlamıyon mu beni ya? (Complaint about the therapist)

2. Reject Intervention

(*Danışan seansa girmek istememektedir*.)

T: Gel karşılıklı oturalım.

Ç: Bana ne ben oturmam. (Reject Intervention)

3. Complaints About Parameters

(*Öncesinde terapist danışana terapiyle ilgili hislerini sormaktadır*.)

Ç: Ben bu arada sana bir şey sorucam. Sizin bak şurada İstanbul Bilgi Üniversitesi'ne gelirken ben tamam mı buradan geçiyorum. Sonra sizin şu gerinizde bir tane kapı var. Gerinizde mi, ilerinizde mi ne, işte her neyse. O kapıdan giriş olmuyor. O kapıyı kilitlemişler. O kapıyı neden kilitlemişler? …

T: Hııı, niye kuralları değiştiriyorlar acaba?

Ç: Oranın kilidini tekrar açsalar aslında hiç yürümeye gerek kalmaz. Boşa yol...

T: Yürümek zorunda mı kalıyorsun?

Ç: Boşa yol gidiyom söylene söylene.

T: Yine öfkelendiriyorlar seni yani. Uf, çok kızıyorsun sen herkese.

Ç: Hayır, oradan giriş olsa ne olacak ki? Altı üstü bir tane daha fazla güvenlik alacaklar (Complaint about parameters)

4. Defending Self

(*Danışan seansın başında gergindir ve terapistin soru sormasını ister ancak sonrasında kendisi hakkında bir şeyler anlatmaya başlar.)*

T: Merak ettim bugün böyle bir şeyler anlatma ihtiyacı duydun, kendi hobilerinden bahsettin doğal olarak seni tanımamı da istiyorsun. Ama bir yandan da gergin hissettiğini söyledin yani, işte böyle durumlarda iyi değilimdir, ne yapacağımı bilmiyorum siz söyleyin gibi. Yeni tanıştığın insanlarla böyle

hissettiğin oluyor mu normalde de? (Redirect + Linking rupture to interpersonal relationship with others.)

Ç: Iı yoo ben bu kadar şey takmıyorum ama. Ne biliyim buraya gelince böyle bir şey oldum. Ya normalde hep gittiğim yerlerde soru-cevapla gittiğimiz için. (Defending self)

5. **Control Therapist**

a.

Ç: ya alacağım onu diyorum yaklaşma ya. Yaklaşma diyorum dimi. Ya yaklaşmasana. Bak hala adımını atıyor ya git biraz geri, gitsene. (Control therapist ve complaint about the therapist)

T: Ç. Burada durmak istiyorum ben. (Therapist contribution to rupture)

Ç: ben de burada durmak istiyorum o zaman gidiyorum ben. (Control therapist ve Complaint about therapist)

T: nereye gidiyorsun?

b. (*Terapist bir önceki hafta yaşanan köpek havlaması olayını konuşmak ister, danışan tedirgin görünür*).

T: biraz konuşalım mı o konu hakkında? Galiba hoşuna gitmeyen konular hakkında konuşmak pek iyi gelmiyor sana. (Redirect)

Ç: nasıl hangi konu?

T: köpek konusu mesela.

Ç:Siz dediniz konuşalım mı diye sen başlatacaksın. (Control therapist)

Resolution Markers

1. **Clarifying a Misunderstanding**

(*Danışan dizi anlatır, terapist diziyle ilgili sorular sorar.*)

Ç: Pek iyi anlatamadım özür dilerim, ama şey. (Self-criticism)

T: Hmm, iyi anlatamıyorsun gibi geldi aslında anladım ben. Yani anladım bir fikrim oldu, çok bilmiyorum yani diziyi bilmiyorum ben, bu diziyi bilmiyorum. Merak ettim neler oldu. Bu sonra devam etti mi dizi anne öldükten sonra?

(Disclosure & Clarifies a misunderstanding)

2. **Changes tasks or goals**

(*Terapist intihar düşünceleriyle ilgili konuşmak ister, ancak danışan istemez*)
T: O yüzden burada ara ara konuşalım istiyorum. Ama şöyle yapalım, bunu sen konuşmak istediğinde konuşalım, olur mu?
Ç: Nasıl yani?
T: Sen bunla ilgili işte bu hafta şöyle bir şey oldu ya da bu hafta aklıma geldi, böyle hissediyorum filan dediğinde, sen bunla ilgili konuşmak istediğinde konuşalım, ben daha fazla sormayayım. (Changing task)
Ç: Olur.

3. **Gives Rationale**

(*Terapist intihar düşünceleriyle ilgili konuşmak ister, ancak danışan terapiye devam etmek istemediğini söyler.*)
Ç: Siz bana bir şey demiyorsunuz ki şunu yapın, bunu yapın diye. Sadece konuşuyoruz, bir şey yapmıyoruz ki. (Complaint about therapist)
T: Sadece konuşmak rahatlatıcı olabiliyor. Çünkü şu an zaten bir intihar riski vesaire olduğunu düşünmüyorum ben. O yüzden tek aklına gelen, geçen sefer konuştuğumuz gibi yani hep bir zarar görme teması, dışarıdan gelecek bir zarar, bir kaygı, bir korku hali var... Daha tedirgin edici içinde ölüm olduğu için ama herkes için tedirgin edici bir şey bu zaten. Seni tedirgin ediyor. O yüzden de konuşması biraz daha zor geliyor... Ya da işte bir intihar haberi daha gelecek belki tanıdığın tanımadığın, internette karşına çıkacak… Hiç konuşulmadığı zaman bir yerde pat diye karşına çıktığında daha zorlanacaksın (Giving a rationale)

4. **Invite discuss feelings**

a. (*Danışan seansa girmek istemez ve terapiste agresyon göstermektedir.*)

T: Seni en çok sinirlendiren nedir burada? (Invite discuss feelings)
Ç: Yani öf be kıt mısın anlamıyon mu beni ya? (Complaint about the therapist)

b.

T: Daha önce terapiye gittin?

Ç: Evet, ıı ama işte hiç böyle olmamıştı. O yüzden garip oldum biraz.

T: Konuşalım ne hissediyorsun. (Invite discuss feelings)

Ç: Ya ben böyle konu açamıyorum işte orda öyle şeyim var. Siz açarsanız ben böyle giderim. Ya siz bir soru sorun. (Possible control therapist)

5. Acknowledgment of rupture

(*Danışan bir olayı terapistine tam anlatamadığını düşünür ve kendini eleştirir. Terapist bu konuyla ilgili konuşmak istediğinde konu değiştirip ardı ardına espriler yapar*.)

T: Bir adam esprileri. Frizbi ile ilgili bir şey aklıma takıldı. Hani bazen bizde burda kelimeleri karşılıklı atıyoruz ya, acaba benim attığım kelimeler çok yüksek mi geliyor sana ya da sert mi atıyorum? (Acknowledgement of rupture)

Ç: Yoo.(Denial, Minimal response)

6. Link interpersonal btw other relationship

(*Danışan seansın başında gergindir ve terapistin soru sormasını ister sonrasında kendisi hakkında bir şeyler anlatmaya başlar*.)

T: Merak ettim bugün böyle bir şeyler anlatma ihtiyacı duydun, kendi hobilerinden bahsettin doğal olarak seni tanımamı da istiyorsun. Ama bir yandan da gergin hissettiğini söyledin yani, işte böyle durumlarda iyi değilimdir, ne yapacağımı bilmiyorum siz söyleyin gibi. Yeni tanıştığın insanlarla böyle hissettiğin oluyor mu normalde de? (Redirect + Linking rupture to interpersonal relationship with others.)

7. Validate defensive posture

(*Terapist intihar düşünceleriyle ilgili konuşmak ister, ancak danışan istemez***)**

T: İnsanın kendini sakinleştirmesi zor konularda böyle zor. Hepimiz için zor.

Sadece senin için değil. Annenin de kötü hissettiği zamanlar vardır, A'nın vardır, babanın vardır. Yani kimisi ağlar, kimisi gidip yardım ister, kimisi eşiyle konuşur, kimisi sevgilisiyle konuşur, kimisi anne babasıyla konuşur. Sen de sakinleştirilmeye ihtiyaç duyduğunda annene ya da babana gidiyorsun.
Ç: Evet.

8. **Redirecting**

a. (*Danışan seansa geç gelmiştir, terapist konuşmak istediğinde konuşmaz sonrasında kitap okumak ister.)*

T: bir şeyler okumak istiyorsun. Bugün senin yüzünden olmayan bir şekilde geç kaldın. Anlatmak ister misin biraz nasıl oldu. (Redirect)

b. (*Terapist danışanlar aralarındaki ilişkiyi konuşmak ister, ancak danışan sürekli konu değiştirir*)

T: He frizbi de bir oyundu, aramızdaki ilişkiyi konuşuyorduk. Sonra sen bir anda bambaşka bir oyuna gittin. (Redirect)

B. **Online**

Withdrawal Markers

1. **Denial**

(*Danışan bir yere gidecektir ve terapist oraya dair kötü hislerini de sorgular, danışan rahatsız olmuş gibidir*.)

T: Ama sanki böyle kafanı kurcalayan da bir şeyler mi var sanki bir tarafın düşünceli gibi (invite discuss feelings)

Ç: Galiba bilmem ki ama gidicem ya o çok mutluluk veriyor yani güzel benim için (Possible denial)

2. **Minimal Response**

a. (*Çocuk seansı unutmuş, geç gelmiştir ve kısa kısa konuşmaktadır*.)

T: Hımm, bizim böyle annenle de görüşmemiz, onla da konuşmamız sana nasıl geliyor? (Invite discuss feelings)

Ç: Güzel geliyor. (Minimal response & Deferential)

T: Hı hımm. Merhaba demek istedin sen de bana o gün.

Ç: Aynen. (Minimal response)

b. (*Çocuk oynadığı oyunun videosu hakkında konuşmaktadır*)

T: … Genelde böyle sabah kalktığında Ç, bu oyunları mı açıyorsun? Yoksa videolar mı izliyorsun?

Ç: Yani. (Minimal response)

T: Ne yaparsın genelde?

Ç: Video.(minimal response)

3. Avoidant Storytelling & Shifting Topic

a. (*Terapist çocuğa sabahları tabletle oyun oynamadığını sormakta, çocuk ise kısa kısa cevaplar vermekte, rahatsız görünmektedir*.)

T: Video izliyorsun sabahları.

Ç: Baksana T abla, neler var… (Shifting Topic)

b. (*Seans sırasında danışanın kardeşi yanına gelip gitmiştir, terapist kardeşiyle ilgili sorular sorar, danışan kısa kısa cevap verir ve rahatsız görünmektedir.)*

T: Hımm. Neler yapıyor E?

(sessizlik) (Minimal response)

Ç: T abla?

T: Efendim.

Ç: Biz kaldık sadece oyunda. (Shifting Topic)

c. (*Danışan bir yere gidecektir ve terapist oraya dair kötü hislerini de sorgular, danışan rahatsız olmuş gibidir*)

T: Sanki bilmem belki dedin var mı öyle bir şey sanki bana düşünceliymişsin gibi geldi ama var mı düşünceli olduğun bir kısım oraya dair? (Redirect + invite discuss feelings)

Ç: Yani evet var aslında annemler falan gitme diyor da gitmek istiyorum. Bu arada bir şey diyicem ben kararmış mıyım (Shifting Topic)

4. **Deferential & Appeasing**

(*Öncesinde terapist, danışanın eski terapisti hakkındaki duygularını araştırmakta ve danışan kısa kısa konuşmakta ve konuyu değiştirmeye çalışmaktadır*.)
T: Hıh. Duyamıyorum seni. Ç? Sesin gelmiyor. Sesini kapadın.
Ç: Şaka yapmıştım. (Deferential)
T: Aa beni kandırmaya mı çalışıyorsun?
Ç: Şaka yapmaya çalışıyorum.

5. **Content - Affect Split**

T:anlaşılmamış hissediyorsundur. Hep kendini açıklaman anlatman gerekiyordur belki sinirleniyorsundur belki bu yüzden Ç1'e.
Ç:yani ben çok sinirli bir insan değilim, sakinim genelde ama şeye çok sinirleniyorum (Güler). az önce de söyledim ya her şeyi yapıyor, her şeyi yapıyor çok saçmalıklar yapıyor bende artık yıldım ama geri döndüğünde bir şey bir tatlı mesaj hemen sevmeye başlıyor Ç1 onu.

6. **Self Criticism & Hopelessness**

(*Danışan o gün doktora gittiğinden bahsediyor, terapist doktorla ilgili hislerini araştırıyor. Danışan rahatsız hisseder gibi görünmektedir*).
Ç: Çok sorunlu bi kızım.
T: Hımm. Sorunlu olduğunu düşündün.

Confrontation Markers

1. **Complaint About Therapist**

a. (*Danışan oyun oynamaktadır, Terapist ise ona sorular sormaktadır. Danışan kısa kısa cevap verir ve konuyu oyuna çekmeye çalışır.*)

Ç: T abla. Off T abla.

T: Öldün mü yoksa?

Ç: Evet konuştuğun için öldüm. (Complaint about the therapist). T abla konuşabilirsin. Konuşunca daha iyi oluyor. (Deferential)

b. (*Terapist danışana sorular sormaktadır, Danışan ise kısa kısa cevaplar verir*.)

T: Hımm. Neler yapıyorsun bu aralar?

Ç: T abla?

T: Hımm.

Ç: Bence bana fazla soru sorma çünkü çok yorgunum. (Complaint about therapist)

c. (*Terapist danışanın yüz yüze seanslara olan özlemi hakkında konuşur*.)

T: Keşke buluşabilseydik (Disclosure). Neler oluyor? (danışan ateş eder gibi yapar) Bana ateş mi ediyorsun? (possible complaint about therapist).

2. Complaint About Parameters

T: ….. Beş dakikamız kaldı Ç.

Ç: Oof. Burası da (ses kapanır) (possible complaint about the therapy parameter)

T: Duyamıyorum seni.

Ç: Ben para biriktiriyorum. (Shifting Topic)

T: Aa.

3. Complaint About Progress

(*Öncesinde terapist bir soru sorar danışan kısaca verir rahatsız olmuş bir ifadesi vardır.)*

Ç:….Şeyi sormak istiyorum mesela şimdi biz o terapi dediğimiz şeyi yapıyor muyuz yoksa sonradan mı yapıcaz. (Possible complaint about therapist & possible complaint about progress)

T:Aslında bunlar ilk görüşmelerimiz olduğu için seni tanımaya çalışıyorum ama yapıyoruz da denebilir burada seni anlamaya çalışıyoruz genel olarak. (Therapist

gives a rationale)

4. **Defending Self Against Therapist**

(*Terapist ve danışan hikaye yazarlar, danışan terapistin hikayesini kendisine çok benzetir ve kendisinkine geçmek ister, terapist ise üzerine konuşmak istemektedir.*)
T: hımm nasıl geldi bu sana
Ç: Bilmem. Benimkine geçelim mi (Shifting Topic)
T: aa konuşmak istemedin (Possible Therapist Contribution to Rupture)
Ç: Ama süre bitiyor o yüzden benimkisi de uzun olduğu için (Defending Self)

Resolution Markers

1. **Gives Rationale**

(Öncesinde terapist bir soru sorar danışan kısaca verir rahatsız olmuş bir ifadesi vardır.)
Ç:….Şeyi sormak istiyorum mesela şimdi biz o terapi dediğimiz şeyi yapıyor muyuz yoksa sonradan mı yapıcaz. (Possible complaint about therapist & possible complaint about progress)
T:Aslında bunlar ilk görüşmelerimiz olduğu için seni tanımaya çalışıyorum ama yapıyoruz da denebilir burada seni anlamaya çalışıyoruz genel olarak. (Therapist gives a rationale)

2. **Invite discuss feelings**

T: Hımm seni mutlu ediyor oraya gitmek heyecanlandırıyor.
Ç: Evet (min response)
T: Ama sanki böyle kafanı kurcalayan da bir şeyler mi var sanki bir tarafın düşünceli gibi (invite discuss feelings)

3. **Disclosure**

(*Terapist çocuğun yüz yüze seanslara olan özlemi hakkında konuşur.)*

T: Keşke buluşabilseydik (Disclosure). Neler oluyor? (çocuk ateş eder gibi yapar) Bana ateş mi ediyorsun? (Possible complaint about therapist).

4. **Validate defensive posture**

(*Danışan terapistin açtığı konudan rahatsız olmuş, konu değiştirmektedir*.)
T: Sanki o düşünceler biraz zor galiba onları düşünmek. (Validating defensive posture)

5. **Redirecting**

(*Terapist, danışanın gideceği bir yerle ilgili kötü hislerini anlamaya çalışır, danışan rahatsız görünür konuyu sıklıkla değiştirir.)*
Ç: Yani evet var aslında annemler falan gitme diyor da gitmek istiyorum. Bu arada bir şey diyicem ben kararmış mıyım (Shifting Topic)
T: Haa bronzlaşıp bronzlaşmadığını soruyorsun…..Sanki böyle annenden çok konuşmak istemedin o konuları birazcık daha çok böyle vücudun kararıp kararmadığına geçmek istedi beynin sanki. (Redirect)

ETHICS BOARD APPROVAL

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