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Transformative Psychotherapy and Telehealth: Qualitative Research Findings

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The upheaval caused by the COVID-19 pandemic reached my psychotherapy practice, as it did almost everyone, everywhere. The fear that in-person contact could cause illness and death was palpable and realistic. I had a stark choice. Close up shop or change. Thirty years in the profession led me to offer Telehealth psychotherapy and supervision.

In my clinical practice, I use all of my senses to be effective during in-person sessions. I am intensely focused, moment-to-moment, as I think about the arc of the client's story. Online, what could go wrong? Would I miss barely audible utterances? Would I miss the incongruence between the facial expression and the clasp of hands? Telehealth doesn't engage the whole of our physicality, so is it as good as in-person?

The surprise finding: There are some clients for whom we can recommend Telehealth with confidence. The caveats are as important to the finding and understanding them is key to sound clinical decisions. This article summarizes the scholarship behind the surprise finding and my explanation for it. The complete literature review, interviews, and discussion are available in the dissertation itself, which is a virtually free eBook. My dissertation study[i] was qualitative research. I interviewed twenty-three experienced clinicians about individual psychotherapy with adults. The question, broadly framed, "What works well or not, why?" Were my doubts about psychotherapy via Telehealth justified? I listened for clues and stories which, if woven together, might resolve or reinforce my doubts about Telehealth.

Another key finding: If the psychotherapist is good at what they do, they figure out how to do it through Telehealth whether it is two-way streaming video or audio-only; and this is true for each of the dominant psychotherapeutic approaches (Cognitive-Behavioral, Relational, and Psychodynamic). This finding has significance because of the dominance of CBT in published research. According to Smith, et al. (2021)[ii] the evidence from research that is

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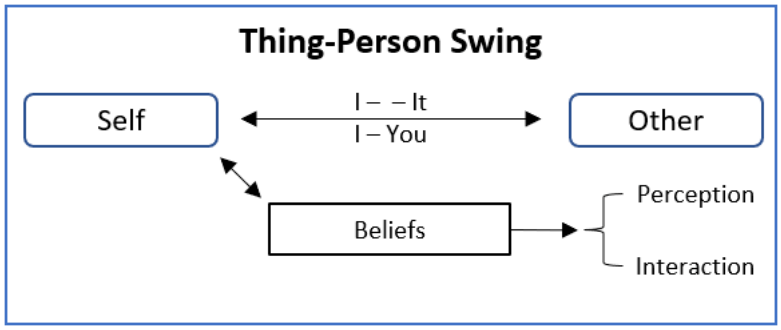
focused on CBT might not be generalizable to other psychotherapeutic approaches: To date, much of the evidence base for video therapy comes from CBT and there is limited evidence to support the delivery of other therapeutic approaches online…Yet, estimates indicate over 80% of UK-based therapists have primary training in person-centered, humanistic or integrative practices [British Association for Counselling and Psychotherapy, 2021, '2.1 CBT focus of evidence base'].

Regardless of approach, the effective clinician establishes a therapeutic alliance[iii] is central to psychotherapy that transforms the person in some way and Telehealth is compatible.

What accounts for these two important findings? Psychotherapists in this study report that personal transformation can be achieved when the clinical focus is improved adaptation in a difficult situation, whether sessions are done in-person or via Telehealth; I explain this with my own theory of transformative psychotherapy: The potential for transformation during talk therapy is realized through a recurring I-Thou[iv] experience while the client is interacting with the clinician. There is a nuance that stood out as I reread Buber's seminal treatise and it is essential for a more complete understanding of effective psychotherapy:

- "For the real boundary, albeit one that floats and fluctuates, runs not between experience and not-experience, not between the given and the not-given, nor between the world of being and the world of value, but across all of the regions between You and It, between presence and object." (p. 63)

I refer to Buber's "floats and fluctuates" as the *Thing-Person Swing*. [Figure 1]. I emphasize



the essential factor of "world of value," beliefs, schemas[v]. The role of beliefs in the *Thing-Person Swing* is important to transformative psychotherapy.

The swing can be beyond conscious awareness, it can be reflexive and it can be a Self-orientation. Imagine a couple. They were in love, so they decided to live together. Their

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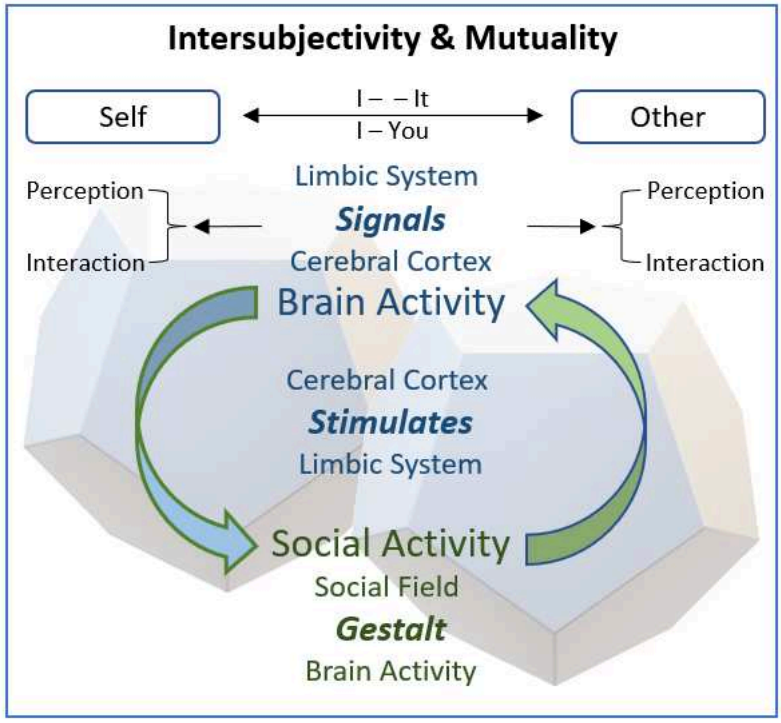
feelings of togetherness motivated each of them to pay attention to their partner whenever they were together. Their I-You orientation was mutual. But then one of them became inconsistently attentive, and the other reflexively reacted to each lapse with Flight-Freeze[vi] behavior. The upset was smoothed over by re-establishing I-You, then the upset occurred again. What happened next? The couple entered psychotherapy because one partner became aloof and the other was angry. In the session, beliefs that converted their orientation to I-It were revealed. The aloof partner's stories showed that each lapse of attention confirmed shaming, Self-It orientation, "I'm worthless." The angry partner's stories showed that each withdrawal confirmed a punishing, Self-It orientation, "I can't get it right." Each pointed their finger to blame their partner, "You're not fair." Their I-It orientation was intersubjective. Psychotherapy can engender an intersubjective[vii] I-Thou experience which engenders an emotion response cycle[viii]. [Figure 2.]



Gains are consolidated in the client's I-Thou orientation to their own self. This is the transformative result that is possible through psychotherapy which produces the paradox of

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safety in the present while during a re-experience of a previous injury. Telehealth can engender transformative change by enhancing a client's sense of safety which is enhanced when the clinician trusts the clinical environment. The skepticism about Telehealth by clinicians is described by Cataldo, et al., (2021, p. 8)[ix]: Psychologists consistently feel limited by technology, especially with clients with strong mental and emotional disorders…[They] complain of the lack of information (especially visual data). This leads them to generate and rely on their own mental picture of the client's state due to the element of uncertainty and on their internal trust toward the whole process, both about themselves and their clients…the absence of sight and physical proximity appears to be a key issue… since it does not allow users to acquire the information needed to establish trustworthy cooperation. As a result, trust appears fragile.

Geller & Porges (2014, p. 178)[x] explain the basis for a clinician's abovementioned "internal trust toward the whole process" this way:

- "According to the [polyvagal theory], when safety is communicated via expressed markers of social engagement… defensiveness is down-regulated. Cultivating presence and engaging in present-centered relationships can therefore facilitate effective therapy by having both client and therapist enter a physiological state that supports feelings of safety."

A qualitative study that interviewed clinicians focused on the topic of trust, which is closely linked with a sense of safety. Fletcher-Tomenius & Vossler (2009)[xi] found:

- "Although trust was discussed as having similarities to the face-to-face environment, there were essential differences between trusting online and face-to-face. In particular, trust was discussed as being tied to the anonymity afforded by online counseling. Interviewees discussed how this affected the speed that online therapeutic relationships developed through processes of disinhibition, feelings of safety, a neutral power balance and a process of internalizing the other." ("Conclusion and Implications")

The clinicians whom I interviewed shared stories about clients who felt safer and more trusting while in session using the telephone or video-conferencing. The words "safe" and "safety" occur 62 times in the interviews, respondents used forms of the word "trust" 40 times.

- My mind immediately went to a client who was born with a physical difference…That creates such a state of anxiety for the client that they find themselves reacting in different ways. It's a constant…I have offered the client several times to go back to a two-way

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video. We've explored that and he says, "No, the phone works for me better." (#27-210409, 6 years, Cognitive)

- She said to me, "I can talk to you about all of these things and any of these things because you don't know me and I don't know you. I've never seen you and you've never seen me." She felt safe. (#19-210330, 34 years, Relational).

- She contacted me during the pandemic and said her life partner had just died. And she's now in her 80s and still very healthy, very high functioning. But suddenly she's all alone, unable to travel, no teaching…What looked like a therapy focused on grief became a life review…The distance Telehealth provided actually helped that, if that makes sense. I think if we were sitting in my office, that might not have happened. It was somehow safer to do that with Telehealth. (#29-210412, 38 years, Psychodynamic)

Summary

Telehealth could be offered strategically, combined with in-person. Our profession needs more training and education about how healing happens via Telehealth psychotherapy. We need more qualitative research to grow that body of knowledge. We need to listen to the great diversity of people using and providing Telehealth psychotherapy and share their stories.

A major limitation of my research is that I do not give full enough consideration to society. Understanding this is essential to fully seeing the individual suffering that any clinician witnesses. Individual transformation achieved through psychotherapy can lead to increased engagement in efforts to change society. Contemporary approaches of liberation psychology, feminist psychotherapy, and intersectional psychotherapy address the impact of social injustice on the psychotherapeutic experience. My theory of transformative psychotherapy is compatible with these modern approaches.

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[iii] Therapeutic alliance and working alliance refer to the strength of the collaborative dimensions of the therapist–client relationship. The concept is rooted in psychodynamic theory, more recently it has evolved into a pan-theoretical concept. Horvath, A. O. (2015). Therapeutic/Working alliance. The Encyclopedia of Clinical Psychology, 1-5. https://doi.org/10.1002/9781118625392.wbecp262

[iv] I-It/I-Thou is a philosophical construct about the perception by one person of another as either an object or a human being. The book's synonymous term for I-Thou is "I-You." Buber, M. (1970). I and thou (W. A. Kaufmann, Trans.) (2nd ed.). Scribner Classics. (Original work published 1923)

[v] Schemas (core beliefs) [are different from] "underlying assumptions (conditional beliefs) and automatic thoughts [that are temporary]". Padesky, C. A. (1994). Schema change processes in cognitive therapy. Clinical Psychology & Psychotherapy, 1(5), 267-278. (p. 267).

[vi] Flight-Freeze is part of the Fight-Flight-Freeze response associated with the amygdala. University of Toledo. (n.d.) Fight/Flight/Freeze response. Counseling Center. https://www.utoledo.edu/studentaffairs/counseling/anxietytoolbox/fightflightfreeze.html

[vii] Intersubjectivity is a shared meaning that emerges from, enacted within the social fabric of interaction. Garte, R. (2016). A sociocultural, activity-based account of preschooler intersubjectivity. Culture & Psychology, 22(2), 254-275.

[viii] Emotion response cycle is a concept based on a model of the sexual response cycle as described by the Cleveland Clinic (2017, October 1, Sexual response cycle. Health library articles. https://my.clevelandclinic.org/health/articles/9119-sexual-response-cycle). Emotion response cycle can be represented as a wave that builds, crests, and subsides. Bloomberg, V. (2015). KaBoom or kaching: E=MC2 or EM->2C. Independently Pub-

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