ONLINE PSYCHOTHERAPY SETTING AND ITS REFLECTIONS ON THERAPEUTIC RELATIONSHIP DURING COVID-19 PANDEMIC

NAZLICAN ÖZKAN ORDULU

YEDITEPE UNIVERSITY

GRADUATE SCHOOL OF SOCIAL SCIENCES

ISTANBUL, 2023

ONLINE PSYCHOTHERAPY SETTING AND ITS REFLECTIONS ON THERAPEUTIC RELATIONSHIP DURING COVID-19 PANDEMIC

NAZLICAN ÖZKAN ORDULU

SUPERVISOR
DR. EZGİ SONCU BÜYÜKİŞCAN

SUBMITTED TO GRADUATE SCHOOL OF SOCIAL SCIENCES IN PARTIAL FULFILLMENT
OF THE REQUIREMENTS FOR THE DEGREE OF
MASTER OF ARTS
IN
DEPARTMENT OF CLINICAL PSYCHOLOGY

YEDITEPE UNIVERSITY
GRADUATE SCHOOL OF SOCIAL SCIENCES
ISTANBUL, 2023

PLAGIARISM

I hereby declare that all information in this document has been obtained and presented in accordance with academic rules and ethical conduct. I also declare that, as required by these rules and conduct, I have fully cited and referenced all material and results that are not original to this work.

Date: 05.06.2023

Name/Surname: Nazlıcan ÖZKAN ORDULU

ABSTRACT

The purpose of this study was to explore how psychotherapy setting is affected by the mandatory conversion from face-to-face psychotherapy setting to online platforms due to COVID-19 pandemic restrictions, mainly with respect to the relationship between subjective perceptions and/or experiences regarding COVID-19 and therapeutic alliance for both psychotherapists and patients. A sample of 94 Turkish participants which consisted of 62 psychotherapy patients and 32 mental health professionals filled out the questionnaire whilst semi-structured interviews were done with nine psychotherapists and seven psychotherapy patients. The data collection process lasted from February 2022 to May 2022. As survey questions present quantitative correlations, semi-structured interviews were done to provide a deeper understanding of the outcomes of this shift. Findings show that while COVID-19 history of patients was not related to their alliance scores, psychotherapists who have first-degree relatives tested for COVID-19 positive show significantly lower Working Alliance Invertory (WAI) scores. Both patients and psychotherapists addressed the advantages and disadvantages of OPT in accordance with their COVID-19 perceptions. While the loss of a shared room and embodied psychotherapy setting is a main consideration of both parts, the length of the ongoing psychotherapy process significantly correlated with WAI scores for patients. Patients who considered there are no advantages of OPT showed significantly lower WAI-Bond scores whereas for psychotherapists, the number of disadvantages of OPT was significantly correlated with lower WAI-Bond scores. Limitations and implications for further research were discussed.

Keywords: COVID-19 pandemic, Online psychotherapy experiences, Perception of COVID-19, Therapeutic alliance

ÖZET

Bu çalışmanın amacı, COVID-19 pandemisi kısıtlamaları nedeniyle yüz yüze psikoterapi ortamından çevrimiçi platformlara zorunlu geçişten psikoterapi ortamının nasıl etkilendiğini araştırmak ve esas olarak COVID-19 pandemisine dair hem psikoterapistlerin hem de danışanların öznel algılar ve/veya deneyimlerini terapötik ilişki açısından incelemektir. 62 psikoterapi hastası ve 32 ruh sağlığı uzmanından oluşan 94 Türk katılımcıdan oluşan bir örneklem anket doldururken, dokuz psikoterapist ve yedi danışan ile yarı yapılandırılmış görüşmeler yapılmıştır. Veri toplama süreci Şubat 2022'den Mayıs 2022'ye kadar sürmüştür. Anket soruları nicel korelasyonlar sunduğundan, bu değişimin sonuçlarının daha iyi anlaşılmasını sağlamak için yarı yapılandırılmış görüşmeler yapılmıştır. Bulgular, danışanların COVID-19 öyküsünün ittifak puanları ile ilişkili olmadığını gösterirken, birinci derece akrabalarında COVID-19 testi pozitif olan psikoterapistlerin Terapötik İttifak Ölçeği (TİÖ) puanlarının önemli ölçüde düştüğünü gösteriyor. Hem danışanlar hem de psikoterapistler, çevrimiçi psikoterapinin (ÇPT) avantaj ve dezavantajlarını COVID-19 algılarına göre ele alırken, paylaşılan bir odanın ve somut psikoterapi ortamının kaybı her iki taraf için de temel bir husus olmuştur. Devam eden psikoterapi sürecinin uzunluğu, danışanlar için TİÖ puanları ile önemli ölçüde ilişkilidir. ÇPT'nin hiçbir avantajı olmadığını düşünen danışanlar anlamlı olarak daha düşük TİÖ-Bağ puanları gösterirken, psikoterapistler için ÇPT'nin dezavantajlarının sayısı, daha düşük TİÖ-Bağ puanları ile anlamlı şekilde ilişkili görülmüştür. Daha fazla araştırma için sınırlamalar ve çıkarımlar tartışılmıştır.

Anahtar kelimeler: COVID-19 algısı, COVID-19 pandemisi, Çevrimiçi psikoterapi deneyimleri, Terapötik ittifak,

ACKNOWLEDGMENTS

Firstly, I would like to express my gratitude to my thesis advisor Dr. Ezgi Soncu Büyükişcan for her support and valuable contributions. I am grateful for her guidance, patience and invaluable feedback during the research and writing processes.

I would like to thank to my department professors Assoc. Prof. Alev Yalçınkaya, Dr. Ezgi Soncu Büyükişcan, Assoc.Prof. Hakan Atalay, Dr. Merve Denizci Nazlıgül and Ayşe Özalkuş Şahin for their generously provided knowledge and support throughout my master's.

I am grateful to my colleagues and psychotherapy patients who voluntarily shared their opinions and feelings which enabled me to fulfill the thesis. I owe thanks to them for their trust and time.

Finally, I would like to express my gratitude to my family. I am grateful to have the support and encouragement of Arzu. For his generous help, deep knowledge, and love, I am thankful to my husband Emre. This thesis would not be possible without them.

TABLE OF CONTENTS

LIST OF TABLES

1. INTRODUCTION

1.1. Electronically Mediated Psychotherapy

Since the beginning of the 2000s, there has been a growing research interest in the future of psychotherapy; especially with regard to online mental health service delivery and associated benefits, ethical considerations, regulations, and practical changes of it (Norcross et al., 2002). Brahnam (2014) described mediated psychotherapy as referring to psychotherapy settings in which electronic media tools (laptops, smartphones, tablets, etc.) are the mediators that connect patients and psychotherapists. In 2004, Rochlen et al. noted that "online psychotherapy" or "online psychotherapist" concepts are not clearly defined and are a source of debate. Likewise, there are terms that fail to denote professionality in practice, such as e-therapy, e-counseling, Internet therapy, cybertherapy, e-health, or telehealth (Barak et al., 2008). In 2012, Backhaus et al. conducted research considering individuals who have mental health problems but had to face various obstacles to access effective psychotherapy services. The authors used the term "telehealth" as an umbrella term to refer to the use of technology to provide health care when providers and patients are geographically distant from each other. Although the term initially underlined the technical side of the service, its definition evolved to include professional therapeutic interaction with the use of Internet connection (Rochlen et al., 2004). Singh and Sagar (2022) note that although tele-psychotherapy is a broader term that refers to the use of any telecommunication or internet-based digital instrument to provide therapy or counseling; the term "online psychotherapy" (OPT) or "e-therapy" refers to psychotherapy services provided solely through internet-based communication tools such as video call, voice call, messages, or e-Mails.

Considering the letters of Sigmund Freud to his friend Wilhelm Fliess as important tools in his self-analysis process, mediated psychotherapy could be perceived as old as the psychotherapy itself (Erikson, 1955). Besides, in the "Little Hans" case: a five-year-old boy with a phobia of horses, Freud used advice letters to Little Hans' father as a therapeutic instrument (Freud, 1916). Some research indicates that by the end of the 1950s, there were many analysts who carried out their analysis through letters (Brahnam, 2014). In 1961, the first videoconference was trialed for group psychotherapy, and it led to growth in the use of video for therapeutic purposes (Simpson, 2009). Starting in the early 1990s, remote psychotherapy was being carried out via Internet connection, which was followed by online advice services that widened into offering various psychological services via chat, e-Mail, or videoconferencing (Brahnam, 2014). Since then, the general term tele mental health refers to providing mental

health care from a distance with the use of videoconferencing, e-Mail, smartphone applications, and remote monitoring devices (Connolly et al., 2020).

In addition to the technological specifications and their definitions, another major aspect of OPT is the preferred therapeutic model or theoretical orientation. In 2009, Simpson investigated these preferences and concluded that mostly preferred and used therapeutic model for OPT is cognitive behavioral therapy (CBT). Yet there are also other studies that investigated OPT with regard to psychoanalysis (Kaplan, 1997), neuropsychological assessment (Schopp et al., 2000), family therapy (Freir et al., 1999), and/or video-hypnosis (Simpson, et al., 2002).

1.2. Discussions on the Practice of Online Psychotherapy

Discussing the utility of online psychotherapy is particularly important with respect to psychoanalytic/psychodynamic psychotherapy; including its concepts of transference-countertransference, therapeutic frame, or analytic field (de Bitencourt Machado et al., 2016; Sfoggia et al., 2014). As a result of their study that aimed to foresee the future of psychotherapy, Norcross et al. (2002) concluded that the number of master's level psychotherapists using virtual therapy services will increase in the future. Likewise, in 2004, Rochlen et al. concluded that the one exact point of agreement is that "online mental health service delivery is under way and is likely to expand in the future" (p. 270). Although it is open to discussions and debates, there is a common opinion on its time-saving quality in addition to making psychotherapy accessible from distance or in cases of inconvenience.

Similar to Ogden's (2004) term "analytic third", Stadter (2012) came forth with the term "e-third" to refer to electronic media tools such as smart phones, laptops, and/or tablets that are co-present between two people's communication and "interferes with intimacy and reflection" (Brahnam, 2014, p. 5). On the other hand, clinical psychologist Todd Essig (2015) claimed that computers are "Cartesian devices" which are "a less suitable conduit for transference and countertransference" (p. 684). That considered deploring of computer-mediated online psychotherapy by Sayers (2021), and he made an analogy of Descartes's maxim cogito ergo sum (I think therefore I am) with his discontent of computer-mediated psychotherapy and persistence on "we are more than just what we think".

1.2.1. Perceptions by Patients and Psychotherapists

Apart from the measurable effectiveness of online psychotherapy, there are studies that focus on how psychotherapists and clients perceive face-to-face and online sessions. In a review of three survey studies in 2015, 2016, and 2018, it was reported that approximately half of the respondent psychotherapists had the perception that OPT is less effective than face-to-face psychotherapy (Boldrini et al., 2020). Likewise, in a survey that took place in 2018, of the 32%

of psychotherapists who had OPT experience, 77.4% claimed that OPT should be used only in exceptional cases, while 10.3% of the respondent psychotherapists were against OPT (Drath & Necki, 2018). Research in 2018 that is formed by Turkish psychotherapists ended up with eight common themes related to OPT: worrisome (1), inappropriate (2), reserve/conditional (3), special training required (4), prone to misconduct (5), prone to problems (6), highly accessible (7), and not different from face-to-face (8) context. The authors concluded that psychotherapists are "aware of the appropriate and facilitating aspects of online therapies yet still refer intensely to their negative features" (Korkmaz and Sen, 2018, p.150).

From the perspective of patients, a study conducted in 2017 revealed that patients express low willingness to use tele psychotherapy, especially if they have already experienced face-to-face psychotherapy (Hantsoo et al., 2017). In a comparative study, Schopp et al. (2000) investigated both psychologists' and neuropsychology clients' feedback on telehealth sessions and concluded that while telehealth clients were more willing to repeat their experiences, psychologists reported lower satisfaction with telehealth sessions. Similarly, in a recent study with 174 psychotherapists, satisfaction with OPT was significantly lower compared to face-to-face psychotherapy (Beck-Hiestermann et al., 2021). Accordingly, the review concluded that there are multiple drawbacks to the use of OPT, although the overall attitudes of providers are positive. In another study, the most commonly mentioned advantage of OPT was the higher accessibility along with the opinion that gaining experience in OPT would work as an antidote to perceive drawbacks and create an improvement in delivering and developing strategies for OPT (Connolly et al., 2020).

1.3. COVID-19 Pandemic and Mandatory Shift to OPT

In March 2020, the World Health Organization (WHO) declared a global pandemic of SARS-CoV-2 (COVID-19). As a starting point, China was the first location the virus spread and caused death to thousands of people. Shortly after, the COVID-19 virus spread to European countries, the United States, and different parts of Asia (Shatri et al., 2021). COVID-19 belongs to the SARS-CoV-2 family, and it is an infectious disease that easily spreads and results in clinical symptoms ranging from mild to severe in intensity. With its rapid spread and initially high mortality rate, COVID-19 has been a source of psychological distress as well (Asmundson & Taylor 2020, Brooks et al. 2020, Shatri et al., 2021). Followed by the global pandemic declaration by WHO, there were isolation measures to stop or slow down the transmission of the virus in countries such as China, Italy, Iran, and Turkey. In the psychotherapy field, regardless of the previous preferences or experiences of psychotherapists, a vast majority of them had to shift their face-to-face therapies into OPT via phone applications,

videoconferences, or tablets (Békés & Doorn, 2020). Since it presents a global health issue and shifts everyone's daily routines, it is claimed that it is something collectively experienced and created a kind of "shared traumatic reality" between patients and psychotherapists (Ronen-Setter & Cohen, 2020).

1.3.1. Different Approaches by Various Countries

In addition to the WHO declaration in March 2020, countries introduced additional restrictions such as isolation measures in their own agenda, mainly in line with the number of cases. One of the very first countries that was affected by COVID-19 and implemented isolation was Italy, where %42.1 of 306 participant psychotherapists in a study suggested that their treatments had been interrupted (Boldrini et al., 2020). A study from Italy identified 3 factors that might make OPT more open to interruptions: (1) lack of previous OPT experience by the psychotherapist, (2) theoretical orientation (CBT-oriented psychotherapists stated more interruptions), and (3) lack of privacy in patients' home. In accordance with the Italian psychotherapist sample, 1162 psychotherapists working in Austria were surveyed about their OPT experiences at the beginning of COVID-19 (between March 2020 and April 2020). Although they concluded that the psychotherapist sample in Austria did not perceive OPT or psychotherapy via telephone as comparable to face-to-face psychotherapy, they reported more positive experiences than they had previously expected, regardless of their theoretical orientation (Humer et al., 2020). Similar to the Italian sample, behavioral psychotherapists in Austria were found to experience OPT less favorably compared to psychotherapists from other theoretical backgrounds. A study that investigated the attitudes of psychotherapists in North America (the USA and Canada) and Europe surveyed 145 psychotherapists, and in accordance with Italy and Austria, they concluded that previous experience with OPT was significantly correlated with more positive attitudes (Békés & Doorn, 2020). However, in contrast to Italian and Austrian samples, they indicated that cognitive behavioral therapy-oriented psychotherapists had a more positive attitude toward OPT in comparison to psychodynamically-oriented psychotherapists. Khatib et al. (2021) conducted a similar survey with 192 psychotherapists in Israel and found that psychotherapists who were better prepared and had more positive attitudes toward OPT rated the effectiveness of their therapy as higher (Khatib et al., 2021). Another study in Poland revealed that both therapists and patients switched to remote psychotherapy, even though the majority of them did not have such an experience before. Between the audio-video connection and telephone options, both psychotherapists and patients preferred audio-video method for OPT. Despite OPT was viewed as effective, both groups preferred the traditional face-to-face psychotherapy (Kluzowicz &

Kluzowicz, 2021). In another study where data on Austrian and German psychotherapists' attitudes were investigated, Korecka et al. (2020) found a positive correlation between the number of OPT patients a psychotherapist has worked with and their attitudes towards remote psychotherapy.

Despite OPT is not a recent technology for the psychotherapy field, it was not something commonly experienced by many psychotherapists until COVID-19 isolation restrictions. Consequently, there is research focusing on the emerging ethical issues related with OPT. Stoll et al. (2020) indicated five main arguments in favor of OPT: (1) increased access and flexibility, (2) enhanced communication, (3) advantages with specific clients such as those residing in rural areas, (4) convenience and increased demand, and (5) economic advantages. Yet, there were another five arguments against engagement in OPT: (1) privacy issues, (2) lack of special training and psychotherapist competence, (3) technological problems that interrupt communication, (4) research gaps, and (5) emergency issues. Regarding privacy and security, Singh and Sagar (2022) point out that third-party applications that are used for OPT, such as WhatsApp, Skype, Zoom, and Google Meet might collect personal information. Even if sessions are not recorded, third parties might use and share any personal information with other parties for advertisement purposes, obviously without explicit consent, and this situation poses an ethical concern. In contrast to the third advantageous matter in Stoll et al.'s (2020) research that points out the importance of accessing specific patients, Singh and Sagar (2022) claim that OPT would not be appropriate for treating specific patients such as people with serious psychiatric illnesses or those in acute crises who might be suicidal and require close monitoring and face-to-face psychotherapy.

Considering the potential need for physical distancing in the future as a result of several challenging situations including natural disasters, different crises or conflicts, there is an argument that this mandatory shift might offer opportunities to expand psychotherapy provision (Inchausti et al., 2020). Psychotherapists interviewed by Machado et al. (2020) stated that their Federal Council of Psychology's (Mexico) guide for OPT helped them in this rapid shift process. Likewise, the Ethics Code of the Turkish Psychological Association, which was first established in 2004 and lastly updated in 2018, mentions OPT in the "Non-Traditional Psychotherapy Settings" section. The section includes the definition of OPT, discussions on its use, and a requirement for psychotherapists to adhere to the ethics code in remote settings just like they have to do so in face-to-face settings. It also asserts that OPT should be avoided if and when ethical guidelines cannot be followed (TPD, 2004, 7.4). A different viewpoint regarding the ethics of OPT, however, argues that if trained psychotherapists would avoid OPT and do

not participate, the so-called “charlatans” will emerge to meet the growing demand; therefore, psychotherapists need to be informed about the risks and benefits (Stoll et al., 2020). Similarly, Sfoggia et al. (2014) claim that specifically psychoanalytic psychotherapists should be open to innovations and stay in line with contemporary society’s growth, which is essential for the continuity of research and curious learning.

1.4. Psychodynamics of Online Psychotherapy

1.4.1. Therapeutic Alliance

In 1965, Greenson emphasized the importance of the therapeutic alliance in the relationship between the psychotherapist and the patient as having the power to make the therapeutic work possible. Similarly, Catty (2004) mentioned the alternative terms that refer to the same concept, such as “therapeutic alliance”, “therapeutic relationship” or “working alliance”, and claimed that it is the “vehicle of success” for psychotherapy (p. 255). It is possible to trace the concept of “alliance” back to Sigmund Freud’s writings (Freud 1958). Freud argued that alliance helped the patient remain in the therapy relationship despite the increased amount of anxiety caused by the therapeutic process. (Horvath et al., 2011). Zetzel (1956) conceptualized therapeutic alliance as a tool of definition that refers to the relationship between a patient and a psychotherapist. It was also viewed as a measure of how the psychotherapist and patient work well together (del Re et al., 2012). The term “alliance” was used interchangeably with “therapeutic alliance”, “working alliance”, and “helping alliance” (Horvath & Luborsky, 1993). In advance of Bordin’s (1979) conceptualization, Rogers (1957) defined psychotherapy as a relational form of care that depends on the relationship and worked on the concept of alliance. One of the most significant developments in this term was done by Bordin (1979), who reconceptualized therapeutic alliance and identified its three main components; (1) agreement on the task (between patient and psychotherapist), (2) agreement on the goals and expected results, (3) affective bond that includes mutual trust and acceptance (as cited in Soygüt & Işıklı, 2008). Bordin (1979) claimed that rather than the particular kind of working alliance, the strength of the alliance is the major factor to achieve any change in the process (Bordin, 1979). Because the alliance is not about any typical or particular form of intervention but represents the mutual collaboration between the two parties, it is possible to achieve this kind of a bond in a short or a long time with various kinds of interventions (del Re et al., 2012). Based on Bordin’s (1979) conceptualization, Horvath & Greenberg (1989) created the Working Alliance Inventory (WAI) to assess the therapeutic alliance between the patient and the psychotherapist.

Prior to the mandatory shift to OPT with the beginning of COVID-19, studies were conducted on how to build therapeutic alliance and communicate empathically via teleconferencing considering the technical problems, Internet connection issues, and privacy (Roesler, 2017; Titzler et al., 2018; Topooco et al., 2017). Some even claimed that OPT and face-to-face psychotherapy have no significantly different working alliance scores (Cook & Doyle, 2002; Roesler, 2017). Accordingly, more recent reviews prior to COVID-19 indicate a good therapeutic alliance did develop with psychotherapists who prefer OPT with their patients (Simpson & Reid, 2014) and, with respect to effectiveness, they claim that OPT did not differ from face-to-face sessions (Backhaus et al., 2012; Simpson, 2009). However, Ertelt et al. (2011) pointed out that psychotherapists generally expect greater differences between OPT and face-to-face psychotherapy while patients are inclined to make more positive evaluations for OPT. Regarding COVID-19 effects on the psychotherapy setting, Garcia et al. (2022) interviewed psychotherapists, and their participants reported that therapeutic relationship did not significantly change as a result of the rapid shift to OPT insofar as the therapeutic alliance was already built-in face-to-face sessions (García et al., 2022). A psychotherapist gave an interview on their views and stated that they could not see much difference even though it is not completely the same; they added: "I think that the therapeutic bond, it is a bit slower to develop, but, furthermore, I cannot see much difference" along with a general opinion on feeling pressured by patients to exert a more active role (Machado et al., 2020, p. 8). Supporting that, Orbach (2020) emphasizes the "animate body" in the room and suspects that its absence could force psychotherapists to be more animated in OPT to make up for the physical absence.

1.4.2. "Body" in Psychotherapy

Another aspect of recently growing OPT considers the absence of the "body" for both sides. Since patient's body is not in the same room with the psychotherapist, the loss and/or the potential loss of non-verbal cues became one of the most discussable subjects of OPT. Some researchers claimed that it has an inevitable implication in sessions, which could make it more difficult to build a secure therapeutic relationship, considering that emotional security in relationships is nourished to a greater extent by non-verbal cues (Roesler, 2017). Yet it is important to think of not solely the body language but facial expressions, gestures, and tone of voice. Sayers (2021) mentions the importance of perceiving the non-verbal cues system of the brain and how OPT and video calls impair these messages while making participants need to sustain intense attention to words instead. Especially if the video call scene is framed from the shoulders up, the hand gestures and body language is out of sight. In the same study, a National Health Service (NHS, in England) psychoanalytic psychotherapist depicts his point of view on

online sessions as something more attention and concentration demanding and adds that it requires more “recovery time” between patients. Similarly, another study suggests that in OPT, psychotherapists may require extra effort to be able to communicate with patients (Siegmund & Lisboa, 2015), which could be related to the loss of smell and pheromones, which are important contributors to communication (Rolnick & Ehrenreich, 2020). Another psychotherapist interviewee underlies the rituals such as greeting patients, a way of sitting, and having a mental representation of the physical presence of the patient, “but that does not exist online” (Fagundes Machado et al., 2020). Rolnick and Ehrenreich (2020) propose ways to bring the body back to the scene, such as using a unique and high-technology camera that would allow psychotherapists to zoom in on the face of the patients and meanwhile see their full body, as well.

1.4.3. Psychotherapy Room

Following the development of communication technologies and new potentials for online psychotherapy practice, the physical psychotherapy room and its representations became a subject of investigation (Augé, 1995; Frykman, 2012; Larsen, 2012; Punzi & Singer, 2018). According to the analyses of interviews with clinical psychologists, it is noted that interviewees accept the psychotherapy room as something that represents continuity and safety; and aims to provide a space that is stable at a certain time and at a certain place (Punzi & Singer, 2018). As it is considered to be a standardized, organized place appropriate for the therapeutic process, it is not solely a place, but it also represents the specific attitudes of the psychotherapist (Baranger et al., 2002). Garcia et al. (2022) made a depiction of the room as somewhere well-guarded that the patient can take refuge in, and feel comfortable and open, and labeled it “a place of shelter”. In a similar fashion, it is important to keep OPT environment (with regard to meeting times, and the physical characteristics of the room from which both parties attend the session) as stable as possible, in order to preserve a sense of continuity in the therapeutic relationship (Machado et al., 2020). Accordingly, in the same study, one of the interviewees (psychotherapist) states that to prevent any interception of conversation, it is essential to have a strong Internet connection; otherwise “you are lost”. In a similar way, another psychotherapist shares her thoughts on losing connection by saying “you are prevented from being with them” (Sayers, 2021).

The symbolic meaning of the therapy room is also important from an intersubjective perspective and is denoted as a shared relational place, to refer to the setting in which unconscious material is communicated. Many researchers accept the leading role of embodied aspects of intersubjectivity for therapeutic processes (Shaw, 2004; Siegel, 2019; Tschacher &

Pfammatter, 2016). There are noted psychotherapists such as Winnicott with his concepts of "holding environment" or "potential space" (1971), Milner with the term "frame" (1950), or Thomas Ogden (2004) with the "analytic third". Donald Winnicott (1971) used the potential space to depict a place where mother and child, or psychotherapist and patient both join and separate; a space where relationships are playfully nourished, and bonding begins (Brahnam, 2014). Likewise, intersubjectivity refers to the experience of mutual presence and recognition (García et al., 2022). Marion Milner (1950) gave importance to "frame" by explaining that even if there is chaos, it is less chaotic when you give it a name. Because the frame has its own assuring and comforting effect of providing a setting to work in. Similarly, since good alliance is accepted as vital for the psychotherapy process, studies claim that this sense of alliance and collaboration creates a "working space" in which patients are able to introduce their concerns in a new way of addressing (Horvath & Luborsky, 1993). While Kernberg (2012) claims that a frame and structure help a lot, specifically with patients who are struggling with a fragmented sense of self and emotion regulation problems, Rolnick and Ehrenreich (2020) point out that "disembodied" OPT questions the traditional assumptions of basic requirements for psychotherapy environment. For instance, both patients' and psychotherapists' breathing patterns become synchronized when their bodies are in the same room sitting near to each other; a state which is not possible to achieve with OPT.

Bondi & Fewell (2003) emphasize the balance of boundaries in face-to-face psychotherapy. Whilst boundaries are related with spaces, this kind of spatiality could offer transformations by acknowledging constraints and limits to offer freedom. This spatiality is depicted as somewhere formed by boundaries, limits, and constraints, which at the same time contain and liberate the patient. The psychotherapy room and its space also work as a tool that separates the internal and external spaces in a symbolic manner. Davidson (2000) states that the whole experience is felt by patients and works as an integrator to create internal and external experiences, such as ringing the door, waiting, or sitting in the waiting hall. Regarding this, the face-to-face psychotherapy setting is open to an imbalance of power because the psychotherapy takes place in the "territory" of the psychotherapist (Simpson, 2009). Supporting that, one of the psychotherapist interviewees in Garcia et al.'s (2022) study claimed that there is a change in the structure of psychotherapy; a more horizontal relationship is opened because of having similar devices, similar situations, and everyone on their own place. Therefore, OPT could be a place where separation between roles becomes less sharp and the symmetrical relationship becomes stronger.

1.5. Present Study

With the beginning of the SARS-CoV-2 (COVID-19) pandemic that caused a global outbreak, Turkey was one of the countries that applied restrictions regarding the codes of social and physical interactions. Since March 2020, many psychotherapists had to shift their face-to-face sessions to online psychotherapy because of the pandemic restrictions. Regardless of their theoretical orientation, years of experience, knowledge, or ability to use technological devices and tools, this mandatory shift put both psychotherapists and clients in a process that demanded rapid adaptation. This study aims to investigate how this mandatory shift to OPT reflects on the psychotherapy process and how personal perceptions and experiences of COVID-19 affected the therapeutic relationship. The main purpose of the study is to investigate the effects of this shift by trying to examine it from both perspectives, considering the experiences of psychotherapists as well as clients. This study therefore aims to explore the following issues:

1) How was psychotherapy process affected by the mandatory shift from face-to-face psychotherapy to OPT?

2) Is there any relationship between personal perceptions and experiences of COVID-19 and therapeutic alliance with regard to OPT?

3) What are the factors that are related to therapeutic alliance in OPT?

Through these questions, current study seeks to identify and understand the outcomes of the addition of the screen as a “technological third” in psychotherapy, as well as the loss of a shared room in the psychotherapy process. It may provide insight into the ongoing psychotherapy processes and possible discretions for the future. While the scales and questionnaires used in the first study were used to present quantitative dispositions, Study 2, which included semi-structured interviews, was intended to understand and discuss the relational challenges in depth.

2. METHOD

2.1. Study I

2.1.1. Participants

Participants who were native Turkish speakers contributed to this study. Ninety-four participants filled out the survey. The survey part was focused on 2 major groups: 66% of the participants were psychotherapy patients who have received both online and face-to-face psychotherapy since the COVID-19 pandemic started while the remaining 34% were mental health professionals who had been actively working as a psychotherapist, including the pandemic period. There were 76 females and 18 males within the overall sample (See Table 1 for the sample's sociodemographic characteristics).

All participants in the mental health professionals group were psychologists. This sample consisted of those with a B.A. degree (21.9%), and clinical psychologists who had a M.A. or Ph.D. degree (71.9%). 28 out of 32 mental health professionals were female, and 4 were male. 56.3% of the sample were single, and 43.8% were married. Their total amount of clinical experience ranged from 1 to 26 years, with a mean of 7.62 years (*SD* = 6.07), and they had a mean age of 32.56 years (*SD* = 6.87). The majority stated that they are living in Istanbul; only 5 participants were from different cities (Diyarbakır, Antalya, Ankara, İzmir, and Sakarya).

A total number of 62 patient participants contributed to the study, whose ages ranged from 18 to 69 years, with a mean of 35.24 (*SD* = 10.08). They consisted of 48 females and 14 males. 35.5% indicated their relationship status as married, 58% as single, and 6.5% as 'other'.

Table 1

Demographic Characteristics of Survey Participants

	Patients (N=62)	**Therapists** (N=32)	**Total** (N=94)
Mean Age (SD)	35 .24 (10.08)	32.56 (6.87)	34.33 (9.16)
Gender (%)			
Female	48 (77.4%)	28 (87.5)	76 (80.9%)
Male	14 (22.6%)	4 (12.5%)	18 (19.1%)
Marital Status (%)			
Single	37 (59.7%)	18 (56.3%)	55 (58.5%)
Married	22 (35.5%)	14 (43.8%)	36 (38.3%)
Other	3 (4.8%)	-	3 (3.2%)
COVID-19 History (%)			
Diagnosed for COVID-19	25 (40.3%)	10 (31.3%)	35 (37.2%)
Relative Diagnosed for COVID-19	19 (30.6%)	13 (40.6%)	32 (34%)
Lost an acquaintance due to COVID-19	8 (12.9%)	2 (6.3%)	10 (10.6%)

2.1.2. Materials

2.1.2.1. Working Alliance Inventory (WAI)

WAI was developed by Horvath and Greenberg in 1989 as a self-report inventory to assess the therapeutic alliance between a psychotherapist and a patient by evaluating three significant aspects of it. One of them is agreement on the tasks of therapy (12 items), the other one is agreement on the goals of therapy (12 items), and the last one is the development of an affective bond (12 items). WAI consists of 36 items, and respondents are asked about their experiences for the present period on a 7-point Likert scale (ranging from 1=Never to 7=Always). A total score is calculated by adding up all the items, and a higher score indicates a stronger alliance.

WAI was adapted to Turkish by Soygüt and Işıklı (2008), and their study suggested the Turkish version as a valid and reliable tool for clinical and research settings. The version was

presented to judges who represented psychoanalytic, gestalt, and cognitive behavioral approaches in order to construct consensus. The Cronbach α value was found as .96 for the therapist form and .90 for the client form. Because of the limited number of therapists who participated in the adaptation study (n=21), factor analysis was conducted only for the client form and was obtained as congruent with the original WAI.

2.1.2.2. The Unified Theory of Acceptance and Use of Technology Model (UTAUT-2)

UTAUT was originally developed by Venkatesh et al. in 2003 as a self-report inventory to assess technological adoptions and acceptance by predicting behavioral intentions for future use. The second version of the test was formed in 2012 under the name of UTAUT-2 (Vankatesh et al., 2012). In the study, online psychotherapy intentions were compared to traditional therapy setting rather than any specific technological progress or online psychotherapy tools in general. As in the study by Bekes and Aafjes-van Doorn (2020), it was possible to adapt the items from a general technological framework to a version that focuses on online psychotherapy. The test consisted of 14 items based on four main factors to predict the future of technology. These were social influence, performance expectancy, effort expectancy, and facilitating conditions. Respondents are asked about their opinions on a 5-point Likert scale (ranging from 1=strongly disagree to 5=strongly agree).

UTAUT-2 was adapted to Turkish by Yılmaz and Kavanoz in 2017. Because of the new cultural context, the study reassessed the validity and reliability of the instrument and the comparative fit index (CFI) of the confirmatory factor analysis was .98.

2.1.2.3. Perception of COVID-19 Scale (P-COVID-19)

This test is developed by Geniş et al. in 2020 to assess the perceptions about COVID-19. Overall, P-COVID-19 consists of 7 items on a 5-point Likert scale (ranging from 1=Strongly disagree to 5=Strongly agree). It has two subscales. The first subscale of the inventory, named “Dangerousness”, claims to assess the perceptions and beliefs about the dangers of COVID-19 (3 items). The second subscale, “Contagiousness” consists of items that assess the perceptions about the contagiousness of the disease (4 items). Overall, P-COVID-19 consists of 7 items on a 5-point Likert scale (ranging from 1=Strongly disagree to 5=Strongly agree). The Cronbach alpha values for the overall scale as well as Dangerousness and Contagiousness subscales in the original study were reported as .74, .64, and .75, respectively.

2.1.3. Procedure

Both groups completed their online survey on Google Forms. Data collection process lasted from February 2022 to May 2022. Following the Informed Consent Form page, participants in each group filled out the sociodemographic questions. Mental health professionals filled out the questions investigating their online psychotherapy and personal COVID-19 experiences. Following questions about their perceptions of COVID-19, the group completed WAI, and in the last step they were asked to fill out the UTAUT-2. In pursuit of the sociodemographic form, patients completed survey questions considering their online psychotherapy experiences as a patient and personal COVID-19 past. Then they answered P-COVID-19, and WAI, respectively. After the survey, each group was given debriefing with contact information. (See Appendix A for the forms for both groups). The whole process took approximately 15 to 20 minutes. In addition to the online survey procedure, 5 mental health professionals working in a clinic in İstanbul filled out the printed copies of the surveys and returned them in a closed envelope.

The study was approved by Yeditepe University Social Sciences and Humanities Ethics Board (Appendix B).

2.2. Study 2: Semi-Structured Interviews

2.2.1. Participants

Semi-structured interviews were carried out with 9 psychotherapists (6 female and 3 male), and 7 patients (4 female and 3 male). Their ages ranged from 25 to 59 years with a mean age of 34.3. Psychotherapists had minimum 3 and maximum 26 years of experience. Psychotherapy patients were in their psychotherapy process for at least one and a half years. While 2 out of 9 psychotherapists stated they exercise schematic psychotherapy orientation in their sessions, 7 of them stated they work with psychodynamic psychotherapy apprehension (See Table 2 for demographic characteristics of the participants).

Table 2

Demographic Characteristics of Semi-Structure Interview Participants

	Patients (N=7)	**Therapists** (N=9)	**Total** (N=16)
Mean Age (SD)	36.71 (10.61)	40.77 (10.74)	34.33 (10.53)
Gender (%)			
Female	4 (57.1%)	6 (66.6%)	10 (62.5%)
Male	3 (42.9%)	3 (33.3%)	6 (37.5%)
Marital Status (%)			
Single	4 (57.1%)	3 (33.3%)	7 (43.7%)
Married	3 (42.9%)	6 (66.6%)	9 (56.3%)
Theoretical Orientation (N)			
Psychodynamic Psychotherapy		7 (77.8%)	
Schema Therapy		2 (22.2%)	
Years of Experience (SD)		11.8 (8.56)	

2.2.2. Materials

The surveys both mental health professionals and patients completed were formed by the researcher. Participants were presented with open ended questions about 5 common themes which are considered as key subjects of the study: i) mandatory shift to OPT and its effects on the psychotherapy process/effectiveness, ii) the function of technological devices, iii) therapeutic alliance in OPT, iv) loss of a shared therapy environment, v) technical problems and emotional reactions accompanying them.

In addition to predetermined question sets, both groups were asked about their own observations and comments about the mandatory transition to online psychotherapy during the COVID-19 pandemic. The survey that was made for mental health professionals and patients included different question sets which aim to collect information about their experiences (see Appendix A).

2.2.3. Procedure

Interviews were conducted online, via the Zoom platform, and lasted approximately 45 minutes. As an inclusion criterion, both group of participants had to be in a face-to-face psychotherapy context before the pandemic and made a shift to online psychotherapy practice

during the pandemic. Participants were briefly informed about the subject of the study, and informed consent was received from each participant to allow the researcher to anonymously use their statements for academic purposes. Data collection process lasted from February 2022 to April 2022.

3. RESULTS

3.1. Descriptive Characteristics of the Sample

Overall, 94 participants completed the survey and the group of patients constituted 66% of the participants included in the analyses. The mean age of this sample was 35.24 years (*SD*=10.08). Forty-eight of them (77.4%) were female whereas 14 (22.6%) of them were male. Twenty-two participants stated that they were married, and more than half of the participants (64.5%) were single. 40.3% of the participants indicated that they had tested positive for COVID-19 previously. 30.6% of them had their first-degree relatives tested positive for COVID-19 while 12.9% of them experienced loss caused by the COVID-19 virus.

In terms of mental health professionals, 32 participants completed the survey. 28 (87.5%) of them were female while 4 (12.5%) were male. They have an age range from 22 to 53, with a mean of 32.56 years (SD=6.867). The mean weekly working hours is 15.61 (SD=9.07). 56.3% of the mental health professionals were single while 43.8% of them were married. 12.5% of them reported that they were living alone while 88.5% live with at least one person.

Regarding COVID-19 history, 10 of them were diagnosed with COVID-19 while 13 of them have first-degree relatives who tested positive for COVID-19. Two participants reported they had experienced loss of a significant other caused by the COVID-19 virus. (See Table 1 for sociodemographic variables and COVID-19 history of the sample).

The majority of patients reported they live with at least one other person (72.6%) whereas 27.4% of them stated they lived alone. In terms of their residential address, 79% stated Istanbul, while there were 3 participants from Ankara, 2 from İzmir, and one from each of the following: Bursa, Eskişehir, Düzce, Konya, Mersin, Frankfurt (Germany), and Netherlands. Most participants had a B.A. degree (45.1%), followed by a master's degree (37.1%), high school degree (9.6%), and Ph.D. degree (8.1%). In terms of level of education of mental health professionals, 71.9% of the participants have masters or doctoral degree, while 21.9% is university graduates. (See Table 3 for educational background of the sample)

Table 3

Educational Background of the Sample

	Patients (N=62)	**Therapists** (N=32)	**Total** (N=94)
Educational Degree (%)			
High school	6 (9.7%)	-	6 (6.4%)
B.A.	28 (45.2%)	7 (71.9%)	35 (37.2%)
M.A.	23 (37.1%)	23 (21.9%)	46 (48.9%)
Ph.D.	5 (8.1%)	2 (6.3%)	7 (7.4%)

3.2. Online Psychotherapy Experience

Table 4 demonstrates participants' use of different online platforms and experiences regarding technical part of OPT. The top 3 online platforms used by patients were Zoom (38.7%), Skype (37.1%), and WhatsApp (25.9%). Regarding technical problems encountered during the sessions, 59.7% of the participants in the patient group stated they experienced video freezing in sessions mostly while 37.1% mentioned asynchronism of the audio of their psychotherapist, in addition to momentary disconnections (45.1%), and loss of internet connection (29%). Fifteen participants marked that they experienced none of these technical problems.

Among online platforms used by mental health professionals, Zoom (75%) and Skype (71.9%) are the most used ones, followed by WhatsApp (31.3%) and FaceTime (3.1%). In terms of technical problems, freezing video is the most reported technical problem (87.5%), followed by disconnection problems during the sessions (75%), loss of Internet connection (59.4%), and audio or video not being in sync (59.4%). One participant stated that they experienced none of these technical problems. (See Table 4 for the distribution of online platforms, technical problems, and emotions they cause)

With regard to feelings experienced as a result of technical problems during OPT, most reported feelings by patients were apathy (27.4%), anger (17.7%), and disappointment (17.7%). When psychotherapists asked about their feelings in case of technical problems, worry (53.1%) was the most reported feeling, followed by panic (37.5%), and anger (34.4%).

Table 4

Online Platforms, Technical Problems, and Emotions They Cause

	Patients (N=62)	**Therapists** (N=32)	**Total** (N=94)
Platform (%)			
Skype	24 (38.7%)	23 (71.9%)	47 (50%)
Zoom	23 (37.1%)	24 (75%)	47 (50%)
WhatsApp	16 (25.9%)	10 (31.3%)	26 (27.7%)
Facetime	6 (9.7%)	1 (3.1%)	7 (7.4%)
Other	3 (4.9%)	2 (6.3%)	5 (5.3%)
Technical Problems (%)			
Video freezing	37 (59.7%)	28 (87.5%)	65 (69.1%)
Disconnection	28 (45.2%)	24 (75%)	52 (55.3%)
Loss of sync	23 (37.1%)	19 (59.4%)	42 (44.7%)
Loss of Internet connection	18 (29%)	19 (59.4%)	37 (39.4%)
Other	3 (4.8%)	-	3 (3.2%)
None	15 (24.2%)	1 (3.1%)	16 (17%)
Emotions (%)			
Worry	15 (14.2%)	17 (53.1%)	32 (34%)
Apathy	17 (27.4%)	7 (21.9%)	24 (25.5%)
Panic	10 (16.1%)	12 (37.5%)	22 (23.4%)
Anger	11 (17.7%)	11 (34.4%)	22 (23.4%)
Disappointment	11 (17.7%)	5 (15.6%)	16 (17%)
Hopelessness	2 (3.2%)	2 (6.3%)	4 (4.3%)
Worthlessness	2 (3.2%)	1 (3.1%)	3 (3.2%)

Both groups' experiences regarding the advantages and disadvantages of OPT are demonstrated in Table 5. Considering the opinions about the advantages and disadvantages of OPT, 17 (27.4%) participants in the patient group stated that there are no disadvantages whereas none of the psychotherapist participants claimed so. As mobility (40.6%) and working from the comfort zone (40.6%) were the most stated advantages by psychotherapists, 43.5% of the patients referred time saving utility as the major advantage of OPT. Regarding

disadvantages, the most mentioned disadvantage by psychotherapists was the loss of body language (34.4%), where patients primarily noted technical problems (24.2%).

Table 5

Advantages and Disadvantages of OPT

	Patients (N=62)	**Therapists** (N=32)	**Total** (N=94)
Advantages of OPT (%)			
Time	27 (43.5%)	12 (37.5%)	39 (41.5%)
Mobility	15 (24.2%)	13 (40.6%)	28 (29.8%)
Comfort Zone	12 (19.4%)	13 (40.6%)	25 (26.6%)
Continuity	6 (9.7%)	9 (28.1%)	15 (16%)
Focus	2 (3.2%)	2 (6.3%)	4 (4.3%)
None	12 (19.4%)	1 (3.1%)	13 (13.8%)
Disadvantages of OPT (%)			
Technical problems	15 (24.2%)	8 (25%)	23 (24.5%)
Loss of body language	13 (21%)	11 (34.4%)	24 (25.5%)
Loss of shared room	8 (12.9%)	6 (18.8%)	14 (14.9%)
Violation of privacy	5 (8.1%)	9 (28.1%)	14 (14.9%)
Loss of affect	5 (8.1%)	5 (15.6%)	10 (10.6%)
Restrained expressions	8 (12.9%)	-	8 (8.5%)
External factors	4 (6.5%)	8 (25%)	12 (12.8%)
None	17 (27.4%)	-	17 (18.1%)

3.3. Online Psychotherapy Experience & Working Alliance

Considering advantageous factors of online psychotherapy, patients who report that there is not any advantageous factor of online therapy (*Mdn*=74) had significantly lower WAI-Bond sub-scale scores than participants who reported at least one advantageous factor of online psychotherapy (*Mdn*=68); $U = 183$, $p = .037$. No such difference in terms of WAI scores was observed between those who did and did not indicate any disadvantages of OPT.

Psychotherapists who saw the "sustainability of the psychotherapy process" (i.e, continuity) as an advantageous part of online psychotherapy were significantly younger

(*Mdn*=27) (*U* = 53.5, *p* = .036) compared to participants who did not report sustainability as an advantage (*Mdn*=33). They also had fewer months of clinical experience (*Mdn*=30) than others (*Mdn*=10) (*U* = 48, *p* = .020), fewer weekly working hours (*Mdn*=8) than others (*Mdn*=20) (*U* = 36, *p* = .006), and higher WAI-Task scores (*Mdn*=75) than others who did not consider "sustainability" as an advantageous part of OPT (*Mdn*=72) (*U* = 51, *p* = .028). Those who reported being and working from their "comfort zone" as an advantage had significantly more weekly working hours (*Mdn*=20); *U* = 60.5, *p* = .029, compared to those who did not mark that option (*Mdn*=9).

Psychotherapists who returned to face-to-face sessions at some point during the pandemic reported significantly higher WAI-Bond scores (*Mdn*=75) compared to participants who continued their sessions without returning to face-to-face setting (*Mdn*=69) (*U* = 46.50, *p* = .011), likewise, higher WAI-Goal scores (*Mdn*=65) than others (*Mdn*=60.5) (*U* = 56, *p* = .035), and higher WAI total scores (*Mdn*=207) than other participants who did not return to face-to-face sessions (*Mdn*=193.5) (*U* = 56.5 *p* = .037

3.3.1. Online Psychotherapy Experience & Perception of COVID-19

Within the patient group, there was a significant difference between those who did and did not report "saving time" as an advantage of online psychotherapy in terms of their P-COV-19- Perceived Dangerousness sub-scale scores; *U* = 296.5, *p* = .011. Those who report "saving time" as an advantageous factor have significantly higher perceived dangerousness scores. No such difference was obtained for other reported advantages of OPT in any of the p-COVID-19 scores. Psychotherapists who reported "time saving" as an advantageous part of online psychotherapy are significantly older (*Mdn*=37) than those who did not report in that way (*Mdn*=29), (*U* = 60.5, *p* = .020), and have more clinical experience (months) (*Mdn* = 138) compared to psychotherapists did not report "time saving" as an advantage (*Mdn* = 54), *(U* = 63, *p* = .026). Those who report "time saving" factor as an advantageous part of online psychotherapy also had significantly higher scores on dangerousness (*Mdn*=13) with respect to participants who did not report that (*Mdn* =11.5), (*U* = 65.5, *p* = .032), also had higher contagiousness scores (*Mdn* = 16) than others (Mdn = 15) (*U* = 70, *p* = .047) and likewise, higher P-COVID-19 total score (*Mdn* = 29) compared to those who did not report "time saving" as an advantageous part of OPT (*Mdn* = 25.5), (*U* = 58.5, *p* = .016).

3.4. Correlational Findings

A series of Spearman correlations were run in order to check the relationship between variables related to OPT experience, perceived working alliance, and perceptions towards COVID-19 for both groups. For patients, there was a significant positive correlation between

WAI total score and the length of the psychotherapy process (in months) (r_s(59) =.35, p = .006). The length of the psychotherapy was also significantly and positively correlated with WAI Bond scores (r_s(59) =.313 p=.014), WAI Goal scores (r_s (59) =.265 p=.039), and WAI Task scores (r_s (59) =.381 p=.002). WAI Bond and the length of the previous psychotherapy (in months) were negatively correlated; r_s (57) =-.265 p=.042. For patients, the reported number of technical problems was positively correlated with the reported number of disadvantages of OPT; r_s (60) =.306 p=.015). Besides, the reported number of disadvantages of OPT was positively correlated with WAI bond subscale (r_s (60) =.267 p=.036) (See Table 6).

For mental health professionals, the reported number of advantages of OPT was found to be negatively correlated with the reported number of technical problems (r_s (30) = -.445 p = .011). The reported number of advantages of OPT was also negatively correlated with their weekly working hours (r_s (30) =-.381 p=.034). Finally, the reported number of disadvantages of OPT was found to be negatively correlated with WAI Bond subscale score; r_s (30) =-.353 p = .048) (See Table 7).

Table 6

Spearman Correlations Between Study Variables for Patients

Variables	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**
1. N of advantages of OPT	-								
2. N of disadvantages of OPT	.332**	-							
3. N of technical problems	-.091	.306*	-						
4. P-COVID-19 - Dangerousness subscale	.109	.102	.115	-					
5. P-COVID-19 - Contagiousness subscale	-.095	.088	.185	.464**	-				
6. P-COVID-19	.012	.124	.192	.882**	.808**	-			
7. WAI - Bond subscale	.155	.267*	-.004	.180	.008	.114	-		
8. WAI - Goal subscale	-.037	.194	.031	.231	-.009	.134	.797**	-	
9. WAI - Task subscale	.042	.178	.038	.205	.034	.121	.761**	.843**	-
10. WAI	.044	.231	.009	.200	-.020	.104	.902**	.941**	.936**

*p<.05; **p<.01

Table 7

Spearman Correlations Between Study Variables for Mental Health Professionals

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
1. Clinical Experience	1.000														
2. Weekly working hour	.468**	1.000													
3. N of advantages of OPT	.064	-.381*	1.000												
4. N of disadvantages of OPT	-.248	-.099	.058	1.000											
5. N of technical problems	-.143	.183	-.459**	.005	1.000										
6. Length of own therapy	.410*	.436*	-.016	-.005	.421*	1.000									
7. WAI - Bond subscale	.043	-.015	.059	-.353*	-.071	-.439*	1.000								
8. WAI - Goal subscale	-.185	-.007	.175	-.304	-.122	-.337	.785**	1.000							
9. WAI - Task subscale	-.205	-.182	.117	-.258	-.027	-.442*	.888**	.747**	1.000						
10. WAI	-.144	-.085	.107	-.322	-.081	-.450*	.948**	.885**	.954**	1.000					
11. UTAUT - PE subscale	-.161	-.274	.172	.088	.126	-.154	.308	.287	.329	.340	1.000				
12. UTAUT - EE subscale	-.236	-.279	.141	-.057	.199	-.210	.383*	.357*	.505**	.476**	.719**	1.000			
13. UTAUT - SI subscale	-.128	-.263	.179	-.013	-.012	-.238	.339	.400*	.362*	.410*	.721**	.832**	1.000		
14. UTAUT - FC subscale	-.065	-.350	.282	-.118	.036	-.344	.531**	.480**	.509**	.544**	.598**	.769**	.813**	1.000	
15. UTAUT	-.152	-.322	.242	.027	.095	-.234	.386*	.375*	.434*	.444*	.895**	.908**	.911**	.834**	1.000

*p<.05; **p<.01

3.5. Semi-structured Interviews

For both practicing psychotherapists and psychotherapy patients, the psychotherapy processes were affected by the COVID-19 pandemic, and they mandatorily shifted to OPT. While more than half of the psychotherapists (5 out of 9 participants) had previous experiences with OPT, only one participant in the patient group had previous OPT experience.

Psychotherapist A (Female, 50 years) notes the importance of previous experience by emphasizing self-confidence:

"I have had patients abroad, and we carried out the psychotherapy process via online platforms. Therefore, I was not distant from the idea, and, how should I say, I did not offer online psychotherapy as something I did not have any experience with or something that I have hesitations to practice. So, this might have enabled them to accept it as a possible option."

However, psychotherapist B (Female, 29 years) considers the COVID-19 pandemic as the main reason that makes it possible for patients to accept OPT and continues:

Before the COVID-19 pandemic, I had to shift to OPT because of my personal health issues. At that time, everyone was worried because there were no common examples of OPT … Since everybody shifted to OPT, things got easier. People got used to communicating via online platforms. One of my former patients made continuous comparisons of herself with her friend, who sees her psychotherapist face-to-face. Nowadays, it is the new normal. In comparison to my previous shift, this is much easier.

Similarly, patients discussed this shift considering their previous experiences. In addition to previous experiences of psychotherapy via online platforms, one of the main issues was the duration they have been in the sessions. Being new in a psychotherapy relationship in comparison to a longer relationship seems to make a difference regarding how patients perceive the process.

Patient D (Female, 32 years):

"I have done it before COVID-19 with my psychotherapist, and it was such a blessing for me when I was abroad. At that time, I was scared of not seeing him (psychotherapist), and it was great that he accepted me online. But now, it is a daily thing, just a normal way of communication. First, I worried about privacy, but my anxiety on that matter diminished over time. We had no choice. I was starting the sessions worried, but at the end I always found myself expressing my deepest emotions."

Patient A (Male, 25 years):

"I started psychotherapy at the beginning of 2020, and two months later, she told me that we are shifting to Skype. Honestly, I did not like it. In our face-to-face sessions, I was just getting

started to talk about some real things. And at the time we shifted to Skype, there were my parents, my aunt, and her husband at our house. There were four other people next to my psychotherapy room."

Regarding privacy and security issues, common attitudes did not appear to differ between patients and psychotherapists. While both groups mentioned the "new normal" as including questions and hesitations about cyber security, psychotherapist C (Male, 42 years) noted that everyone accepts the risks under these conditions:

"Ultimately, we all take risks carrying out psychotherapy via online platforms. Everyone is talking about these privacy issues. Yes, maybe I have risked it, and I never had a problem. Honestly, I thought, "Who would ever follow me? Who would show any effort to listen to my sessions?". However, I needed to back up my Internet connection with my cell phone, and that's why I kept my phone beside my laptop. I realized that just keeping it there caused some attention problems for me. In my opinion, in addition to the laptop screen as a mediator, the connection tools could also cause some problems."

Psychotherapist D (Male, 32 years) approached the issue by considering the privacy of the psychotherapist, as well:

"I think it is weird to have something such as a screen between me and the patient. We both stay in a frame. In one session, there was a fly in the room, and I did this thing with my hands to get it off of my face. My patient asked me if I had a cat or something in my house. I have a cat, but I could not say that at that moment, and I reacted: "No!". It seems like I was worried; the responsibility of the environment or psychotherapy space makes me worried. I feel like I should keep it stable. No flies, no cats."

Similarly, psychotherapists discussed similar personal questions while considering therapeutic alliance in OPT. Psychotherapist E (Female, 41 years) stated that there is not any loss in terms of therapeutic alliance due to online psychotherapy shifts and added:

"Yet I am questioning the relationship when patients say, "Is there anybody else?" when I stare somewhere near the screen for a moment. This is a different thing to experience compared to face-to-face sessions. It affects the relationship."

Patient E (Female, 39 years):

"I see him playing with the screen; what does he do? Is he changing the volume, am I too loud, or did he hear me well? Whatever it is, I feel like he is not listening… It is extremely uncomfortable."

Some psychotherapists claim that OPT is a completely different experience.

Psychotherapist D:

"It is a different process in every sense, I can say that the therapeutic alliance gets significantly worse in OPT. When I think of it, I should accept that I made more ungentle confrontations with a less emphatic approach…

Firstly, patients struggle with trust. I heard that many times: "It is hard to open up". We did not shake hands, or we did not meet in person, which made the trust process harder and slower. In my opinion, they feel like they are talking to a stranger; many of my patients mentioned that. So, maybe it is not something that would break the therapeutic alliance, yet it does damage and impedes the process."

Psychotherapist H (Female, 51 years):

"… Very different process, it is very hard. We were only able to see their face for a long period of time. We did not know their real voice. However, I think there are surprising advantages to it, as well. One of my patients started online, and after a long time, we wanted to do it in person and decided to meet at the office. I felt like I was doing psychotherapy with a different patient. He told me that he was able to open up easily in OPT, and was freer to have confrontations with himself. It was a very clear feedback. I also felt like he was a stranger with his body in the room, his stance, gestures…".

Patient A:

"… I realized that when I got back to her office. It is much easier to work this way. OPT was not going well for me, and I accepted it later. I was inclined to run away from the hardest things in my life, and there was this self-censor mechanism of mine. OPT was totally negative for me; hard to talk, hard to trust, and hard to open myself. We lost a lot of time in OPT sessions."

Psychotherapist C claims that there is a way to hold the therapeutic alliance by making a new and strong framework:

"I created a terms and conditions document and presented it to my patients. The sessions should be done in an isolated room, there should be enough light, they should have water, and there should not be cell phones. I also did not accept to do sessions anywhere else except where we accepted previously. For example, if he was in a car, I would not accept it, and the session would be canceled. I sent them this document beforehand, and only if they accepted these terms and conditions, I agreed to work with them online."

As a result of the loss of a shared room, the environment in which online sessions are done became a crucial subject that psychotherapists discuss.

Psychotherapist E:

"I feel bad… You do not have an idea where they are. It is okay for me to do sessions in a car or somewhere else, but the question is: Is he really here? Sometimes I feel like there are other

people around them. One of my patients has an extremely invasive mother who was interrupting her during the sessions, barging in the room. Or another one, the husband of my patient, did not give her a space to attend sessions. In the end, she dropped out."

Similar to Psychotherapist C, Psychotherapist K (Male, 34 years) claims that stability plays the main role:

"I worried a lot when we lost the room. The physical environment is extremely important. But I noticed that if we are able to stabilize the environment, both psychotherapist and patient, we can feel like we are in the same room. I feel like we are there. Because of this, we do not lose that much of the sessions."

Regarding these discussions, psychotherapist D defends that having a comfort place is the most important thing for a patient:

"… I think it is okay. The main issue under these conditions is the best and most comfortable place a patient would prefer. If he is feeling more isolated and comfortable in his car rather than his house, then I would accept it as it is. For me, privacy is more essential. Maybe his house environment is not appropriate to talk about the things he wants to talk."

Patient F (M, 34 years):

"… Since then, I have been living with my girlfriend. But we have a little apartment, and there were harsh restrictions, you will remember. During one of those lockdowns, I asked my therapist whether I can attend the session from my car. It felt good to do it that way because it is like, we are finding a way to get better, right? It felt like solidarity in hard times."

Patient G (Male, 39 years):

"For me, it was hard to stay in OPT. For a long period of time, my psychotherapist and I tried hard to find an appropriate place for me. A place I will feel safe. I think she and her room gave me the feeling of security."

There are different solutions psychotherapists examined to overcome the loss of the "body" and its messages.

Psychotherapist K (Male, 34 years):

"I reviewed the studies which focus on facial mimics instead of gestures. I tried to understand what these mimics project about the body or about the feelings. It is important to identify the gestures that belong to the body. We cannot give up on the messages from the body."

Psychotherapist F (Female, 59 years):

"I have many psychotherapy groups in which I work with the messages from the body. It is much easier to recognize any deformation or spasm when we are in the same room. OPT diminishes the data significantly. I found myself asking before the sessions how they feel or

where they feel any tension. We started to give points before and after sessions. I handled this by listening a lot, asking them for more details, and motivating them to do more reflections on their body."

Patient C (Female, 58 years):

"At first, it all seemed very artificial, the little phone screen and all applications, platforms. But I convinced myself by saying that it was just temporary and it would pass in a couple of weeks. It did not… Just as my body language is a tool for my therapist, her attitudes are also a tool for me and have their own language. In OPT, I only saw her face, but she was giving me messages by crossing her legs. Now I cannot read her reactions. It is the major loss of this."

Most psychotherapists stated that they struggled with managing technical problems. There was not a single psychotherapist participant who did not experience any technical issues such as connection loss, frozen video, or unsynchronized audio. Psychotherapist A especially emphasizes the importance of knowledge about technological devices:

"Thank God, my son helped me through this period. I would be very happy if I knew how to use Ethernet cable from the beginning. It saved my life. I did not have any problems since I started to use it… Free associations were lost! Patients felt terrible to be interrupted! Well, I feel terrible too. Whose dynamic it is, I am not sure. For instance, we lost ten minutes, who is responsible for that? Who is going to make this up?"

Patient B (Female, 30 years):

"Connection loss is the worst! Well, it is not my fault, maybe it is not her fault either, but I pay for 45 minutes… I remember I felt guilty at first. Then I got used to it. And I think my therapist got used to it, as well. She changes her Wi-Fi, and we carry on. If it is my connection, we just wait (laughs)."

Psychotherapist H (Female, 51 years) notes that technical problems might give a clue about the patient or the relationship between the patient and the psychotherapist:

"It is interesting that I am experiencing this kind of technical problems with the same patients. I mean, a kind of coincidence. With some of my patients, I did not experience such a thing, yet I have these technical issues with the same patients repeatedly, despite the fact that I warn them about the connection. In each session, we have 'What should I do, maybe I can change the network, let me take my phone' dialogues. However, it does not happen with other patients. I still could not understand this."

Most psychotherapists noted that the worst part of the OPT is the immense effort it demands just to follow the patient and their affect. In addition to the therapeutic alliance, "holding" was another subject that was discussed. Psychotherapists B, G, and D defined "establishing a holding environment in OPT" as "exhausting"; Psychotherapist A had a different perspective, making a distinction between old and new patients:

"At first, I put so much effort. But now I feel like I can do the same with less energy. I felt burned out when I saw three patients in a day, but that has changed. We must accept that there is a fragile connection, but it is something both parties are aware of. I think patients are also trying harder to stay connected. In some of my patients, I can really see that. I suppose it is valid for new patients who have started online since the beginning. They put more effort into it."

Psychotherapist D:

"I have had many dropouts. I struggled to create a holding environment. I even had to try hard to follow their affect. It is not something I experience in my office. Under these conditions, I do not believe any therapeutic relationship could carry on without any disruptions."

Patient A:

"For a long time, I tried to resist such technical issues. I tried to stay in the feeling, but the feelings run fast. I remember after one disconnection that lasted approximately 5 minutes, we connected again, and at the time we were able to hear each other, I found myself explaining the rest like, 'I was going to say, bla bla bla'. So, there were no emotions. It is like reading half of the poem as you should read it and continuing the other half as if it is a plain text."

In semi-structured interviews, both patients and psychotherapists mostly used comparative thinking. To make assessments on the practice of OPT, they compared current practice with different practice experiences they observed in their environment and with the traditional psychotherapy practice, which refers to the times before the COVID-19 pandemic. As a common concept both groups mentioned, OPT has created its own vulnerabilities, mainly due to "not having a shared room". From the perspective of patients, they have mostly mentioned the importance of their psychotherapists having a stable room in online meetings along with ongoing eye contact without having to make any arrangements on their screen in order to feel they are being listened to. Similarly, psychotherapists have mentioned new significant responsibilities they felt to hold their patients in sessions and make them feel comfortable, such as maintaining a stable environment and eliminating extraneous stimuli during the sessions. Considering the possible loss of messages from the body in the practice of OPT, psychotherapists expressed their worries more than patients while they were trying to find

new ways to compensate for the loss of messages. Contrary to this, patients were mostly focused on the feeling of not being present in the same room. With respect to the messages from the body of their psychotherapists, two patients mentioned that not being able to get the “time is up” signal is the thing they noticed.

4. DISCUSSION

This study aimed to address how psychotherapy context was affected by the mandatory shift to OPT due to SARS-CoV-2 pandemic in 2020. Since it is a complex subject that could be discussed around various aspects, the study sets out from personal COVID-19 perceptions and experiences of both patients and psychotherapists as well as the perceived therapeutic alliance in the psychotherapy processes. Considering the global pandemic conditions, both psychotherapists and patients were exposed to the same external limitations at the same time, although they engage in different roles in the therapy process. Therefore, personal experiences and perceptions of both sides had to be taken into account in order to get a more holistic perception of the psychotherapy context.

4.1. Findings

4.1.1. Online Psychotherapy Experiences of Patients and Psychotherapists

In accordance with the existing literature, psychotherapists have noted that earlier experience of OPT is a significant aspect of this shift. In semi-structured interviews, psychotherapist A (Female, 50) stated that “I did not hesitate to offer OPT to my patients”, thinking that because she had an earlier OPT experience. Supporting that, psychotherapist E (Female, 41) ended her sessions with the lockdown and did not start OPT for three months stating that she thought that would end soon, and she was not prepared and had this belief that OPT would not be useful. After waiting for three months, she started to do online sessions and did not return to face-to-face sessions since then. As Fagundes et al. (2020) considered this as a limitation in doing research on OPT because the lack of earlier experience plays a significant role. Bekes et al. (2020) and Boldrini et al. (2020) concluded that past experiences of psychotherapists significantly influence their attitude towards OPT.

As well as earlier experiences, this study noted that the COVID-19 perceptions could be considered in accordance with the attitudes towards OPT for both groups of participants. Regarding psychotherapists, participants who state that the disadvantage of OPT is “the loss of a shared room” had significantly lower dangerousness, lower contagiousness, and lower P-COV-19 total scores. Similarly, patients who think that the disadvantage is “the loss of a shared room” have significantly lower COVID-19 contagiousness scores. Likewise, psychotherapists who noted that there are privacy issues as the disadvantage of OPT and OPT is more open to interruption had significantly lower COVID-19 contagiousness scores as well as significantly lower P-COV-19 scores. Notedly in literature, Gerhold (2020) addresses that risk perception and conscious fear result in two possible coping mechanisms that are defined as emotion-focused and problem-focused. Participants who are inclined more toward

problem-focused coping mechanisms prefer to listen to the experts and follow their advice while emotion-focused coping behaviors are linked with the will to turn back to work and distract themselves. This could be taken into consideration for the groups of patients and psychotherapists. Participants who perceive COVID-19 with lower contagiousness scores are more likely to turn back to face-to-face setting and emphasize OPT's disadvantages.

Although the loss of a shared room was a commonly reported problem with OPT leading to disembodiment of the psychotherapy context, it appears that there are different aspects to it. In semi-structured interviews, patient D (F, 32) pointed out that she is missing the smell of coffee in her psychotherapist's clinic, and emphasized the importance of being with her in the same room in waking her different senses. While she is missing the smell of fresh coffee, she mentioned that during the lockdown she wanted to buy the same room fragnance as her psychotherapist's. Recent studies included synchronized breathing patterns into these discussions. For psychotherapists and patients, it occurs when they sit close to each other in the same room (Rolnick & Ehrenreich, 2020). Supporting that, Porges (2011) argues that remote psychotherapy (OPT) would not allow making mutual regulation because there is no body in the room to regulate the other. There is also research focusing on the experiential aspect by pointing out that rituals such as ringing the buzzer at the door or sitting in the waiting area could have a function of splitting internal and external spaces within the psychotherapy process (Bondi, 2003). Patient C (F, 58) addressed that she thinks OPT is much easier in certain aspects than face-to-face psychotherapy. "I sometimes miss the rituals I have before and after my sessions. The clinic is located in a central place, and I used to take short walks before my sessions, and usually, I made dinner plans with a friend of mine afterwards. Now, I feel I miss this. But I have to say that most of the time I checked my back when I rang the buzzer. I kind of felt… I do not know. I did not want anybody to see me there going to a psychotherapy session.". In accordance with these comments, Singh and Sagar (2022) discussed stigmatization that could block patients from seeking help or prevent them from visiting a mental health professional. For such patients, OPT might be preferable to face-to-face psychotherapy. However, OPT has obligatory exposure to see a physical interior as well, such as a bedroom, kitchen, or study. Psychotherapist D (M, 32) complained about his setting as he feels he is supposed to be more attentive to control everything such as his pet or a fly in the room. Orbach (2020) explains this with an experience of a psychotherapist participant who states it is possible "to be surprised by an occasional child that floats in" and adds, "We hear the suddenly hushed voice of someone not wanting their partner to get a drift of the conversation we are having. It illuminates aspects we didn't see before. … Above all,

the animate body in the room. I suspect that I am more animated to make up for the loss of that precious physicality" (Orbach, 2020, n.p.). In accordance with this common consideration by psychotherapists in the semi-structured interviews, Porges (2011) claims that psychotherapy context is based on the experience of safety that the psychotherapist provides to their patient and the physical proximity in the face-to-face setting enhances the patient's perception of safety. In interviews, psychotherapist E (F, 41) stated that "At first it was much harder, but it still goes like this. I feel much more tired after online sessions. I think I am trying and working harder to hold them in the sessions, hold them on screen, hold them despite any distractions. When I think of tiredness, I cannot compare face-to-face sessions with OPT". On contrary, psychotherapist A (F, 51) claimed that patients have this feeling as well and because of this feeling her patients are trying to focus more compared to face-to-face psychotherapy setting.

This study found that the stated number of disadvantages and advantages of OPT have a correlational relationship with the experienced technical problems and working hours of psychotherapist. For patients, as the number of technical problems they experienced increased, the number of disadvantages they mentioned significantly increased as well. In a similar way, the group of psychotherapists mentioned significantly fewer advantages as their experience of technical problems increased. Sayers (2021) emphasized the importance of technical problems and included a psychotherapist's opinion: "For me, the most frustrating of all [interruptions] is when you have a client who has taken a long time to open up and talk about something very difficult...and then they freeze, or break up, or you do, and you are prevented from 'being with them' through this difficult experience" (p. 226). Similarly, in the current study, patient A (M, 25 years) made an analogy and stated that "It is like reading half of the poem as you should read it and continuing the other half as if it is a plain text." regarding continue the session after experience a technical issue in the middle of sessions. There is a similar analogy in the study by Bizzari (2022) which is put forward as something like "living a scene rather than an experience" (p. 340).

4.1.2. The Relationship between Online Psychotherapy and WAI

It is seen that seven studies which include nine countries affected by the mandatory OPT shift did not investigate COVID-19 history as a variable (Bekes and Aafjes-van Doorn, 2020; Humer et al., 2020; Korecka et al., 2020; Boldrini et al., 2020; Khatib et al., 2021; Kluzowicz & Kluzowicz, 202; Konieczny, 2021). Yet, psychotherapists who have first-degree relatives that tested COVID-19 positive perceived COVID-19 pandemic significantly more contagious. Additionally, they had significantly lower WAI-Bond, WAI-Goal, WAI-Task and WAI-Total

scores. In accordance with these findings, a systematic review by Cipoletta et al. (2022) noted that direct experience with COVID-19 has great effect on risk perception, and added that indirect experiences have an effect, too. Just like professionals including nurses, healthcare professionals, and physicians tend to perceive COVID-19 as riskier due to their vicarious exposure, it might be assumed that psychotherapists with first-degree relatives who tested positive might be more likely to perceive the condition as riskier.

Psychotherapists who had longer working hours noted significantly fewer advantages of OPT. Relatedly, for the group of psychotherapists, the number of disadvantages had a significant relationship with WAI-Bond scores. As the number of disadvantages increases, WAI-Bond scores tended to decrease. In line with these findings, Nissen-Lie (2014) addressed that therapists' negative reactions and/or their in-session anxiety are related to WAI scores. A similar tendency in the patient group was noted for the participants who stated there are no advantages of OPT. In line with the results of psychotherapists, patients who did not state any advantages had significantly lower WAI-Bond scores.

Notedly in semi-structured interviews, living alone or living with at least one person appeared to have a great role considering the process of OPT during the COVID-19 pandemic. Patient A (M, 25 years) defined his main issue with OPT as his household which consisted of his father, mother, aunt, and her husband. He emphasized that he was not aware that he had an auto-sensor mechanism until he returned to face-to-face sessions. He stated that it was incredible for him to let himself free and open in his home. Supporting that, patient B (F, 30 years) who lives with her mother and grandmother has a similar worry, and she stated: "I did my sessions knowing that they can hear me, so it was sort of boring and nonsense sessions. After lockdown conditions got easier, I started to do the sessions in outdoor places.". Psychotherapist G (F, 29 years), psychotherapist C (M, 42 years) and E (F, 41 years) emphasized that they had patients who had to end sessions due to their house environment and lack of a comfort place to attend sessions. Yet, psychotherapists in semi-structured interviews were glad about their household and 8 out of 9 psychotherapists were living at least with one person. Psychotherapist A (F, 50) mentioned that her son gave her technical support while psychotherapist K (M, 34) was glad that he is married and has his wife's psychological support during the pandemic.

For patients, the length of their current psychotherapy was significantly and positively correlated with WAI scores. The longer they were in the psychotherapy process, the higher were their WAI-Bond, WAI-Goal, WAI-Task and WAI-Total. On the other hand, patients who previously have longer psychotherapy process with other psychotherapists than current have

significantly lower WAI-Bond scores. As Hill et al. (2014) found there is no association between the length of the psychotherapy process and alliance, these findings support the claims by Herzoug (2001), Kasper et al. (2008) and Shafran (2016) that address current and past relationships affecting early working alliance. Considering as an in-session consequence, studies emphasize the immediacy that patients experience which provides them to score higher in therapeutic alliance and rate higher quality for their sessions. Immediacy defined and associated as "emotional awareness or insight, resolution of problems in the therapeutic relationship, and a model for how clients could resolve relationship problems outside of therapy" which is possible to develop over the course of time (Shafran, 2016, p. 9).

As the loss of a shared room is a common debatable issue for OPT, it was found that among psychotherapists, participants who returned to face-to-face psychotherapy setting anytime between lockdowns had significantly higher WAI-Bond, higher WAI-Goal and higher WAI-Total scores. Findings support the studies by Rees and Stone (2005) and Rickard et al. (2021) addressing that videoconferencing conditions lead to lower therapeutic alliance scores compared to face-to-face setting. Rickard et al. (2021) indicated that eye contact, proximity and sitting in the same room are highly effective on developing therapeutic alliance. Current study also revealed that preferred online communication platforms might be related to OPT experiences. Patients who attended their sessions via Zoom reported significantly fewer numbers of disadvantages of OPT. Compared to other online platforms such as Skype, WhatsApp, or FaceTime; Zoom has a setting that allows psychotherapists to use a waiting room for their patients. Patients must wait until their psychotherapists let them in the meeting room to start the session. By doing this, both patients and psychotherapists might be involved in a setting that relatively demonstrates the traditional entrance that is discussed by Bondi (2003) and Sayers (2021) considering the experience of stepping into "inside" and "outside". Providing this, Zoom user participants whose experience a virtual waiting room and be greeted by their psychotherapists could perceive fewer disadvantages of OPT.

4.2. Limitations and Implications for Further Research

There are limitations in this study that should be taken into consideration while evaluating the findings. The number of participants was relatively limited, and since the sample consisted of volunteers, there was no way to ensure representation of the overall psychotherapist population in Turkey. In addition, the majority of the sample consisted of female participants.

Another possible limitation was the theoretical orientations of psychotherapists. There is research indicating that CBT-oriented psychotherapists have more positive attitudes towards

OPT compared to psychodynamically-oriented psychotherapists in USA and Canada (Bekes and Aafjes-van Doorn, 2020), although it was also suggested that CBT-oriented psychotherapists had more difficulty in shifting to OPT compared to psychodynamically-oriented psychotherapists in Italy (Boldrini et al., 2020). The current study sample did not have equally distributed participants from different orientations but mostly consisted of psychodynamically-oriented psychotherapists. Therefore, it is not clear whether those working from other theoretical orientations would indicate similar points. It should, however, be noted that there are also similarities across orientations among psychotherapists' perceptions of OPT during the pandemic (Humer et al., 2021; Messina and Loffler-Stastka, 2021; Stefan et al., 2021).

In addition to the characteristics of the sample, there are certain methodological limitations. Since the survey was based on self-report, it was not possible to objectively verify participants' answers. Social desirability effect and a number of different potential motivations might have affected participants' reactions. For future research, it is recommended that semi-structured or in-depth interviews would be conducted with more psychotherapists with different theoretical backgrounds. Furthermore, there are studies suggesting that personal reactions to such a global and social shift along with new rules and restrictions might be influenced by different social and cultural parameters (Alqahtani et al., 2021; Vaughan and Tinker, 2009;). Therefore, such social and cultural factors should also be explored in future studies, particularly in interviews. Another limitation is related to the use of WAI. Current study lacks WAI scores data of participants before the COVID-19 pandemic, therefore it was not possible to detect whether the pandemic conditions led to a change in the perceived working alliance. In addition, while measuring the WAI scores of psychotherapists, there was not specifically paired patient of theirs. Furthermore, cultural and social factors should also be explored in the future studies, in addition to individually experienced difficulties, such as financial problems.

Therewithal, this study provides insight into comprehending the mandatory and rapid shift that the psychotherapy setting got exposed to. The current study tried to address relationships between COVID-19 experiences and OPT, by taking the experiences of both patients and psychotherapists into consideration. The study emphasizes the concerns, difficulties, and benefits that both sides experience whilst present a general understanding on which factors could lead to a harder or easier OPT experience.

REFERENCES

Alqahtani, M. M., Arnout, B. A., Fadhel, F. H., & Sufyan, N. S. S. (2021). Risk perceptions of COVID-19 and its impact on precautionary behavior: A qualitative study. *Patient Education and Counseling*, *104*(8), 1860-1867.

Augé, M. (1995). *Non-places: An introduction to supermodernity*. London: Verso.

Asmundson, G. J., Paluszek, M. M., Landry, C. A., Rachor, G. S., McKay, D., & Taylor, S. (2020). Do pre-existing anxiety related, and mood disorders differentially impact COVID-19 stress responses and coping? *Journal of Anxiety Disorders, 74*,102271. doi: 10.1016/j.janxdis.2020.102271

Barak, A., Hen, L., Boniel-Nissim, M., & Shapira, N. (2008). A comprehensive review and a meta-analysis of the effectiveness of internet-based psychotherapeutic interventions. *Journal of Technology in Human Services*, *26*(2–4), 109–160. https://doi.org/10.1080/15228830802094429

Baranger, M., Baranger, W., & Mom, J. (2002). Processo e não processo no trabalho analítico. *Revista FEPAL*, 114-131.

Backhaus, A., Agha, Z., Maglione, M. L., Repp, A., Ross, B., Zuest, D., Rice-Thorp, N. M., Lohr, J., & Thorp, S. R. (2012). Videoconferencing psychotherapy: A systematic review. *Psychological Services, 9*(2), 111–131. https://doi.org/10.1037/a0027924

Beck-Hiestermann, F. M. L., Kästner, D., & Gumz, A. (2021). Online psychotherapy in times of coronavirus disease 2019: Cross-sectional survey of German psychotherapists. *Psychotherapeut*, *66*(5), 372–381. https://doi.org/10.1007/s00278-021-00519-0

Békés, V., & Doorn, K. A. van. (2020). Psychotherapists' attitudes toward online therapy during the COVID-19 Pandemic. *Journal of Psychotherapy Integration*, *30*(2), 238–247. https://doi.org/10.1037/int0000214

Bizzari, V. (2022). Absent bodies: Psychotherapeutic challenges during COVID-19. *Psychopathology*, *55*(6), 335-344.

Boldrini, T., Schiano Lomoriello, A., del Corno, F., Lingiardi, V., & Salcuni, S. (2020). Psychotherapy During COVID-19: How the Clinical Practice of Italian Psychotherapists Changed During the Pandemic. *Frontiers in Psychology*, *11,* 591170. https://doi.org/10.3389/fpsyg.2020.591170

Bondi, L., & Fewell, J. (2003). "Unlocking the cage door": The spatiality of counselling. *Social and Cultural Geography*, *4*(4), 527–547. https://doi.org/10.1080/1464936032000137948

Bordin, E. S. (1979). The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy: Theory, research & practice*, *16*(3), 252.

Brahnam, S. (2014). Therapeutic presence in mediated psychotherapy: The uncanny stranger in the room. In *Interacting with Presence: HCI and the Sense of Presence in Computer-Mediated Environments* (pp. 123–138). De Gruyter Open Ltd. https://doi.org/10.2478/9783110409697.8

Brooks, S. K., Webster, R. K., Smith, L. E., Woodland, L., Wessely, S., Greenberg, N., et al. (2020). The psychological impact of quarantine and how to reduce it: rapid review of the evidence. *Lancet, 395*, 912–920. doi: 10.1016/S0140-6736(20)30460-8

Catty, J. (2004). 'The vehicle of success': Theoretical and empirical perspectives on the therapeutic alliance in psychotherapy and psychiatry. *Psychology and Psychotherapy: Theory, Research and Practice*, *77*(2), 255-272.

Cipolletta, S., Andreghetti, G. R., & Mioni, G. (2022). Risk perception towards COVID-19: A systematic review and qualitative synthesis. *International Journal of Environmental Research and Public Health*, *19*(8), 4649.

Connolly, S. L., Miller, C. J., Lindsay, J. A., & Bauer, M. S. (2020). A systematic review of providers' attitudes toward telemental health via videoconferencing. *Clinical Psychology: Science and Practice*, *27*(2), 10.1111/cpsp.12311. https://doi.org/10.1111/cpsp.12311

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

Davidson, J. (2000) A phenomenology of fear: Merleau-Ponty and agoraphobic life-worlds, *Sociology of Health and Illness: A Journal of Medical Sociology, 22*, 640–660.

de Bitencourt Machado, D., Braga Laskoski, P., Trelles Severo, C., Margareth Bassols, A., Sfoggia, A., Kowacs, C., Valle Krieger, D., Benetti Torres, M., Bento Gastaud, M., Stella Wellausen, R., Pigatto Teche, S., & Laks Eizirik, C. (2016). A psychodynamic perspective on a systematic review of online psychotherapy for adults. *British Journal of Psychotherapy*, *32*(1), 79–108. https://doi.org/10.1111/bjp.12204

del Re, A. C., Flückiger, C., Horvath, A. O., Symonds, D., & Wampold, B. E. (2012). Therapist effects in the therapeutic alliance-outcome relationship: A restricted-maximum likelihood meta-analysis. *Clinical Psychology Review*, *32*(7), 642–649. https://doi.org/10.1016/j.cpr.2012.07.002

Drath, W., & Necki, S. (2018). Online psychotherapy: Polish psychotherapists' perspective. *Psychoterapia*, *186*(3), 55-63.

Erikson, E. H. (1955). Freud's' The Origins of Psycho-Analysis. *International Journal of Psycho-Analysis*, *36*, 1-15.

Ertelt, T. W., Crosby, R. D., Marino, J. M., Mitchell, J. E., Lancaster, K., & Crow, S. J. (2011). Therapeutic factors affecting the cognitive behavioral treatment of bulimia nervosa via

telemedicine versus face-to-face delivery. *International Journal of Eating Disorders*, *44*(8), 687–691. https://doi.org/10.1002/eat.20874

Essig, T. (2015). The gains and losses of screen relations: Aclinical approach to simulation entrapment and simulation avoidance in a case of excessive internet pornography use. *Contemporary Psychoanalysis*, *51*(4), 680–703. https://doi.org/10.1080/00107530.2015.1023669

Freud, Sigmund. (1916). Analysis of the Phobia of a Five-Year-Old Boy. *The Psychoanalytic Review (1913-1957)*, *3*(90).

Freir, V., Kirkwood, K., Peck, D., Robertson, S., Scott-Lodge, L., & Zeffert, S. (1999). Telemedicine for clinical psychology in the Highlands of Scotland. *Journal of Telemedicine and telecare*, *5*(3), 157-161.

Frykman, J. (2012). *Berörd: plats, kropp och ting i fenomenologisk kulturanalys*. Carlssons.

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. https://doi.org/10.1111/papt.12359

Geniş, B., Gürhan, N., Koç, M., Geniş, Ç., Şirin, B., Çırakoğlu, O. C., & Coşar, B. (2020). Development of perception and attitude scales related with COVID-19 pandemia. *Pearson Journal of Social Sciences-Humanities*, *5*(7), 306-328

Gerhold, L. (2020). COVID-19: risk perception and coping strategies.

Greenson R. R. (1965), The working alliance and the transference neurosis. In: *Explorations in Psychoanalysis.* New York: International Universities Press, 1978, pp. 199–224.

Hantsoo, L., Podcasy, J., Sammel, M., Epperson, C. N., & Kim, D. R. (2017). Pregnancy and the acceptability of computer-based versus traditional mental-health treatments. J. *Womens Health 26,* 1106–1113. doi: 10.1089/jwh.2016.6255

Hersoug, A. G., Monsen, J. T., Havik, O. E., & Høglend, P. (2002). Quality of early working alliance in psychotherapy: Diagnoses, relationship and intrapsychic variables as predictors. *Psychotherapy and Psychosomatics*, *71*(1), 18-27.

Hill, C. E., Gelso, C. J., Chui, H., Spangler, P. T., Hummel, A., Huang, T., & Miles, J. R. (2014). To be or not to be immediate with clients: The use and perceived effects of immediacy in psychodynamic/interpersonal psychotherapy. *Psychotherapy Research*, *24*(3), 299-315.

Horvath, A. O., del Re, A. C., Flückiger, C., & Symonds, D. (2011). Alliance in Individual Psychotherapy. *Psychotherapy*, *48*(1), 9–16. https://doi.org/10.1037/a0022186

Horvath, A. O., & Greenberg, L. S. (1989). Development and validation of the Working Alliance Inventory. *Journal of Counseling Psychology*, *36*(2), 223.

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

Humer, E., Stippl, P., Pieh, C., Pryss, R., & Probst, T. (2020). Psychodynamic, humanistic, systemic, and behavioral psychotherapists' experiences with remote psychotherapy during COVID-19 in Austria: A cross-sectional online survey. *Journal of Medical Internet Research*, *22*(11), e20246.

Humer, E., Haid, B., Schimböck, W., Reisinger, A., Gasser, M., Eichberger-Heckmann, H., ... & Probst, T. (2021). Provision of psychotherapy one year after the beginning of the COVID-19 pandemic in Austria. *International Journal of Environmental Research and Public Health*, *18*(11), 5843.

Inchausti, F., MacBeth, A., Hasson-Ohayon, I., & Dimaggio, G. (2020). Telepsychotherapy in the age of COVID-19: A commentary. In *Journal of Psychotherapy Integration* (Vol. 30, Issue 2, pp. 394–405). American Psychological Association Inc. https://doi.org/10.1037/int0000222

Kaplan, E. H. (1997). Telepsychotherapy: Psychotherapy by telephone, videotelephone, and computer videoconferencing. *Journal of Psychotherapy Practice and Research,6*, 227237.

Kasper, L. B., Hill, C. E., & Kivlighan Jr, D. M. (2008). Therapist immediacy in brief psychotherapy: Case study I. *Psychotherapy: Theory, Research, Practice, Training*, *45*(3), 281.

Kernberg, O. F. (2012). *The inseparable nature of love and aggression: Clinical and theoretical perspectives*. American Psychiatric Pub.

Khatib, A., Gelkopf, M., Kapolnik, E., & Hassan-Abbas, N. (2022). The assessment of effectiveness by therapists of online therapy during the COVID-19 pandemic era in Israel. *Journal of Psychotherapy Integration*, *32*(1), 83.

Kluzowicz, J., & Kluzowicz, M. (2021). PSYCHOTHERAPY DURING SOCIAL ISOLATION CAUSED BY COVID-19-THERAPISTS'AND CLIENTS'PERSPECTIVES. *Psychoterapia*, 5-31.

Konieczny, K. (2022). Online psychotherapy during COVID-19 pandemic–experiences of psychotherapists. Research review. *Archives of Psychiatry and Psychotherapy*, 37-41.

Korecka, N., Rabenstein, R., Pieh, C., Stippl, P., Barke, A., Doering, B., ... & Probst, T. (2020). Psychotherapy by telephone or internet in Austria and Germany which CBT psychotherapists rate it more comparable to face-to-face psychotherapy in personal contact and have more positive actual experiences compared to previous expectations. *International Journal Of Environmental Research and Public Health*, *17*(21), 7756.

Korkmaz, B. & Şen, G. (2018). Psikoterapistlerin çevrimiçi yürütülen psikoterapilere yönelik algılarına ilişkin bir tematik analiz çalışması. *Klinik Psikoloji Dergisi*, *2*(3). https://doi.org/10.31828/kpd2602443829092018m000004

Larsen, I. (2011). Materiality talks. Including materiality in mental health research. *INTERACTIONS, HEALTH AND COMMUNITY*, 101.(255–267). Pisa: Pisa University Press.

Machado, L. F., Feijó, L. P., & Serralta, F. B. (2020). Online psychotherapy practice by psychodynamic therapists. *Psico*, *51*(3), e36529-e36529. https://doi.org/10.15448/1980-8623.2020.3.36529

Messina, I., & Loffler-Stastka, H. (2021). Psychotherapists' perception of their clinical skills and in-session feelings in live therapy versus online therapy during the COVID-19 pandemic: a pilot study. *Research in Psychotherapy: Psychopathology, Process, and Outcome*, *24*(1).

Milner, M. (1952). Aspects of symbolism in comprehension of the not-self. *International Journal of Psychoanalysis*, *33*, 181-194.

Nissen-Lie, H. A., Havik, O. E., Høglend, P. A., Rønnestad, M. H., & Monsen, J. T. (2015). Patient and therapist perspectives on alliance development: Therapists' practice experiences as predictors. *Clinical psychology & psychotherapy*, *22*(4), 317-327.

Norcross, J. C., Hedges, M., & Prochaska, J. O. (2002). The Face of 2010: A Delphi Poll on the Future of Psychotherapy. *Professional Psychology: Research and Practice*, *33*(3), 316–322. https://doi.org/10.1037/0735-7028.33.3.316

Ogden, T. H. (2004). The analytic third: Implications for psychoanalytic theory and technique. In *Psychoanalytic Quarterly* (Vol. 73, Issue 1, pp. 167–195). Wiley-Blackwell Publishing Ltd. https://doi.org/10.1002/j.2167-4086.2004.tb00156.x

Orbach, S. (2020) Patterns of pain: What Covid-19 can teach us about how to be human.The Guardian, 7 May.

Porges, S. W. (2021). *Polyvagal Safety: Attachment, Communication, Self-Regulation (IPNB)*. WW Norton & Company.

Punzi, E., & Singer, C. (2018). 'Any room won't do.' Clinical psychologists' understanding of the consulting room. An interview study. *Psychodynamic Practice*, *24*(4), 319–333. https://doi.org/10.1080/14753634.2018.1526107

Rickard, E., Hevey, D., & Wilson, C. (2021). The impact of seating arrangement and therapy task on therapeutic alliance formation. *Counselling and Psychotherapy Research*, *21*(3), 683-696.

Rees, C. S., & Stone, S. (2005). Therapeutic alliance in face-to-face versus videoconferenced psychotherapy. *Professional Psychology: Research and Practice*, *36*(6), 649.

Rochlen, A. B., Zack, J. S., & Speyer, C. (2004). Online Therapy: Review of Relevant Definitions, Debates, and Current Empirical Support. In *Journal of Clinical Psychology* (Vol. 60, Issue 3, pp. 269–283). https://doi.org/10.1002/jclp.10263

Roesler, C. (2017). Tele-analysis: the use of media technology in psychotherapy and its impact on the therapeutic relationship. *Journal of Analytical Psychology*, *62*(3), 372–394. https://doi.org/10.1111/1468-5922.12317

Rogers, C. R. (1957). The necessary and sufficient conditions of therapeutic personality change. *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 Video Psychotherapy. *Biofeedback*, *48*(1), 20–23. https://doi.org/10.5298/1081-5937-48.1.1

Ronen-Setter, I. H., & Cohen, E. (2020). Becoming "Teletherapeutic": Harnessing Accelerated Experiential Dynamic Psychotherapy (AEDP) for Challenges of the Covid-19 Era. *Journal of Contemporary Psychotherapy*, *50*(4), 265–273. https://doi.org/10.1007/s10879-020-09462-8

Sayers, J. (2021). Online Psychotherapy: Transference and Countertransference Issues. *British Journal of Psychotherapy*, *37*(2), 223–233. https://doi.org/10.1111/bjp.12624

Schopp, L., Johnstone, B., & Merrell, D. (2000). Telehealth and neuropsychological assessment: New opportunities for psychologists. *Professional Psychology: Research and Practice*, *31*(2), 179–183. https://doi.org/10.1037/0735-7028.31.2.179

Sfoggia, A., Kowacs, C., Gastaud, M. B., Laskoski, P. B., Bassols, A. M., Severo, C. T., Machado, D., Krieger, D. V., Torres, M. B., Teche, S. P., Wellausen, R. S., & Eizirik, C. L. (2014). Relação terapêutica na rede: To face or not to face? In *Trends in Psychiatry and Psychotherapy 36*(1), 3–10. Sociedade de Psiquiatria do Rio Grande do Sul. https://doi.org/10.1590/2237-6089-2013-0048

Shafran, N., Kivlighan, D. M., Gelso, C. J., Bhatia, A., & Hill, C. E. (2016). Therapist immediacy: The association with working alliance, real relationship, session quality, and time in psychotherapy. *Psychotherapy Research*, *27*(6), 737-748.

Shatri, H., Prabu, O. G., Tetrasiwi, E. N., Faisal, E., Putranto, R., & Ismail, R. I. (2021). The role of online psychotherapy in COVID-19: an evidence based clinical review. *Acta Med Indones*, *53*(3), 352-359.

Shaw, R. (2004). *The embodied psychotherapist: The therapist's body story*. Routledge.

Siegel, M. L., Gullestad Binder, E. M., Dahl, H. S. J., Czajkowski, N. O., Critchfield, K. L., Høglend, P. A., & Ulberg, R. (2020). Therapeutic Atmosphere in Psychotherapy Sessions. *International Journal of Environmental Research And Public Health*, *17*(11), 4105.

Siegmund, G., & Lisboa, C. (2015). Orientação Psicológica On-line: Percepção dos Profissionais sobre a Relação com os Clientes. *Psicologia: Ciência e Profissão*, *35*(1), 168–181. https://doi.org/10.1590/1982-3703001312012

Simpson, S., Morrow, E., Jones, M., Ferguson, J., & Brebner, E. (2002). Tele-hypnosis the provision of specialized therapeutic treatments via teleconferencing. *Journal of Telemedicine and Telecare,8*(2), 7879.

Simpson, S. (2009). Psychotherapy via videoconferencing: A review. *British Journal of Guidance & Counselling*, *37*(3), 271-286.https://doi.org/10.1080/03069880902957007

Simpson, S. G., & Reid, C. L. (2014). Therapeutic alliance in videoconferencing psychotherapy: A review. *Australian Journal of Rural Health*, *22*(6), 280-299.

Singh, S., & Sagar, R. (2022). Online Psychotherapy During the COVID-19 Pandemic: The Good, the Bad, and the Ugly. In *Indian Journal of Psychological Medicine* (Vol. 44, Issue 2, pp. 177–180). SAGE Publications Ltd. https://doi.org/10.1177/02537176211070427

Soygüt, G., & Işikli, S. (2008). Assessment of the Therapeutic Alliance: Reliability and Validity of the Working Alliance Inventory. *Turkish Journal of Psychiatry*, *19*(4).

Stadter, M. (2012). Presence and the present–Relationship and time in contemporary psychodynamic psychotherapy. *Maryland: Jason Aronson*.

Stefan, R., Mantl, G., Höfner, C., Stammer, J., Hochgerner, M., & Petersdorfer, K. (2021). Remote psychotherapy during the COVID-19 pandemic. Experiences with the transition and the therapeutic relationship. A longitudinal mixed-methods study. *Frontiers in psychology*, *12*, 5500.

Stoll, J., Müller, J. A., & Trachsel, M. (2020). Ethical issues in online psychotherapy: A narrative review. *Frontiers in psychiatry*, *10*, 993. https://doi.org/10.3389/fpsyt.2019.00993

Swartz, H. A. (2020). The role of psychotherapy during the COVID-19 pandemic. *American Journal of Psychotherapy*, *73*(2), 41-42.

Titzler, I., Saruhanjan, K., Berking, M., Riper, H., & Ebert, D. D. (2018). Barriers and facilitators for the implementation of blended psychotherapy for depression: A qualitative pilot study of therapists' perspective. *Internet interventions*, *12*, 150-164.

Topooco, N., Riper, H., Araya, R., Berking, M., Brunn, M., Chevreul, K., ... & behalf of the E-COMPARED, O. (2017). Attitudes towards digital treatment for depression: a European stakeholder survey. *Internet interventions*, *8*, 1-9.

Tschacher, W., & Pfammatter, M. (2016). Embodiment in psychotherapy—A necessary complement to the canon of common factors. *European Psychotherapy*, *13*, 9-25.

Vaughan, E., & Tinker, T. (2009). Effective health risk communication about pandemic influenza for vulnerable populations. *American Journal Of Public Health*, *99*(S2), S324-S332.

Venkatesh, V., Morris, M. G., Davis, G. B., & Davis, F. D. (2003). User acceptance of information technology: Toward a unified view. *MIS quarterly*, 425-478.

Venkatesh, V., Thong, J. Y., & Xu, X. (2012). Consumer acceptance and use of information technology: extending the unified theory of acceptance and use of technology. *MIS quarterly*, 157-178.

Winnicott, D. W. (1971). Playing and reality. *London: Routledge*.

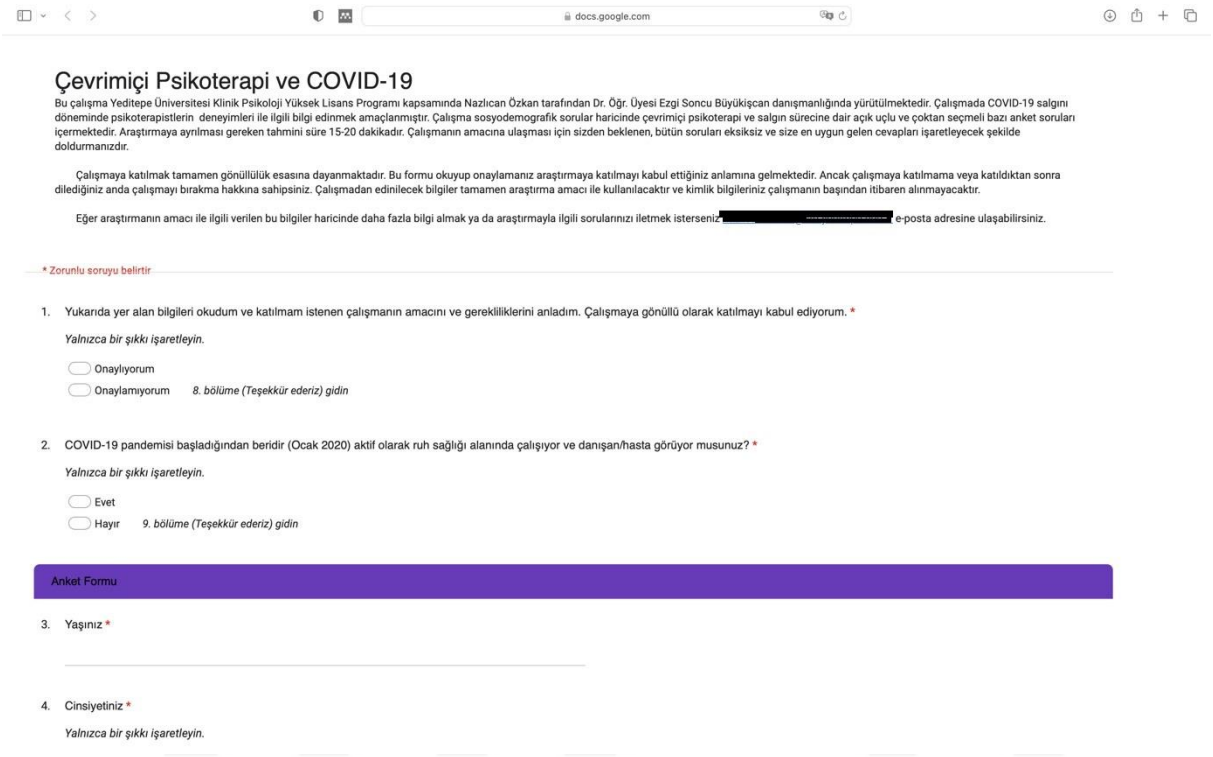
Yılmaz, M, B. Ve Kavanoz, S. (2017). Teknoloji Kabul ve Kullanım Birleştirilmiş Modeli-2 Ölçeğinin Türkçe Formunun Geçerlik ve Güvenilirlik Çalışması. *Journal of Turkish Studies*, *12*(32), 127–146. https://doi.org/10.7827/turkishstudies.12064

Zetzel, E. R. (1956). An approach to the relation between concept and content in psychoanalytic theory: With special reference to the work of Melanie Klein and her followers. *The Psychoanalytic Study of the Child*, *11*(1), 99-121.

APPENDIX

Appendix A

Terapist – Anket Formu



docs.google.com

Çevrimiçi Psikoterapi ve COVID-19

Bu çalışma Yeditepe Üniversitesi Klinik Psikoloji Yüksek Lisans Programı kapsamında Nazlıcan Özkan tarafından Dr. Öğr. Üyesi Ezgi Soncu Büyükişcan danışmanlığında yürütülmektedir. Çalışmada COVID-19 salgını döneminde psikoterapistlerin deneyimleri ile ilgili bilgi edinmek amaçlanmıştır. Çalışma sosyodemografik sorular haricinde çevrimiçi psikoterapi ve salgın sürecine dair açık uçlu ve çoktan seçmeli bazı anket soruları içermektedir. Araştırmaya ayrılması gereken tahmini süre 15-20 dakikadır. Çalışmanın amacına ulaşması için sizden beklenen, bütün soruları eksiksiz ve size en uygun gelen cevapları işaretleyecek şekilde doldurmanızdır.

Çalışmaya katılmak tamamen gönüllülük esasına dayanmaktadır. Bu formu okuyup onaylamanız araştırmaya katılmayı kabul ettiğiniz anlamına gelmektedir. Ancak çalışmaya katılmama veya katıldıktan sonra dilediğiniz anda çalışmayı bırakma hakkına sahipsiniz. Çalışmadan edinilecek bilgiler tamamen araştırma amacı ile kullanılacaktır ve kimlik bilgileriniz çalışmanın başından itibaren alınmayacaktır.

Eğer araştırmanın amacı ile ilgili verilen bu bilgiler haricinde daha fazla bilgi almak ya da araştırmayla ilgili sorularınızı iletmek isterseniz [redacted] e-posta adresine ulaşabilirsiniz.

* Zorunlu soruyu belirtir

1. Yukarıda yer alan bilgileri okudum ve katılmam istenen çalışmanın amacını ve gerekliliklerini anladım. Çalışmaya gönüllü olarak katılmayı kabul ediyorum. *

   Yalnızca bir şıkkı işaretleyin.

   - ◯ Onaylıyorum
   - ◯ Onaylamıyorum *8. bölüme (Teşekkür ederiz) gidin*

2. COVID-19 pandemisi başladığından beridir (Ocak 2020) aktif olarak ruh sağlığı alanında çalışıyor ve danışan/hasta görüyor musunuz? *

   Yalnızca bir şıkkı işaretleyin.

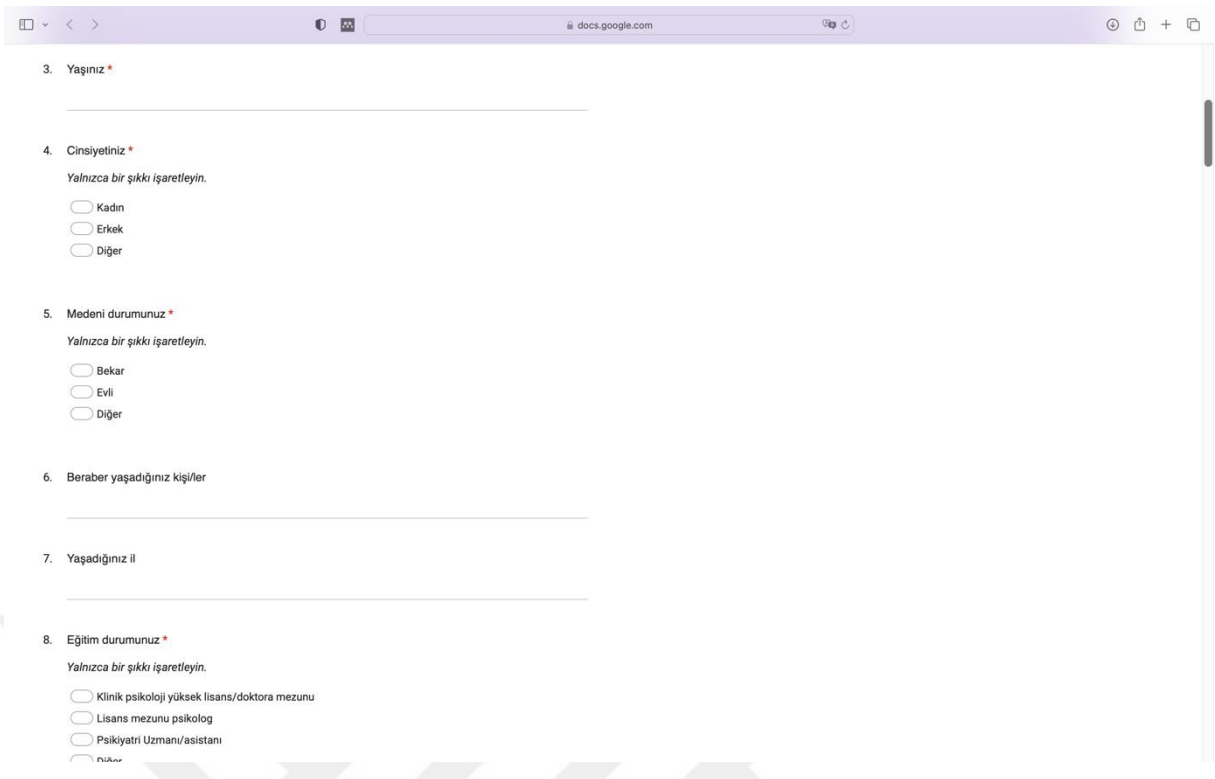
   - ◯ Evet
   - ◯ Hayır *9. bölüme (Teşekkür ederiz) gidin*

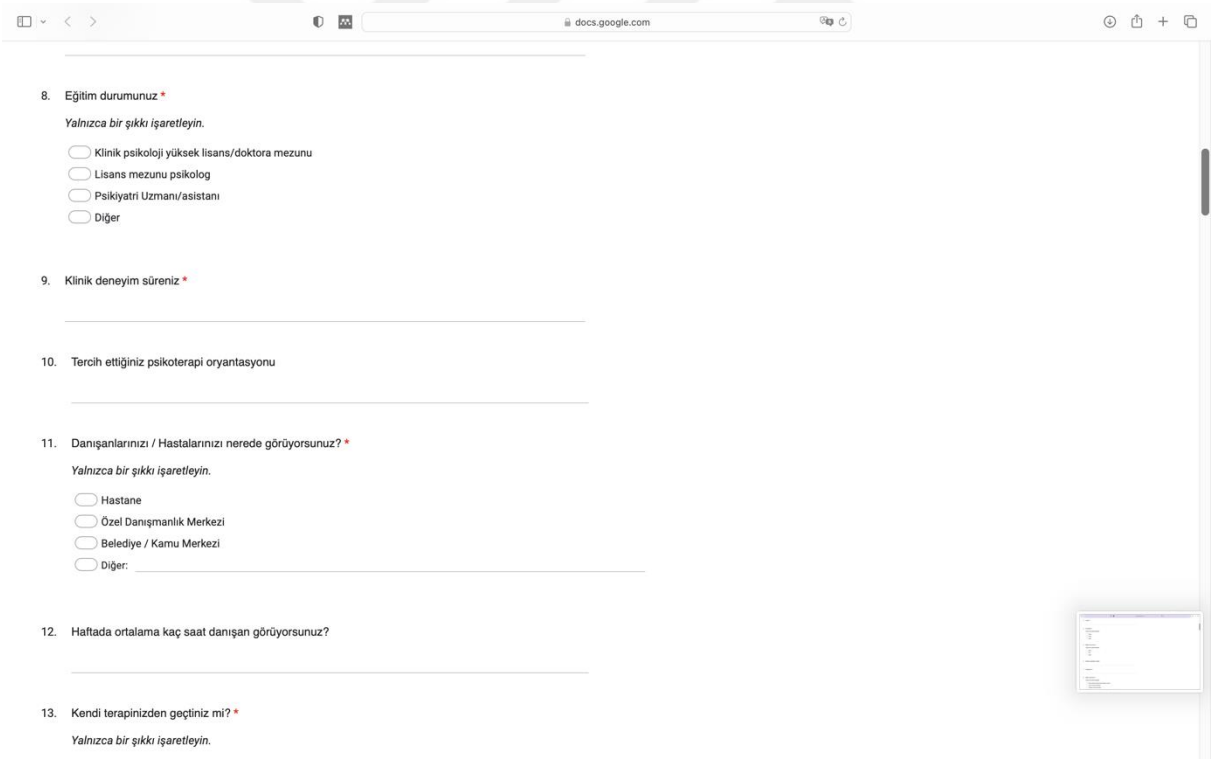
Anket Formu

3. Yaşınız *

4. Cinsiyetiniz *

   Yalnızca bir şıkkı işaretleyin.


docs.google.com
3. Yaşınız *
4. Cinsiyetiniz *
Yalnızca bir şıkkı işaretleyin.
Kadın
Erkek
Diğer
5. Medeni durumunuz *
Yalnızca bir şıkkı işaretleyin.
Bekar
Evli
Diğer
6. Beraber yaşadığınız kişi/ler
7. Yaşadığınız il
8. Eğitim durumunuz *
Yalnızca bir şıkkı işaretleyin.
Klinik psikoloji yüksek lisans/doktora mezunu
Lisans mezunu psikolog
Psikiyatri Uzmanı/asistanı


docs.google.com
8. Eğitim durumunuz *
Yalnızca bir şıkkı işaretleyin.
Klinik psikoloji yüksek lisans/doktora mezunu
Lisans mezunu psikolog
Psikiyatri Uzmanı/asistanı
Diğer
9. Klinik deneyim süreniz *
10. Tercih ettiğiniz psikoterapi oryantasyonu
11. Danışanlarınızı / Hastalarınızı nerede görüyorsunuz? *
Yalnızca bir şıkkı işaretleyin.
Hastane
Özel Danışmanlık Merkezi
Belediye / Kamu Merkezi
Diğer:
12. Haftada ortalama kaç saat danışan görüyorsunuz?
13. Kendi terapinizden geçtiniz mi? *
Yalnızca bir şıkkı işaretleyin.

13. Kendi terapinizden geçtiniz mi? *

Yalnızca bir şıkkı işaretleyin.

- ◯ Evet
- ◯ Hayır
- ◯ Devam ediyor

14. Danışan olarak ne kadar süreyle bir terapi süreci içinde bulundunuz?

15. COVID-19 sürecinde (Mart 2020'den itibaren): *

Uygun olanların tümünü işaretleyin.

- ☐ COVID-19 Pozitif oldum
- ☐ COVID-19 Pozitif olmadım
- ☐ Birinci derece yakınlarım pozitif oldu
- ☐ Kayıp yaşadım

16. COVID-19 sürecinde hangi tarihlerde online psikoterapi yaptınız?

17. Pandemi sürecinde online terapiden yüz yüze psikoterapiye döndünüz mü? Döndüyseniz ne kadar süre ile yüz yüze terapi hizmeti verdiğinizi belirtiniz.

18. Online psikoterapi için kullandığınız platform/lar *

Uygun olanların tümünü işaretleyin.

- ☐ Skype
- ☐ Zoom
- ☐ WhatsApp
- ☐ Diğer: _____

docs.google.com

19. Online psikoterapi sırasında teknik sorunlardan hangilerini deneyimlediniz? *

Uygun olanların tümünü işaretleyin.

- ☐ Senkron bozulması
- ☐ İnternetin kesilmesi
- ☐ Bağlantının kopması
- ☐ Görüntünün donması
- ☐ Hiçbir teknik aksaklık yaşamadım
- ☐ Diğer: _____

20. *

Her satırda yalnızca bir şıkkı işaretleyin.

	Kesinlikle katılmıyorum	Katılmıyorum	Kararsızım	Katılıyorum	Kesinlikle katılıyorum
Teknik sorunların psikoterapi sürecinde olumsuz etkileri olduğunu düşünüyorum.	◯	◯	◯	◯	◯
Teknik sorunların danışanlarda olumsuz duygular uyandırdığını düşünüyorum.	◯	◯	◯	◯	◯

21. *

Uygun olanların tümünü işaretleyin.

	Kayıtsızlık	Panik	Öfke	Hayal kırıklığı	Değersizlik	Ümitsizlik	Kaygı	Diğer
Yaşanan teknik sorunlar sizde hangi duyguları uyandırıyor?	☐	☐	☐	☐	☐	☐	☐	☐

22. Yukarıdaki soruya "Diğer" cevabını verdiyseniz, deneyimlediğiniz duyguyu lütfen belirtiniz.

23. Size göre online psikoterapide verdiğiniz hizmeti/psikoterapi sürecini zorlaştıran şeyler var mı? Varsa nelerdir?

23. Size göre online psikoterapide verdiğiniz hizmeti/psikoterapi sürecini zorlaştıran şeyler var mı? Varsa nelerdir?

24. Size göre online psikoterapide verdiğiniz hizmeti/psikoterapi sürecini kolaylaştıran şeyler var mı? Varsa nelerdir?

25. Size göre online psikoterapi görüşmelerinde çalışmanın daha kolay olduğunu düşündüğünüz danışanlarınızın ortak birtakım özellikleri var mı?

Yalnızca bir şıkkı işaretleyin.

- Evet
- Hayır

26. Varsa bunlar nelerdir?

27. Size göre online psikoterapi görüşmelerinde çalışmanın daha zor olduğunu düşündüğünüz danışanlarınızın birtakım ortak özellikleri var mı?

Yalnızca bir şıkkı işaretleyin.

- Evet
- Hayır

28. Varsa bunlar nelerdir?

29. Yüz yüze görüşmeler ardından zorunlu online psikoterapiye geçiş süreciyle ilgili sizin eklemek istediğiniz gözlemleriniz/yorumlarınız…

docs.google.com

COVID-19 Dönemi

Aşağıdaki her bir cümleyi okuduktan sonra, ifadelerle ilgili değerlendirmenizi sağdaki beş seçenekten birine işaret koyarak yapınız.

30. *

Her satırda yalnızca bir şıkkı işaretleyin.

	Kesinlikle katılmıyorum	Katılmıyorum	Kararsızım	Katılıyorum	Kesinlikle katılıyorum
Bu hastalık söylendiği kadar tehlikeli değil.					
Medya salgını abartıyor.					
Virüs ölümcül bir hastalığa neden olmaktadır.					
Bu hastalık herkese bulaşabilir.					
Kolayca bulaşan bir hastalıktır.					
Hastalığın kadınlara ve erkeklere bulaşma olasılığı benzerdir.					
Virüs kargo veya alışveriş ürünlerinden bulaşabilir.					

Psikoterapi Değerlendirme Formu

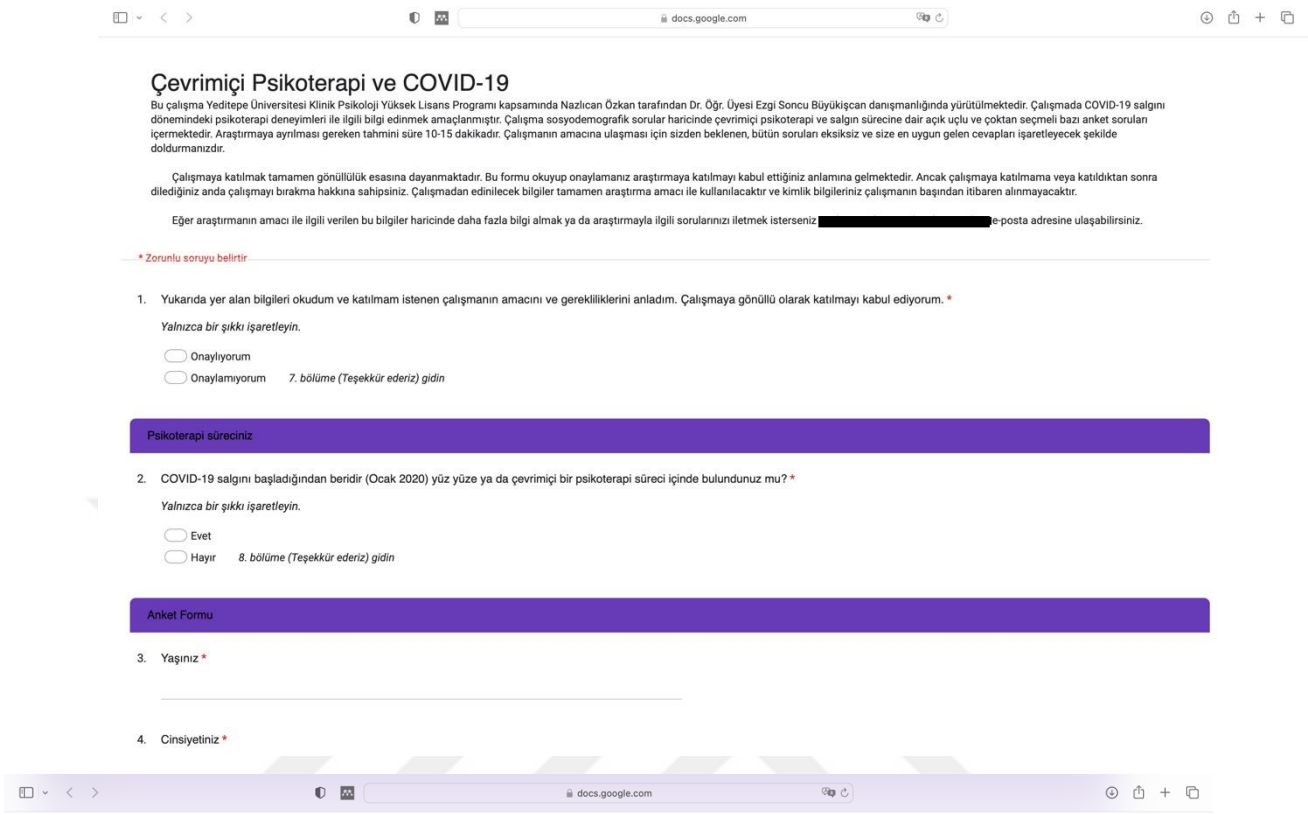
Aşağıdaki her bir cümleyi okuduktan sonra, ifadelerle ilgili değerlendirmenizi sağdaki yedi kutucuktan birine işaret koyarak yapınız.

31. *

Her satırda yalnızca bir şıkkı işaretleyin.

	Hiçbir zaman	Çok seyrek	Seyrek	Bazen	Sık sık	Çok sık	Her zaman
Hastamla kendimi rahat hissetmiyorum.							
Hastam ve ben, sorunlarının düzelmesi için terapide neler yapması gerektiği konusunda aynı şekilde düşünüyoruz.							

Danışan – Anket Formu



docs.google.com

Çevrimiçi Psikoterapi ve COVID-19

Bu çalışma Yeditepe Üniversitesi Klinik Psikoloji Yüksek Lisans Programı kapsamında Nazlıcan Özkan tarafından Dr. Öğr. Üyesi Ezgi Soncu Büyükişcan danışmanlığında yürütülmektedir. Çalışmada COVID-19 salgını dönemindeki psikoterapi deneyimleri ile ilgili bilgi edinmek amaçlanmıştır. Çalışma sosyodemografik sorular haricinde çevrimiçi psikoterapi ve salgın sürecine dair açık uçlu ve çoktan seçmeli bazı anket soruları içermektedir. Araştırmaya ayrılması gereken tahmini süre 10-15 dakikadır. Çalışmanın amacına ulaşması için sizden beklenen, bütün soruları eksiksiz ve size en uygun gelen cevapları işaretleyecek şekilde doldurmanızdır.

Çalışmaya katılmak tamamen gönüllülük esasına dayanmaktadır. Bu formu okuyup onaylamanız araştırmaya katılmayı kabul ettiğiniz anlamına gelmektedir. Ancak çalışmaya katılmama veya katıldıktan sonra dilediğiniz anda çalışmayı bırakma hakkına sahipsiniz. Çalışmadan edinilecek bilgiler tamamen araştırma amacı ile kullanılacaktır ve kimlik bilgileriniz çalışmanın başından itibaren alınmayacaktır.

Eğer araştırmanın amacı ile ilgili verilen bu bilgiler haricinde daha fazla bilgi almak ya da araştırmayla ilgili sorularınızı iletmek isterseniz [redacted] e-posta adresine ulaşabilirsiniz.

* Zorunlu soruyu belirtir

1. Yukarıda yer alan bilgileri okudum ve katılmam istenen çalışmanın amacını ve gerekliliklerini anladım. Çalışmaya gönüllü olarak katılmayı kabul ediyorum. *

Yalnızca bir şıkkı işaretleyin.

- ◯ Onaylıyorum
- ◯ Onaylamıyorum *7. bölüme (Teşekkür ederiz) gidin*

Psikoterapi süreciniz

2. COVID-19 salgını başladığından beridir (Ocak 2020) yüz yüze ya da çevrimiçi bir psikoterapi süreci içinde bulundunuz mu? *

Yalnızca bir şıkkı işaretleyin.

- ◯ Evet
- ◯ Hayır *8. bölüme (Teşekkür ederiz) gidin*

Anket Formu

3. Yaşınız *

4. Cinsiyetiniz *

docs.google.com

3. Yaşınız *

4. Cinsiyetiniz *

Yalnızca bir şıkkı işaretleyin.

- ◯ Kadın
- ◯ Erkek
- ◯ Diğer

5. Medeni durumunuz *

Yalnızca bir şıkkı işaretleyin.

- ◯ Bekar
- ◯ Evli
- ◯ Diğer

6. Beraber yaşadığınız kişi/ler

7. Yaşadığınız il

8. Eğitim durumunuz *

Yalnızca bir şıkkı işaretleyin.

- ◯ Lise Mezunu
- ◯ Lisans Mezunu
- ◯ Yüksek Lisans Mezunu
- ◯ Doktora Mezunu

9. Danışan olarak devam ettiğiniz terapi süreciniz ne zamandır devam ediyor? *

10. Daha önce başka bir psikoterapi sürecinde bulunmuş muydunuz? Bulunduysanız ne kadar süre ile? *

11. Seanslarınızı COVID-19 salgını öncesinde nerede gerçekleştiriyordunuz? *

Yalnızca bir şıkkı işaretleyin.

- ◯ Hastane
- ◯ Özel Danışmanlık Merkezi
- ◯ Belediye / Kamu Merkezi
- ◯ Diğer: _____

12. COVID-19 sürecinde (Mart 2020'den itibaren): *

Uygun olanların tümünü işaretleyin.

- ☐ COVID-19 Pozitif oldum
- ☐ COVID-19 Pozitif olmadım
- ☐ Birinci derece yakınlarım pozitif oldu
- ☐ Kayıp yaşadım

13. COVID-19 sürecinde hangi tarihlerde online psikoterapi hizmeti aldınız? *

14. Pandemi sürecinde online terapiden yüz yüze psikoterapiye döndünüz mü? Döndüyseniz ne kadar süre ile yüz yüze görüştüğünüzü belirtiniz.

15. Online psikoterapi için kullandığınız platform/lar *

docs.google.com

15. Online psikoterapi için kullandığınız platform/lar *

Uygun olanların tümünü işaretleyin.

- ☐ Skype
- ☐ Zoom
- ☐ WhatsApp
- ☐ Diğer: _____

16. Online psikoterapi hizmeti alırken aşağıdaki teknik sorunlardan hangilerini deneyimlediniz? *

Uygun olanların tümünü işaretleyin.

- ☐ Senkron bozulması
- ☐ İnternetin kesilmesi
- ☐ Bağlantının kopması
- ☐ Görüntünün donması
- ☐ Hiçbir teknik aksaklık deneyimlemedim
- ☐ Diğer: _____

17. *

Her satırda yalnızca bir şıkkı işaretleyin.

	Kesinlikle katılmıyorum	Katılmıyorum	Kararsızım	Katılıyorum	Kesinlikle katılıyorum
Teknik sorunların psikoterapi sürecinde olumsuz etkileri olduğunu düşünüyorum.	◯	◯	◯	◯	◯
Teknik sorunların psikoterapistimi olumsuz etkilediğini düşünüyorum.	◯	◯	◯	◯	◯

18. *

Uygun olanların tümünü işaretleyin.

	Kayıtsızlık	Panik	Öfke	Hayal kırıklığı	Değersizlik	Ümitsizlik	Kaygı	Diğer
Yaşanan teknik sorunlar sizde hangi duyguları uyandırıyor?	☐	☐	☐	☐	☐	☐	☐	☐

18. *

Uygun olanların tümünü işaretleyin.

	Kayıtsızlık	Panik	Öfke	Hayal kırıklığı	Değersizlik	Ümitsizlik	Kaygı	Diğer
Yaşanan teknik sorunlar sizde hangi duyguları uyandırıyor?	☐	☐	☐	☐	☐	☐	☐	☐

19. Yukarıdaki soruya "Diğer" cevabını verdiyseniz, deneyimlediğiniz duyguyu lütfen belirtiniz.

20. Size göre online psikoterapide aldığınız hizmeti/psikoterapi sürecini kolaylaştıran şeyler var mı? Varsa nelerdir?

21. Size göre online psikoterapide aldığınız hizmeti/psikoterapi sürecini zorlaştıran şeyler var mı? Varsa nelerdir?

22. Yüz yüze görüşmeler ardından zorunlu online psikoterapiye geçiş süreciyle ilgili sizin eklemek istediğiniz gözlemleriniz/yorumlarınız...

COVID-19 Dönemi

Aşağıdaki her bir cümleyi okuduktan sonra, ifadelerle ilgili değerlendirmenizi sağdaki beş seçenekten birine işaret koyarak yapınız.

23. *

Her satırda yalnızca bir şıkkı işaretleyin.

	Kesinlikle katılmıyorum	Katılmıyorum	Kararsızım	Katılıyorum	Kesinlikle katılıyorum
Bu hastalık söylendiği kadar tehlikeli değil.	◯	◯	◯	◯	◯
Medya salgını abartıyor.	◯	◯	◯	◯	◯
Virüs ölümcül bir hastalığa neden olmaktadır.	◯	◯	◯	◯	◯
Bu hastalık herkese bulaşabilir.	◯	◯	◯	◯	◯
Kolayca bulaşan bir hastalıktır.	◯	◯	◯	◯	◯
Hastalığın kadınlara ve erkeklere bulaşma olasılığı benzerdir.	◯	◯	◯	◯	◯
Virüs kargo veya alışveriş ürünlerinden bulaşabilir.	◯	◯	◯	◯	◯

docs.google.com

Aşağıdaki her bir cümleyi okuduktan sonra, ifadelerle ilgili değerlendirmenizi sağdaki beş seçenekten birine işaret koyarak yapınız.

23. *

Her satırda yalnızca bir şıkkı işaretleyin.

Değerlendirme Formu

Aşağıdaki her bir cümleyi okuduktan sonra, ifadelerle ilgili değerlendirmenizi sağdaki yedi kutucuktan birine işaret koyarak yapınız.

24. *

Her satırda yalnızca bir şıkkı işaretleyin.

	Hiçbir zaman	Çok seyrek	Seyrek	Bazen	Sık sık	Çok sık	Her zaman
Terapistimin yanında kendimi rahat hissetmiyorum.	◯	◯	◯	◯	◯	◯	◯
Terapistim ve ben sorunlarımın düzelmesi için terapide neler yapmam gerektiği konusunda aynı şekilde düşünüyoruz.	◯	◯	◯	◯	◯	◯	◯
Bu görüşmelerin sonucunda ne olacağı konusunda endişelerim var.	◯	◯	◯	◯	◯	◯	◯

Ölçekler

1) Terapötik İttifak Formları (Terapist & Danışan)

Ek 11: Terapötik İttifak Ölçeği – Terapist Formu (TİÖ-T)

GÖRÜŞME DEĞERLENDİRME ÖLÇEĞİ (TERAPİST FORMU)

Aşağıdaki her bir cümleyi okuduktan sonra, ifadelerle ilgili değerlendirmenizi sağdaki yedi kutucuktan birinin içine (x) işareti koyarak yapınız.

	Hiçbir zaman	Çok Seyrek	Seyrek	Bazen	Sık sık	Çok sık	Her zaman
1. Hastamla kendimi rahat hissetmiyorum.							
2. Hastam ve ben, sorunlarının düzelmesi için terapide neler yapması gerektiği konusunda aynı şekilde düşünüyoruz.							
3. Bu görüşmelerin sonucunda ne olacağı konusunda endişelerim var.							
4. Hastam ve ben, terapide yaptıklarımızın işe yaradığına inanıyoruz.							
5. Hastamı anladığımı düşünüyorum.							
6. Hastam ve ben, onun terapiden neler beklediği konusunda hemfikiriz.							
7. Hastam terapide yaptıklarımızı kafa karıştırıcı buluyor.							

	Hiçbir zaman	Çok Seyrek	Seyrek	Bazen	Sık sık	Çok sık	Her zaman
8. Hastamın bana yakın hissettiğine inanıyorum.							
9. Hastam için görüşmelerimizin amacını netleştirmeye ihtiyacım var.							
10. Terapiden ne elde etmesi gerektiği konusunda hastamla aynı fikirde değiliz.							
11. Hastamla zamanı etkin kullanmadığımıza inanıyorum.							
12. Terapide neye ulaşmak istediğimiz konusunda şüphelerim var.							
13. Hastamın terapide üzerine düşenlerin ne olduğunu bildiğine eminim.							
14. Bu görüşmelerin amaçları hastam için önemli.							
15. Terapide yaptıklarımızın, hastamın sorunlarıyla ilişkili olmadığını düşünüyorum.							
16. Terapide yaptıklarımızın, hastamın istediği değişikliklere ulaşmada ona yardımcı olacağını hissediyorum.							

	Hiçbir zaman	Çok Seyrek	Seyrek	Bazen	Sık sık	Çok sık	Her zaman
17. Hastamın iyiliğini gerçekten düşünüyorum.							
18. Görüşmelerde hastamdan ne beklediğimi biliyorum.							
19. Hastam ve ben birbirimize saygı duyuyoruz.							
20. Hastama gösterdiğim duygularımda tam olarak dürüst olmadığımı hissediyorum.							
21. Hastama yardım edebileceğime inanıyorum.							
22. Hastam ve ben, ortak hedeflerimize doğru ilerliyoruz.							
23. Hastamı takdir ediyorum.							
24. Hastam için neyin üzerinde durmamızın daha önemli olacağı konusunda hemfikiriz.							
25. Hastam bu görüşmelerin sonunda neler yaparak değişebileceğini daha iyi anladı.							
26. Hastam ve ben birbirimize güveniyoruz.							
27. Hastam ve ben sorunlarının neler olduğu konusunda farklı düşünüyoruz.							
28. İlişkimiz hastam için çok önemli.							

	Hiçbir zaman	Çok Seyrek	Seyrek	Bazen	Sık sık	Çok sık	Her zaman
29. Hastamın, eğer yanlış şeyler söyler ya da yaparsa, benim terapiye devam etmeyeceğime dair korkuları var.							
30. Görüşmelerin amaçlarını belirleme konusunda hastam ve ben işbirliği içindeyiz.							
31. Hastam terapide yapmasını istediğim şeylerden dolayı yerinde saydığını hissediyor.							
32. Ne tür değişikliklerin onun yararına olacağı konusunda anlaşmaya vardık.							
33. Terapide yaptıklarımız hastama anlamlı gelmiyor.							
34. Hastam terapinin sonucunda neye ulaşacağını bilmiyor.							
35. Hastam sorununu ele alma yollarımızın doğru olduğuna inanıyor.							
36.Onaylamadığım şeyler yapsa da hastama olan saygım devam eder.							

Ek 7: Terapötik İttifak Ölçeği – Hasta Formu (TİÖ-H)

GÖRÜŞME DEĞERLENDİRME ÖLÇEĞİ (HASTA FORMU)

Aşağıdaki her bir cümleyi okuduktan sonra, ifadelerle ilgili değerlendirmenizi sağdaki yedi kutucuktan birinin içine (x) işareti koyarak yapınız.

	Hiçbir zaman	Çok Seyrek	Seyrek	Bazen	Sık sık	Çok sık	Her zaman
1 Terapistimin yanında kendimi rahat hissetmiyorum.							
2. Terapistim ve ben sorunlarımın düzelmesi için terapide neler yapmam gerektiği konusunda aynı şekilde düşünüyoruz.							
3. Bu görüşmelerin sonucunda ne olacağı konusunda endişelerim var.							
4. Terapide yaptıklarım, bana sorunumla ilgili yeni bir bakış açısı kazandırıyor.							
5. Terapistim ve ben birbirimizi anlıyoruz.							
6. Terapistim, terapiden neler beklediğimi doğru anlıyor.							
7. Terapide yaptıklarımı kafa karıştırıcı buluyorum.							
8. Terapistimin bana yakın hissettiğine inanıyorum.							
9. Terapistimle görüşmelerimizin amaçlarını belirleyebilmiş olmayı isterdim.							
10. Terapiden ne elde etmem gerektiği konusunda terapistime katılmıyorum.							
11. Terapistimle zamanı etkin kullanmadığımıza inanıyorum.							
12. Terapistim terapide neye ulaşmak							

istediğimi anlamıyor.							
	Hiçbir zaman	Çok Seyrek	Seyrek	Bazen	Sık sık	Çok sık	Her zaman
13. Terapide üzerime düşenlerin ne olduğunu biliyorum.							
14. Bu görüşmelerin amaçları benim için önemli.							
15. Terapide yaptıklarımızın, sorunlarımla ilişkili olmadığını düşünüyorum.							
16. Terapide yaptıklarımın, istediğim değişikliklere ulaşmamda bana yardımcı olacağını hissediyorum.							
17. Terapistimin iyiliğimi gerçekten düşündüğüne inanıyorum.							
18. Görüşmelerde terapistimin benden ne beklediğini biliyorum.							
19. Terapistim ve ben birbirimize saygı duyuyoruz.							
20. Terapistimin bana gösterdiği duygularında tam olarak dürüst olmadığını hissediyorum.							
21. Terapistimin bana yardım edebileceğine inanıyorum.							
22. Terapistim ve ben, ortak hedeflerimize doğru ilerliyoruz.							
23. Terapistimin beni takdir ettiğini hissediyorum.							
24. Benim için neyin üzerinde durmamızın daha önemli olacağı konusunda hemfikiriz.							
25. Bu görüşmelerin sonunda neler yaparak değişebileceğimi daha iyi anladım.							
26. Terapistim ve ben birbirimize güveniyoruz.							
27. Terapistim ve ben sorunlarımın neler olduğu konusunda farklı düşünüyoruz.							
28. Terapistimle olan ilişkim benim için çok önemli.							

	Hiçbir zaman	Çok Seyrek	Seyrek	Bazen	Sık sık	Çok sık	Her zaman
29. Eğer yanlış şeyler söyler ya da yaparsam, terapistim terapiye devam etmeyecekmiş gibi geliyor.							
30. Terapistim ve ben terapiden neler kazanmam gerektiği konusunda hemfikiriz.							
31. Terapide yaptığım şeyler bana yerimde saydığımı hissettiriyor.							
32. Ne tür değişikliklerin benim yararıma olacağı konusunda anlaşmaya vardık.							
33. Terapistimin yapmamı istediği şeyler bana anlamlı gelmiyor.							
34. Terapimin sonucunda neye ulaşacağımı bilemiyorum.							
35. Sorunumu ele alma yollarımızın doğru olduğuna inanıyorum.							
36. Onun onaylamadığı şeyler yaptığımda da terapistimin beni önemsediğini hissediyorum.							

Teknoloji Kabul ve Kullanım Birleştirilmiş Modeli Ölçeği

1. Online terapi araç ve ortamlarının psikoterapi mesleğinde işimi kolaylaştıracağını düşünüyorum.
2. **Online terapi araç ve ortamları programları benim için önemli şeylere ulaşma şansımı arttıracaktır.**
3. **Online terapi araç ve ortamları işleri daha hızlı bitirmeme yardımcı olacaktır.**
4. Online terapi araç ve ortamları benim üretkenliğimi arttıracaktır.
5. Online terapi araç ve ortamlarını öğrenmek benim için kolay.
6. **Online terapi araç ve ortamlarından psikoterapist olarak net ve anlaşılabilir sonuçlar alabileceğimi düşünüyorum.**
7. Online terapi araç ve ortamlarından psikoterapist olarak yararlanmanın kolay olduğunu düşünüyorum.
8. **Online terapi araç ve ortamlarında başarılı olmak için gerekli becerilerimi geliştirmek benim için kolay.**
9. **Önem verdiğim kişiler Online terapi araç ve ortamlarının benim için önemli olduğunu söylüyorlar.**
10. Davranışlarımda model aldığım kişiler Online terapi araç ve ortamlarının gerekli olduğunu söylüyorlar.
11. Düşüncelerine değer verdiğim kişiler Online terapi araç ve ortamlarını kullanmamı tercih ediyorlar.
12. Online terapi araç ve ortamları için gerekli kaynaklara/olanaklara sahibim.
13. Online terapi araç ve ortamlarını kullanmada başarılı olmak için gerekli bilgi birikimine sahibim.
14. Online terapi araç ve ortamları bildiğim diğer psikoterapi ortamları ile uyumlu.
15. Online terapi araç ve ortamlarında zorluk yaşadığımda başkalarından yardım alabilirim.
16. Online terapi araç ve ortamlarını kullanmak eğlencelidir.
17. Online terapi araç ve ortamlarını kullanmak zevklidir.
18. Online terapi araç ve ortamlarını kullanmak çok keyiflidir.
19. Online terapi araç ve ortamlarını öğrenmek için harcadığım çaba makuldür.
20. Online terapi araç ve ortamlarına verilen paraya değer.
21. **Şu anki ücreti ile Online terapi araç ve ortamlarını öğrenmek için düzenlenen eğitimler, verdiğim çabaya değecek hizmetler/imkânlar sunuyor.**
22. Online terapi araç ve ortamlarını kullanmak benim için alışkanlık haline geldi.

23. Bundan sonra psikoterapi seansları için her zaman online terapi araç ve ortamlarını tercih ederim.
24. Online terapi araç ve ortamlarını kullanmak zorundayım.
25. Online terapi araç ve ortamları benim için yadırgamadığım, doğal bir psikoterapi ortamı.
26. İleride başka Online terapi araç ve ortamlarını kullanmaya devam etmek niyetindeyim.
27. Gelecekteki online terapi gereksinimleri için başka online görüşme araç ve ortamlarını araştıracağım.
28. Online terapi araç ve ortamlarını bol bol kullanmaya devam etmeyi planlıyorum.

COVID-19 Algı Ölçeği

1 Bu hastalık söylendiği kadar tehlikeli değil. (T)
2 Medya salgını abartıyor. (T)
3 Virüs ölümcül bir hastalığa neden olmaktadır.
4 Bu hastalık herkese bulaşabilir.
5 Kolayca bulaşan bir hastalıktır.
6 Hastalığın kadınlara ve erkeklere bulaşma olasılığı benzerdir.
7 Virüs kargo veya alışveriş ürünlerinden bulaşabilir.

1 Bu hastalık gelişmiş ülkelerin ortaya koyduğu politik bir oyundur.
2 Bu salgının nedeni gelişmiş ülkelerin ilaç ve aşı satma çabasıdır.
3 Bu virüs ekonomik sisteme katkı sağlamak için bilinçli olarak yayıldı
4 Bu hastalık biyolojik bir silah olarak üretildi.
5 Bu salgın büyük bir deneyin parçasıdır.
6 Bu hastalığın nedeni ekonomik krizdir.
7 Çevre kirliliği hastalığın önemli nedenlerinden biridir
8 Salgının nedenlerinden biri su kaynaklarının kirlenmesidir
9 Bu hastalık sağlıksız yaşam tarzının bir sonucudur.
10 Küresel ısınma salgının nedenlerinden bir tanesidir.
11 Bu tür salgınlar tabiatın dengesini kurması çabasıdır.
12 Bu tür salgınlar toplumun dinden uzaklaşmasına karşı Tanrının verdiği bir cezadır.
13 Bu salgın toplumsal bozulmaya karşı Tanrının bir gazabıdır.
14 Bu salgın kaderimizde var.

Ülkemizdeki önleyici çalışmalar yeterlidir
Hastalığın yayılmasını durdurmak için yapılanlar yeterlidir
Hastalıkla mücadele için sağlık kurumlarının yaptığı çalışmalar yeterlidir
Dünyadaki önleyici çalışmalar yeterlidir
Kişisel temizliğime dikkat edersem hastalık bana bulaşmaz
Beslenmeme dikkat edersem bu hastalık beni etkilemez
Hastalıktan kişisel tedbirler alarak korunmak mümkündür
Salgını durdurmak için herkesin ellerini sıkça yıkaması yeterli olur
Hastalığa yakalanmak kişinin kendi elinde değildir. (T)
Görmediğin bir virüsten kaçınmak mümkün değildir. (T)
Ne kadar önlem alınırsa alınsın hastalığın bulaşmasını engelleyemeyebiliriz. (T)
Alacağım kişisel tedbirler hastalıktan korunmam için yetersiz kalır. (T)

Hastalıkla ilgili haberlere maruz kaldığınızda dikkatinizi başka yere çevirmek
Hastalıkla ilgili konulardan söz edilirken başka şeyler düşünmek
Salgınla ilgili haberleri okumamak
TV'de hastalıkla ilgili haberler çıktığında kanalı değiştirmek
Hastalıkla ilgili konuşmaları sonlandırmak için konuyu değiştirmek
Davranışsal Kaçınma
Hasta olmamak için tanıdığınız insanlarla selamlaşırken onları öpmemek
Hasta olmamak için sosyal etkinliklere katılmamak (sinema, tiyatro vs.)
Hasta olmamak için toplu taşıma araçlarına binmemek
Hasta olmamak için tanıdığınız insanlarla selamlaşırken ellerini sıkmamak
Hasta olmamak için umumi tuvaletleri kullanmamak

Ailemdekilerin bu hastalıkla ilgili geliştirilecek/geliştirilen aşıyı olmasını isterim
İlk fırsatta bu hastalıkla ilgili geliştirilecek/geliştirilen aşıyı olmak isterim
Bence herkes bu hastalıkla ilgili geliştirilecek/geliştirilen aşıyı yaptırmalı
Geliştirilecek/geliştirilen aşı hakkında yapılan açıklamalara güveniyorum

Geliştirilecek/geliştirilen aşı hastalığın bulaşmasına neden olabilir. (T)
Geliştirilecek/geliştirilen aşının koruyucu etkisinin olmayacağını/olmadığını düşünüyorum. (T)

Geliştirilecek/geliştirilen aşı tehlikelidir. (T)

Geliştirilecek/geliştirilen aşının etkililiği yeterince test edilmeyeceğini/edilmediğini düşünüyorum. (T)

Aşı olmadan da salgını atlatabileceğimi düşünüyorum. (T)

6.2. Appendix B

T.C.
YEDİTEPE ÜNİVERSİTESİ REKTÖRLÜĞÜ
Yazı İşleri Müdürlüğü

22.04.2021

Sayı : E.21568116-302.14.01-825
Konu : Nazlıcan Özkan Etik Kurul Onayı

DAĞITIM YERLERİNE

Üniversitemiz Sosyal Bilimler Enstitüsü Klinik Psikoloji Yüksek Lisans öğrencisi Nazlıcan Özkan'a ait "Online Psychotherapy Setting and Its Reflections on the Therapeutic Relationship during COVID-19 Pandemic" başlıklı tez araştırma önerisinin beşeri bilimler etik standartlarına uygunluğuna ilişkin Yeditepe Üniversitesi Beşeri ve Sosyal Araştırmalar Etik Kurul Onayı ektedir.

Gerekli iznin verilmesi hususunu bilgilerinize arz ve rica ederim.

Prof. Dr. Fatma Yeşim EKİNCİ
Rektör a.
Rektör Yardımcısı

Ek: Etik Kurul Onayı.pdf

DAĞITIM :
Gereği :
İLGİLİ MAKAMA

Bilgi :
İletişim Fakültesi