Transformative Psychotherapy and Telehealth

Original Dissertation

By Dr. Victor D. Bloomberg

**Educational Purpose and Copyright**

This is a reproduction of my dissertation, presented to the Graduate Review Board of the Western Institute for Social Research and approved for the doctoral degree in “Higher Education and Social Change” conferred on September 30, 2021. This book is for educational purposes only. It contains segments of interviews that have been de-identified, reviewed by each interviewee and they are shared with each of their permission.

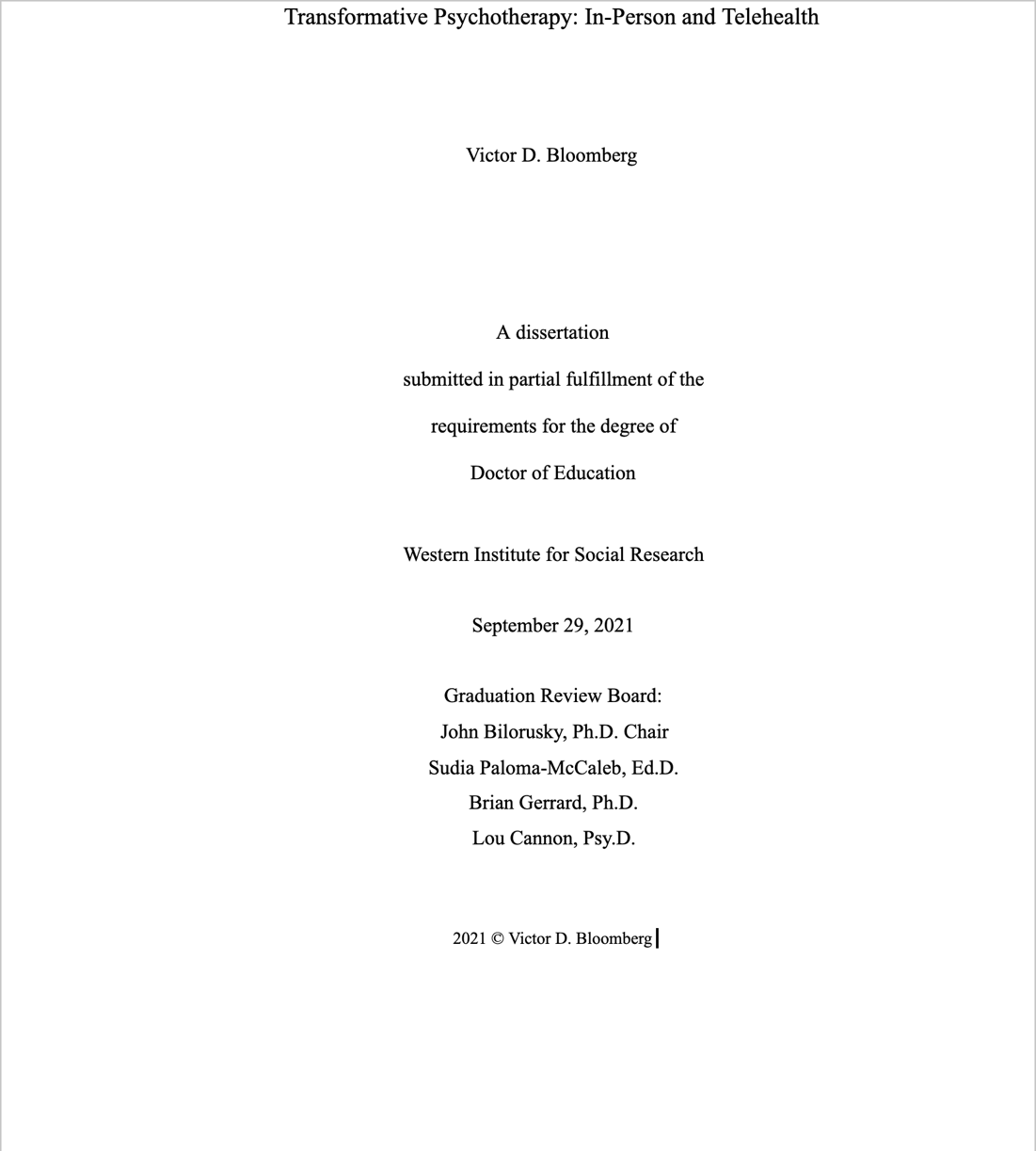
I am the author and sole owner of “Transformative Psychotherapy and Telehealth.” Unless otherwise attributed, each illustration presented as a “Figure” and the cover art are by Victor D. Bloomberg.

Copyright © 2021 by Victor D. Bloomberg.

All rights reserved.

I cite all material attributable to works published by others in the body of my book, and in the chapters “Definitions” and “References.” No part of this book may be reproduced or used in any manner without written permission beyond short quotes with proper citation. Permission may be requested by writing to Victor D. Bloomberg, P.O. Box 3483, San Diego, CA 92163 or by using the “Contact Form” <https://www.drvicbloomberg.com/contact>

Imprint: Dr. Victor D. Bloomberg



**Dedication**

For S.M.B. and G.M.B.

Sooner or later, though, no matter where in the world we live, we must join the diaspora, venturing beyond our biological family to find our logical one, the one that actually makes sense for us.

― Armistead Maupin

*Logical Family: A Memoir*

**TABLE OF CONTENTS**

[Abstract](#_Toc88991472)

[Acknowledgments](#_Toc88991473)

[Chapter 1: Introduction](#_Toc88991474)

[General Statement](#_Toc88991475)

[Statement of the Problem](#_Toc88991476)

[Purpose of the Study](#_Toc88991477)

[Importance of the Study](#_Toc88991478)

[Theoretical Framework](#_Toc88991479)

[Research Questions](#_Toc88991480)

[Overall Research Design](#_Toc88991481)

[Assumptions and Limitations](#_Toc88991482)

[Summary](#_Toc88991483)

[Chapter 2: Literature Review](#_Toc88991484)

[Transformative Psychotherapy](#_Toc88991485)

[A Few Theories about Individual Psychology](#_Toc88991486)

[Transformative Psychotherapy, Theories Relevant to Mine](#_Toc88991487)

[The Origin of the Term “Transformative Psychotherapy”](#_Toc88991488)

[Transformative Talk-Therapy and “2nd-Order Change”](#_Toc88991489)

[Different Definitions of Transformative Psychotherapy](#_Toc88991490)

[Contemporary Psychotherapies can be Transformative](#_Toc88991491)

[Psychotherapy and Telehealth](#_Toc88991492)

[Some Studies about Modalities](#_Toc88991493)

[Client and Psychotherapist Experience](#_Toc88991494)

[Therapeutic Alliance](#_Toc88991495)

[Outcomes](#_Toc88991496)

[Summary and Analysis](#_Toc88991497)

[What does the literature address?](#_Toc88991498)

[Strengths and Limitations of the Literature](#_Toc88991499)

[The Significance of the Literature for My Inquiry](#_Toc88991500)

[Gaps of Knowledge which Need Further Research](#_Toc88991501)

[Concluding Thoughts from the Literature Review](#_Toc88991502)

[Chapter 3: Research Methods and Findings](#_Toc88991503)

[Research Methods](#_Toc88991504)

[The Research Questions](#_Toc88991505)

[Strengths of My Qualitative Research Design](#_Toc88991506)

[My Data](#_Toc88991507)

[Whom I Interviewed and Why](#_Toc88991508)

[How Well the Interviews Went](#_Toc88991509)

[Respondent Data Viewed from the Lens of the Literature](#_Toc88991510)

[How I Analyzed the Data](#_Toc88991511)

[The Twenty-Three Interviews](#_Toc88991512)

[How My Insights Emerged and Viewpoint Evolved](#_Toc88991513)

[Limitations Imposed by the Sample Size](#_Toc88991514)

[Methodological Recommendations](#_Toc88991515)

[Findings](#_Toc88991516)

[General Observations](#_Toc88991517)

[A Few Statistics](#_Toc88991518)

[What I Learned from Psychotherapists’ Stories](#_Toc88991519)

[Chapter 4: My Theory of Transformative Psychotherapy](#_Toc88991520)

[How and Why I Formed My Theory](#_Toc88991521)

[Transformative Psychotherapy](#_Toc88991522)

[What is “Thing-Person Swing”?](#_Toc88991523)

[What is the “Emotion Response Cycle”?](#_Toc88991524)

[Considerations for Telehealth](#_Toc88991525)

[Chapter 5: Conclusion](#_Toc88991526)

[Main Findings and Insights](#_Toc88991527)

[The Impact of Psychological Injury on a Person](#_Toc88991528)

[How a Psychotherapist Helps an Injured Person](#_Toc88991529)

[How Healing Happens](#_Toc88991530)

[Telehealth Effects on Healing](#_Toc88991531)

[Recommendations](#_Toc88991532)

[Improvements in Therapeutic Practice](#_Toc88991533)

[Training and Education of Psychotherapists](#_Toc88991534)

[Chapter 6: Future Inquiry and Activity](#_Toc88991535)

[Inquiry](#_Toc88991536)

[Activity](#_Toc88991537)

[Epilogue](#_Toc88991538)

[Definitions](#_Toc88991539)

[References](#_Toc88991540)

[Appendix A: Safeguards](#_Toc88991541)

[Appendix B: Interview, Recording to Text](#_Toc88991542)

[Appendix C: The Interviews](#_Toc88991543)

[Appendix D: Website Concept](#_Toc88991544)

[Vita](#_Toc88991545)

**LIST OF FIGURES**

[Figure 1. Dissertation Frame](#_Figure_1._Dissertation)

[Figure 2. Transformative/2nd Order Change](#_Figure_2._Transformative/2nd)

[Figure 3. Thing-Person Swing](#_Figure_3._Thing-Person)

[Figure 4. Amygdala](#_Figure_4._Amygdala)

[Figure 5. Nodes-Synapses](#_Figure_5._Nodes-Synapses)

[Figure 6. Field Theory – Emotions](#_Figure_6._Field)

[Figure 7. Intersubjectivity-Mutuality](#_Figure_7._Intersubjectivity)

[Figure 8. Therapeutic Action](#_Figure_8._Therapeutic)

[Figure 9. Psychotherapy, In-Person and Telehealth](#_Figure_9._Psychotherapy,)

[Figure 10. Cicero-Chicago 1951](#_Figure_10._Cicero-Chicago)

[Figure 11. Site Map Concept](#_Figure_11._Site)

**LIST OF TABLES**

[Table 1. Licensed (Years) / Telehealth (Years)](#_Table_1._Licensed)

[Table 2. Community Identifiers](#_Table_2._Community)

[Table 3. Main Approaches](#_Table_3._Main)

[Table 4. Beginning Methods for Improved Stability](#_Table_4._Beginning)

[Table 5. Qualities of the Clinician Needed by the Client](#_Table_5._Qualities)

[Table 6. Experience, Approach, Factors](#_Table_6._Experience,)

[Table 7. Conditions Whereby Telehealth is Less Effective](#_Table_7._Conditions)

# Abstract

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.

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?

**Main Questions**

My study was qualitative research[[1]](#footnote-1). I interviewed experienced clinicians. The question, broadly framed, “What works well or not, why?” Were my doubts about psychotherapy via Telehealth[[2]](#footnote-2) justified?

**Methods**

I interviewed experienced psychotherapists. I listened for clues and stories which, if woven together, might resolve or reinforce my doubts about Telehealth.

I found participants for interviews through snowball sampling[[3]](#footnote-3). I interviewed twenty-three.

**Main Findings**

My findings suggest that 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. A therapeutic alliance[[4]](#footnote-4) is central to psychotherapy that transforms the person in some way and Telehealth is compatible.

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*[[5]](#footnote-5) experience while the client is interacting with the clinician. Intersubjective[[6]](#footnote-6) *I-Thou* experience engenders an *emotion response cycle*[[7]](#footnote-7). Gains are consolidated in the client’s *I-Thou* orientation to their own self.

Telehealth can engender transformative change by enhancing a client’s sense of safety; that is essential. Telehealth increases the probability of transformative change by improving access for some clients who can be identified by characteristics such as isolation caused by geographical distance, inadequate transportation, social and psychological reasons, and financial constraints. 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.

# Acknowledgments

My work is a reflection that has taken me a lifetime to form. Before I mention people who were part of this inquiry, the first call out goes to my parents. Yearly they served up a delicious Seder and we read aloud this passage, “Love the stranger as your neighbor.”

I chose to go for a doctorate because a dear friend urged me, for nearly a decade. Thank you Richard Lawrence for being my compadre making Good Trouble and all the while we play cards. I was able to get across the goal line with joy with the love and support of my spouse Diane Bloomberg.

WISR is a community with a vision and mission of alternative higher education for social justice. The community welcomed me and supported me. I am a better person and I learned a lot. In addition to the faculty on my Review Board – John Bilorusky, PhD, Sudia Paloma, EdD and Brian Gerrard, PhD – I am grateful to faculty member [Ronald Mah, PhD](http://www.ronaldmah.com/), [Karen Wall, EdD](https://www.linkedin.com/in/drkarenwall-rn-lmft/) as well as Professor Emeritus Cynthia Lawrence, EdD.

“Outside Expert” is the title given to my fourth Review Board member. “Outside” fits in relation to the college. “Inside Expert” is the truth in every other sense of the word for Lou Cannon, PsyD. My insides give thanks to Lou.

I needed to find expert psychotherapists for the interviews. I began by asking friends from decades of community work. [Steve O’Kane](https://www.lung.org/about-us/our-leadership/stephen-r-okane) and [Barbara Mandel](https://www.sdchip.org/board-of-directors/) recommended people. I’ve known for 30 years Dominique Fragoso, LCSW and [Susan Wingfield-Ritter, LMFT](https://motivationalinterviewing.org/profile/susanwingfield-ritter) and each said, “Yes” to being interviewed. [Aspacia Birmingham, LMFT](https://www.aspasiatherapy.com/), Cindy Ferguson, LCSW, [Julia Rosengren, PsyD](https://drjuliarosengren.com/), Lydia Lewis, LCSW and Therese Adair, LCSW recommended people and/or participated. My village introduced me to people whom I never otherwise would have met. Support from my own home town was extra special for this online higher education experience. Next, I mention the people who treated me, a stranger, as their neighbor and gave me their time and their truth: [Dan Keady, LMFT](https://www.psychologytoday.com/us/therapists/dan-keady-san-francisco-ca/286750), [Elva Hoxie, PhD](https://www.linkedin.com/in/elva-hoxie-phd-rn-phn-mph-mft-8534858/), [Gloria Saltzman, LMFT](https://www.psychologytoday.com/us/therapists/gloria-saltzman-san-francisco-ca/38719), [Jeani Hebert-Brown, LCSW](https://jeanhebertbrown.com/), Jeanne Strauss, LMFT, [Karolyn Johnson, LMFT](https://www.psychologytoday.com/us/therapists/karolyn-johnson-del-mar-ca/133486), [Mar Ortmann, LCSW](https://www.psychologytoday.com/us/therapists/mar-ortmann-alameda-ca/61796), [Marcia Weisbrot, LPCC](http://marciaweisbrot.blogspot.com/), [Margaret Bouher, LCSW](https://www.margaretbouherlcsw.com/), [Mary Fox Squire, PhD](https://www.psychologytoday.com/us/therapists/mary-fox-squire-san-diego-ca/325548), [Na Limopasmanee, LMFT,](https://traumapartners.org/our-team/) [Patricia Lindquist, PhD](http://www.relationshipspsychotherapysolutions-sandiego.com/), Robert Brem, NCC, [Suzanne Quijano, LMFT](https://www.psychologytoday.com/us/therapists/suzanne-quijano-davis-ca/346918), [Toni Nemia, LMFT](https://www.wisr.edu/center-for-child-and-family-development/), [Wayne Hart, PhD](https://www.ta-now.com/about).

I had imagined telling you more in Acknowledgments about each person who gave generously their time, stories and reflections. Now I imagine a webpage where I could do that. It would be another way to say “thank you” and to make it easy for you to find clinicians who say “yes” to artisanal mutual support.

# Chapter 1: Introduction

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, realistic. I was like a lot of other clinicians who had not used video calls to provide services. We all had a stark choice. Close up shop or change our practice. One respondent described it:

\* The irony of ironies, in January of 2020, I thought to myself, “I need to get on board with Telehealth.” Just as a means of having another venue. It’s true that I had heard of COVID. My best friend, a school district nurse, was telling me, “Yeah, something’s out there.” She was making me aware that something’s coming. I had no idea, like many of us, what the hell was coming. So, I decided to explore Telehealth. And then everything happened. In March a different friend asked, “Are you ready?” I think I said “Yeah, but I think I’ll wait it out, I’m sure it’ll be fine.” I thought, “I don’t think it’s gonna be a big deal.” After that first week, “Whoa, what is going on?” Some people went into telephone mode, audio only. Some used videophones. Then I got on the computer Telehealth and now I’m fairly Telehealth conversant. (#24-210402)

I became a licensed psychotherapist in 1991. When I asked colleagues about online versus in-person psychotherapy, I saw right away that people used different words to say the same thing (i.e., telemedicine, telehealth, brand names) and vague or idiosyncratic use of similar terms (i.e., counseling, therapy, psychotherapy). These informal talks with colleagues revealed a lot of “ifs, ands and buts” to their assessment of psychotherapy done online.

My specialty is transformative psychotherapy which seeks resolution of root causes underneath problems that recur, recede and intensify. In my clinical practice, I use all of my senses to be effective during in-person sessions. I am intensely focused, moment-to-moment, 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?

The literature about Telehealth[[8]](#footnote-8) asserts that it can be useful to mitigate disparities suffered by people in marginalized communities (e.g., impoverished) if there is access to cellular service, community-based kiosks, etc. A lot of the disparity mitigation has been crisis intervention, stabilization, solution-focused counseling, health coaching and the like. Strategies to mitigate disparities often emphasize reduction of costs through economies of scale.

Telehealth and transformative personal change do not seem to be a concern in much of the literature about disparity-reduction. Even if the researchers are aware of psychotherapy for this kind of personal change among marginalized populations, there could be a bias or assumption that poor people achieve their transformative results through stabilization and adaptation. There are ways to achieve transformative success without talk-therapy. I’ve seen that while working for the Kumeyaay Nation which straddles Baja California, Mexico and San Diego, California, U.S.A. and while working with Paraguayans in South America. Culturally-competent clinicians who serve marginalized communities might find this study to be useful for their consideration of online technology for transformative psychotherapy.

My study is qualitative research[[9]](#footnote-9). I explore perceptions of clinicians regarding transformative psychotherapy, the differences between in-person and Telehealth. The question, broadly framed, for clinicians was, “What works well or not, why?” The pandemic forced the issue to the forefront for many clinicians. The perceptions of early adopters and late-comers (like myself) could help all of us gain perspective and insight.

In order to evaluate the online modality, I detail the significance of emotions during in-person psychotherapy. I show that not all emotional expression has the same significance; there is a unique quality of emotional experience which is essential to transformative effects. I use the perspective of “I and Thou” (Buber, 1970) to discuss the distinct emotional quality.

As you read, keep in mind a few themes, lenses through which I view the topics:

1. The impact of psychological injury on a person.

2. How a psychotherapist helps that person.

3. How healing happens.

4. Telehealth effects on healing.

My goal is to contribute to discussions about Telehealth psychotherapy among clinicians, educators and scholars. When is it transformative versus adaptive? How might decisions be made to use in-person sessions or Telehealth? My dissertation considers whether or not, under which circumstances, a clinician’s theory and methods for in-person transformative psychotherapy transfer to Telehealth. I explore explanations or questions associated with each modality, in-person or Telehealth.

The Western Institute for Social Research (WISR)[[10]](#footnote-10) emphasizes the authentic voice of the student and collaboration. Its history and accomplishments demonstrate these qualities in scholarship are essential for higher education to be relevant for empowerment of marginalized communities. I use my personal, first-person voice and cite my collaboration with WISR faculty. My dissertation tells a story of learning-by-doing.

An advisor for my dissertation, Brian Gerrard, PhD, in an email (November 7, 2020) shared a construct developed by Fraser & Solovey (2007), “First-order change refers to solutions that do not change the problem but that create stability, while second-order change transforms the first-order solutions, resulting in a resolution of the problem.” Another WISR professor, Ronald Mah, PhD, during a conversation (January 22, 2021) put it a little differently:

First-order change is change without change, you take what you know, who you are, from experience and your culture, and you reapply them. The question is how to hold on and when to push harder. With second-order change, you change the model, and you let go of some of what has been the way to be and do. What are the foundational beliefs to retain versus replace?

Already, I’ve given three ways to describe second-order change. Mine, “resolution of root causes underneath problems that recur, recede and intensify” draws upon psychodynamic theory[[11]](#footnote-11). Dr. Gerrard evokes family systems theory[[12]](#footnote-12). Dr. Mah brings to mind the concept of core beliefs[[13]](#footnote-13) from Cognitive Theory. Our different use of language points to the idea of theoretical cross-validation and that helped me develop my own theory of transformative psychotherapy. It also points to a challenge of terminology for the literature review and interviews.

Terminology, language can be problematic. I routinely make sure that I understand commonly used words when they are spoken by clients and interns with a question such as, “I know what I mean by that word, I’d like to make sure that I understand what you mean by it, could you tell me a little more?” Imagine the difficulty of using technical language which is ladened with complexity and elaboration, when my purpose is to clarify concepts so that clients, interns and lay persons might use them. With this in mind, let’s return to the term “second-order change.” According to Murray (2002), “[It is] characterized by the transcendence of one's usual experience of self” (p. 167). If I was in a conversation with Murray, I would ask, “What do you mean by transcendence?” I’d be thinking, “I don’t use that word with clients, interns or anyone else.” I found that most practitioners whom I interviewed did not connect to the terms “first-order” and “second-order” and so while they remained in the formal interview schedule, they were barely used in conversation. The psychotherapists whom I interviewed were descriptive story-tellers and that is my preferred style.

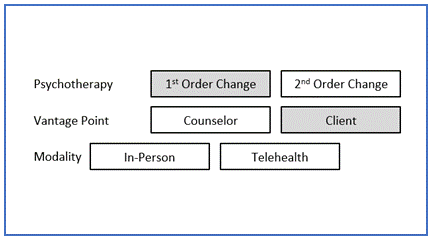
I needed to clarify what I meant by “transformative psychotherapy,” in a way that was inclusive of a wide array of clinical perspectives. I described psychotherapy, “Talk-therapy can be focused on adaptation to daily life or transforming patterns of living that developed from past experience.” I used Yin-Yang as an analogy for adaptation-transformation and said there often is a back-and-forth in the clinical emphasis. Some respondents described it as a continuum.

My dissertation has a frame, it considers psychotherapy for transformative change as viewed by clinicians who use two distinct modalities, in-person and Telehealth. I used order-of-change terminology interchangeably with language that was more familiar to me and most respondents. Here is a graphic representation of my dissertation frame that focuses my inquiry. It shows what is included, the grey-boxes indicate subject matter that is excluded.

Spoiler Alert: It turns out that psychotherapy that is focused on solving problems can be transformative. I will explain why that is so.

Client perceptions were not a focus of my inquiry. Yet a client’s awareness is the concern of any psychotherapy. Clients’ views were the focus of my Master’s thesis (Bloomberg & Meyers, 1984) as they are for ongoing research being done by others.

Figure 1. Dissertation Frame

An introductory comment on the structure of the dissertation and its contents: I received guidance from my review board members. One faculty specializes in transformative action-research, one faculty has led School-based Family Counseling and Cognitive Behavioral Therapy Research, one faculty has worked worldwide for decades in oppressed communities, my outside expert has been a practicing psychologist for decades. Some of my decisions (which flowed from the whole of their guidance) deviate from certain norms of academia, just as I am unconventional in other ways too.

I kept in mind that WISR received a grant awarded by the U.S. Department of Education to develop alternatives, innovations that might change practices in higher education. I have been thinking about that. How might this dissertation be repurposed for higher education outside of and apart from institutional academia. The doctorate title includes the term “social change.” That drives my passion which has sustained me throughout my work in the doctoral program. My peers are not to be found in institutional academia. My peers are found in marginalized communities. They are people bending under intolerable suffering and they want to stand upright, proud, free. My peers are psychotherapists who help people, day in and day out. My peers are allies in the struggle for human dignity. For these considerations, I’ve constructed a website for alternative higher education and social change based on this dissertation. Please see “Appendix D.” I will celebrate my graduation by making it “live.” In my mind’s eye, I see Gene Wilder standing over Peter Boyle in the movie “Young Frankenstein” (1974). I am both characters. With joy, Wilder’s character exclaims, “He’s alive!!”

## General Statement

Goals of talk-therapy are often pragmatic; at times the intention is or becomes transformational. I have seen this as I sat in the client’s and clinician’s chair. The same observation was commonly voiced by clinicians whom I interviewed.

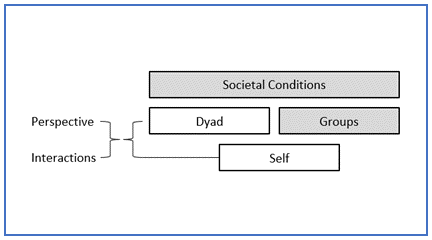
Transformation is evidenced by new behaviors (ad hoc and routine) which maintain and promote *I-You*[[14]](#footnote-14) experiences. I discuss *I-You* in “Chapter One –Theoretical Framework”, “Chapter Two – Transformative Psychotherapy” and “Chapter Four – My Theory.” Transformational learning alters beliefs such that a life can become dedicated to empowerment and emancipation from the forms of oppression which are woven together: personal, social, societal.

I have long been concerned that the psychotherapy profession often neglects societal dynamics that are connected to an individual’s suffering. My concern is rooted in personal experiences such as being bullied in elementary school for refusing to sing Christmas songs on the grounds that I’m Jewish. I’m sure that I got the idea for standing up for my rights because I was raised by parents who were nonconformists. Our father was a social justice activist and our mother was an artist; both were aligned with the Counterculture of the 1960s. After high school I worked in farm fields, canneries and restaurants; I was a cook while getting my undergraduate degree in studio art (which emphasized social justice). I kept cooking until returning to college to earn my Master’s in Social Work. For the next five years, I worked for and helped manage nonprofits that addressed community problems. Only after all of that did I become a licensed psychotherapist in 1991. I continued to manage nonprofit programs until I joined the Peace Corps in 2006.

While my concept of transformation includes society, while understanding this is essential to understanding individual suffering that any clinician witnesses, while individual transformation achieved through psychotherapy can lead to increased engagement in efforts to change society, it is beyond the scope of my dissertation to explore and discuss these things fully. I will at times mention these issues. Social justice is an ever-present concern of mine. I hope to find the sweet spot of acknowledgment of the “Bigger Picture” (WISR, 2015) even as I constrain my dissertation with a focus on one-on-one psychotherapy with adults.

Psychotherapy with couples, families, children and youth are not the subject of my inquiry. Some clinicians whom I interviewed talked about their work with kids and parents. I hope that my study provides useful food for thought for clinicians who serve them.

Figure 2. Transformative/2nd Order Change

What is the well-spring of my interest in transformative psychotherapy and how transformation is achieved? I’ve experienced both. (A commonplace, general story for many clinicians.) Sometimes I say to a client, “That’s a ‘Big Change’” and then I ask, “Do you feel different in some way?” Here is a brief version of my *Big Change* story.

I am one of four sons. Our mother and father, how shall I say this, were “complicated.” The four brothers, in adulthood, went in very different directions to live and work. But we had something in common, explosive anger, sometimes rage. We didn’t tell our stories amongst ourselves until both of our parents were dead. Sharing experiences turned out to be a good thing. I learned that I wasn’t the only one, I hadn’t imagined things. And I saw that two types of emotions dominated while we were growing up: fear that turned into terror and anger that became rage. Oh yes, we had fun, we did good things together. We all cared about social injustice. We still do. Speaking only for myself, it has taken me a lifetime to live comfortably in my own skin, be happy in my relationships and think clearly about it all. And yet, at any moment, a disturbance in The Force[[15]](#footnote-15) can knock me on my ass and when I get up my legs are wobbly before my gait becomes steady. What is the moral of my story? “I have faith in my own *Big Change*. I always reclaim a sensation of contentment. My relationships remain loving. My thinking serves as a useful perspective and helps me make good choices. My values lead me to make Good Trouble.”

I’ve been considering the question, “How do I explain my own necessity to persist, in order to maintain and reclaim my own *Big Change*?” The answer is my generalized theory of transformative psychotherapy; a portion of my dissertation describes it. You will read about a few theories (psychology, psychotherapy, neuroscience) and a philosopher/theologian’s ideas, all of which inform my theory.

The pandemic forced me and other clinicians (who had only provided in-person psychotherapy and supervision) to provide Telehealth services (Carter, 2020; Doran & Lawson, 2021). I had become familiar with Telehealth as I participated in the expanded use of Health Information Technology (HIT)[[16]](#footnote-16) after I returned from Peace Corps service (2006-2008). Once I made the personal decision to deploy Telehealth for my own private practice, I wondered, “Is transformative psychotherapy possible via Telehealth?” Thus, a dissertation was born

## Statement of the Problem

Is transformative psychotherapy possible via Telehealth? My question is distinct from the more common discussion among psychotherapists about what they like and dislike about it.

Telehealth is a feature of Web 2.0[[17]](#footnote-17) and it deploys ICT[[18]](#footnote-18) – Information and Communication Technology (National Assessment Governing Board, n.d.). ICT usage for collaboration is commonly experienced in education and business, so much so that a brand has become synonymous with the activity. Two-way streaming video supports dialogue, as does a landline telephone. The use of the telephone for stabilization counseling (e.g., crisis intervention) is well-established. Its use for brief intervention (that supports stabilization, maintenance, incremental progress) is well-established. An example is telephonic “health coaching.”[[19]](#footnote-19) The problem is that the psychotherapeutic profession has not established whether or not Telehealth supports transformative psychotherapy, if so under which conditions.

## Purpose of the Study

It might be that online is fine for transformative psychotherapy. One online model combines in-person and Telehealth sessions (Wentzel et al., 2016). Another model, Telepsychotherapy[[20]](#footnote-20), is entirely online (Rosen et al., 2020).

In conversation (November 9, 2020) my dissertation advisor Dr. Paloma-McCaleb observed, “Let’s say that a client releases emotion during a session and the therapist is there in-person, it is very likely that the result will be good. But if the other person is somewhere else, only online, there might be greater risk of a bad experience.” Clinicians in California are required by the Board of Behavioral Sciences (BBS) to confirm the physical location of the client during a Telehealth session (California Association of Marriage and Family Therapists, n.d.) in order to minimize such risks, especially those associated with crisis intervention or stabilization needed to prevent a crisis.

I discuss thoroughly what happens when “a client releases emotions during a session.” I show that not all emotional expression has the same significance; there is a unique quality of emotional experience which is essential to transformative effects. What are Telehealth conditions through which the unique emotional experience can be achieved or blocked?

A member of my dissertation review committee, Dr. Gerrard commented in an earlier draft of this paper: “I think you would agree that ‘there is a quality of cognition that is essential to transformative psychotherapy.’ Indeed, there is considerable evidence that emotion is a product of cognition. Can you broaden your discussion about this?”

This is a great example of a limitation imposed by my approach, purpose and bias. I view emotions and cognition as two threads of a triple helix, the third strand is the whole of our physicality. This way of understanding an individual’s struggles can be traced, for me, to Georg Groddeck (1977). He had a long-lived, collegial correspondence with Freud and they never resolved their disagreement (Grossman & Grossman, 1965). They argued over a theory of physicality versus a theory of the mind.

My approach incorporates the triple-helix model, understands emotions in that context and begs the question, “Telehealth doesn’t engage the whole of our physicality, so is it as good as in-person?” My view doesn’t represent the truth. It’s my worldview, paradigm. I imagine that some of you see things very differently. According to Reese & Overton (1970) cited by Abney & Maddux (2004, p. 144):

\* Theories built upon radically different models are logically independent and cannot be assimilated to each other. They reflect representations of different ways of looking at the world and as such are incompatible in their implications. Different worldviews involve different understanding of what knowledge is and hence the meaning of truth. Therefore, synthesis is, at best, confusing.

I am using my synthesis of worldviews and the science derived from them to evaluate the efficacy of Telehealth psychotherapy. Hopefully I have done this in a way that does not confuse.

I agree with psychotherapeutic theory that says we use our methods to help people become more fully human. We exist as creatures before we experience ourselves as human beings, that is why no one is born a Mensch:

\* Mensch can be [characterized as]:"responsibility fused with compassion, a sense that one's own personal needs and desires are limited by the needs and desires of other people. A mensch acts with self-restraint and humility, always sensitive to the feelings and thoughts of others" (Rabbi Neil Kurshan, quoted in Rocker, 2015).

It may seem contradictory to anyone outside of our culture; we are known as having a core trait of intellectual dedication. Yet the highest compliment that we give acknowledges “sensitivity to the feelings” as well as the thoughts. I can’t say for certain, but I imagine Martin Buber was influenced by our shared culture’s view of the Mensch.

Changes in cognition can generate incremental progress in emotional/behavioral stabilization, and then results can become global. Or cognitive processes consolidate gains that flow from healing release of emotions. These two cognitive pathways, incremental progress and reflective consolidation, can lead to the *Big Change* which engages *I-You* presence, recurringly. This is not a matter of so-called depth, an idea I have often heard from psychotherapists. It is about the nature of healing which occurs regardless of the intent of the session or the methods which are deployed.

The purpose of my study is to consider current knowledge about psychotherapy via Telehealth and raise questions for future study specifically with regard to methods to achieve transformative change. I welcome objections from readers and hope for discourse a la Groddeck and Freud.

## Importance of the Study

There is an adage, “It’s sometimes hard to see the forest from the trees.” I felt this when I started to conduct psychotherapy and supervision via Telehealth. The pandemic forced the issue to the forefront for many clinicians. The perceptions of early adopters and late-comers (like myself) could help all of us gain perspective and insight.

One of the challenges in this type of study is that clinicians have varying degrees of explanatory ability. Some answers were vague in response to the question, “What psychotherapy theory do you use?” The same thing happened in reply to the question, “How do your methods work?” The ambiguity is understandable if the forest that the clinician inhabits is making a living; that often does not give much time for conceptualization. The ambiguity is also characteristic of a clinician who has expert-level proficiency[[21]](#footnote-21) in the psychotherapeutic arts.

My theory provides readers with a clear description of therapeutic dynamics in psychotherapy. An aspect of therapeutic dynamics, previously mentioned, is quality of emotional experience. Here’s the next one, inherent for all of us who are effective, but often not articulated. As soon as you read it many of you will think, “Oh, I remember that!”

Martin Buber (1970) published his theological, philosophical treatise, “I and Thou” in 1923. In his book, *I-You* denotes human encounter and *I-It* signifies objectification. While it has seeped into the popular culture and the psychotherapeutic profession, I discuss it anew. “I and Thou” is indispensable to understand the nature of transformation which is achievable with psychotherapy and in other ways, too.

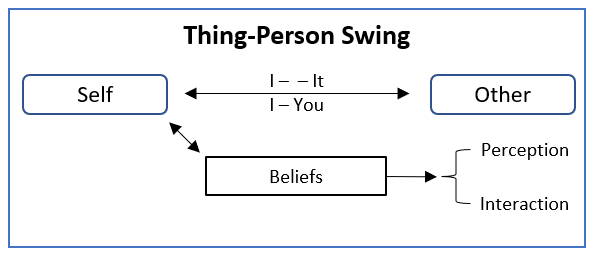
My dissertation explores the strengths and limitations of Telehealth, using concepts from “I and Thou.” Readers, as a consequence, can reflect on their own practice benefitting from Buber’s perspective.

## Theoretical Framework

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)

Figure 3. Thing-Person Swing

I refer to Buber’s “floats and fluctuates” as the *Thing-Person Swing*. I emphasize the essential factor of “world of value,” beliefs, schemas[[22]](#footnote-22). The role of beliefs in the *Thing-Person Swing* is important to transformative psychotherapy.

The concepts of *I-It* and *I-You* are a bit awkward, because they do not fit common speech. *I-It* turns the other into a thing and the term places the reader as the subject (“I”). We need to refer to the experience of one’s own self as a thing, for that let’s use the term “Self-It.”

Imagine a client believes that an entire population is subhuman, a type of *Thing*. As soon as that classification is activated, the client is in *I-It* orientation. Transformative psychotherapy cannot ignore the belief.

The swing can be beyond conscious awareness, it can be reflexive, it can be Self-orientation. Imagine a couple. They were in love, so they decided to live together. Their 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[[23]](#footnote-23) 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 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. Intersubjectivity is a shared meaning that emerges from and is enacted within the social fabric of interaction (Garte, 2016, para. 1). These concepts are discussed fully in “Transformative Psychotherapy” (Chapter Two) and “How and Why I Formed My Theory” (Chapter Four).

**My theoretical framework in a nutshell:**

There is a quality of emotional experience which is essential to transformative psychotherapy. Think of a time when you cried and the person with you was supportive and safe. Afterward, you felt better; you might have better been able to talk about it, gaining a new perspective. The term that I use is *emotion response cycle*[[24]](#footnote-24) and the cognition that heals is in the post-wave repose. Now think of an emotional time when you cried and a person responded aggressively, punitively or dismissively. Once the tears stopped there was not a feeling of well-being and talking was not helpful. In this situation, I liken the tears to spasms.

My theoretical frame posits that there is a polarity in the quality of emotional experience, an *emotion response cycle* versus spasms. The *emotion response cycle* flows from safety, trust and respect (*I-You*); spasms flow from insecurity, doubt and disregard (*I-It*). Transformative psychotherapy generates a recurring *emotion response cycle*.

## Research Questions

My study was qualitative research (Glaser & Strauss, 1967; Pathak et al., 2013; Singh & Estefan, 2018). I interviewed experienced clinicians. The question, broadly framed, “What works well or not, why?” I wanted to learn if my doubts about psychotherapy via Telehealth were justified. Intuitively, I knew that Telehealth cannot be the same as in-person where I use all of my senses to be effective. 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? Are Telehealth enthusiasts missing nuance? What if there are circumstances or conditions that support the use of Telehealth rather than in-person? How might decisions be made whether to see clients in-person or via Telehealth?

“It all depends” applies to psychotherapy, so I sought interviews with experienced psychotherapists. All of them recognized the overlap of transformative and solution-focused psychotherapy. In different ways they said the session’s focus, strengthening abilities for daily living and transformative personal growth, is more like Ying-Yang than it is either-or. I listened for stories and clues, if woven together they might resolve or reinforce my doubts:

1. Is transformative psychotherapy possible when all sessions are Telehealth?

2. Is there a theoretical orientation that is enhanced by Telehealth?

3. Is there a kind of client for whom Telehealth is more viable?

I thought about my overall question, “What works well, why or why not?” I thought about secondary questions such as those I just listed. I wondered if Telehealth was good preparation for in-person transformative psychotherapy. Does solution-focused change via Telehealth activate strengths needed for transformative psychotherapy? Are certain clients more amenable to Telehealth transformative psychotherapy? I planned the interview and then fine-tuned it. My curiosity was a guide during the interviews. With each interview, my curiosity developed.

## Overall Research Design

I began with a criterion that participants for interviews be licensed psychotherapists with a minimum five years of experience. I found through snowball sampling[[25]](#footnote-25) that the paths of experienced clinicians were varied; some took years to become licensed. I changed the criteria to eight years post-graduate practice experience and four years licensed, or five years licensed experience. As conversations continued with prospects for interviews, I encountered a few experienced psychotherapists who were clear about their reasons not to use Telehealth for transformative work. I decided to include them. As a result of expanded criterion, there was more diversity among respondents in terms of culture, gender identity and language (theirs and the client communities whom they serve).

My rationale for these modifications was that this was a qualitative inquiry and the expansion of criteria would provide valuable insights. The sample was twenty-three respondents. The pool of respondents was developed by the snowball sampling method; I started with inquiries drawn from my professional network and recommendations of my dissertation advisors. Nominal variables[[26]](#footnote-26) included characteristics of the clinician (e.g., apparent gender), number of years as a licensed practitioner, number of years using Telehealth. Each respondent provided psychotherapy in-person and via Telehealth. For some, Telehealth started sometime during the pandemic, others started before. Privacy, confidentiality and full disclosure considerations can be read in “Appendix A: Safeguards.”

My dissertation explored the views of clinicians about the qualities of psychotherapy that provide transformative potential. I provided, before the initial interview, a few examples of distinct theories/methods. It provided each respondent an initial reference to identify their own, main theoretical orientation for transformative psychotherapy.

## Assumptions and Limitations

Clinicians sometimes make assumptions that the meaning of terms that they use are understood among peers; unless they are in academia or other settings that require strict definitions. For example, in my experience, counseling and psychotherapy are often used interchangeably. My first assumption was that my research needed to convey clear terms. I tried “first-order and second-order change.” I returned to a more commonly recognized vocabulary and that provided a solid foundation for the interviews.

My next assumption was that in-person and Telehealth provide experiences that are very different, these differences are not well understood in terms of the effects on transformative psychotherapy. The assumption grew out of my own training in and experiences from providing in-person psychotherapy, as well as my supervision of interns. My experience spanned decades before my immersion in Health Information Technology (HIT) as a consultant to physician practices, community clinics, hospitals. Then the pandemic led me to become a late adopter of Telehealth to provide psychotherapy and supervision.

My study had three significant limitations:

1. There is not a lot of literature about Telehealth that is specifically focused on transformative psychotherapy.

2. My sample size was twenty-three.

3. The concept of personal transformative change, regardless of the words used by the psychotherapist, often neglects societal dynamics that are connected to an individual’s suffering.

## Summary

Talk-therapy can be focused on adaptation to a status quo or transforming patterns of living that developed from past experience. The order-of-change construct (Fraser & Solovey, 2007) is one way to discuss it.

My goal is to contribute to discussions about Telehealth psychotherapy among clinicians, educators and scholars. The pandemic forced the issue to the forefront for many clinicians. The perceptions of early adopters and late-comers (like myself) could help all of us gain perspective and insight.

My dissertation considers whether the efficacy of a clinician’s theory and methods for in-person, transformative psychotherapy transfers to Telehealth, well or not. I explore explanations and questions about that.

Transformation, to be described, requires a prior condition for contrast. The before-and-after contrast is associated with the method, psychotherapy. Transformation is observed in development of the individual and their social relationships, in the context of societal conditions. While my concept of transformation includes society, while understanding this is essential to comprehending an individual’s suffering, while individual transformation achieved through psychotherapy can lead to increased engagement in efforts to change society, it was beyond the scope of my dissertation to explore and discuss these things fully.

I asked the question, “Is transformative psychotherapy possible via Telehealth?” The problem is that the psychotherapeutic profession has not established whether or not Telehealth supports transformative psychotherapy, if so under which conditions. I use the perspective of “I and Thou” (Buber, 1970) to understand “transformative.”

The literature review (Chapter Two) has two parts. The first explores a few developments in theories about transformative psychotherapy. The second summarizes current literature about psychotherapy and Telehealth, with a guiding interest in transformative personal growth. Chapter Three describes my research methods and findings from interviews of experienced psychotherapists. Chapter Four is a presentation of my own generalized theory of transformative psychotherapy and its relevance to the evaluation of Telehealth; in effect it is a description of my perspective (that can be considered a form of bias). Chapter Five is the conclusion, my main findings, insights, recommendations. Chapter Six suggests ideas for future inquiry and my initial plans for future activity.

# Chapter 2: Literature Review

The literature review has two parts. The first is a general discussion about developments in theories about transformative psychotherapy. My selections are based upon the relevance to my theory. It is not a complete or comprehensive review of theory in psychology or psychotherapy. But it is essential to start with it, in order to consider the efficacy of Telehealth for transformative personal growth.

The second part summarizes literature about psychotherapy and Telehealth, with an emphasis on transformative change. Key questions for my review about Telehealth are: What does the literature address; what are the gaps in knowledge that need further research?

## Transformative Psychotherapy

Psychotherapy is a specialized discipline of learning. I begin with a view of transformative learning from the field of higher education:

The central focal point and power of transformative learning is fundamental change in perspective that transforms the way that an adult understands and interacts with his or her world. Reflective thinking is the foundational activity that supports and cultivates such perspective transformations. (Wang et al., 2016, p. 43)

It is not incidental that I start with an observation about transformative learning and higher education. My WISR doctoral program title includes, “Higher Education and Social Change.” The WISR curriculum emphasizes a broad vision of higher education that reaches into the community, the vision is not bound by or into institutions.

Transformation, to be described, requires a prior condition for contrast. The before-and-after contrast is associated with the method, psychotherapy. Transformation is observed in the psychological development of the individuals, changes in social relationships; both occur in the context of societal conditions.

What is the difference between psychology and psychotherapy? Psychology gives us a foundation to understand psychotherapy. Psychotherapy is a method to affect a person’s psychology. In order to understand theories and methods of psychotherapy, it is useful to start with some theories about psychology. I summarize only those which are most relevant to my own theory of transformative psychotherapy.

### A Few Theories about Individual Psychology

A psychodynamic premise is that emotions of an individual have conflicting characteristics, they form conflicting impulses which occur beyond the conscious awareness of the person (Horney, 1939, pp. 23-25).

Neuroscience describes the influence of the limbic system on such impulses. The cerebral cortex is a part of the brain where memory, awareness and conscious thinking take place (Ruud, 2019, para. 1). Cognition is influenced by the nonverbal limbic system and vice versa.

Psychodynamic theory posits conflicting impulses beyond conscious awareness; neuroscience describes conflicting impulses from the interaction of the limbic system and cerebral cortex. Another view of conflicting impulses and associated perception is offered by Gestalt psychology.

Gestalt psychology (Köhler, 1972; Köhler, 1973) provides a “field theory” of psychology. The theory proposes there is foreground and background perception, based upon bioelectrical activity in the brain, emotions condition perception. Cognitive psychology refers to resultant structured cognition as schema.

I have pulled ideas from four disciplines that explore psychology: psychodynamics, neuroscience, gestalt, cognitive. All of these will give us a basis to evaluate Telehealth as a modality for psychotherapy.

### Transformative Psychotherapy, Theories Relevant to Mine

In this part of the literature review, my focus is the concept “transformative” as seen through the lens of psychotherapy – I touch on some basic theories.

1. What is the origin of the term “transformative psychotherapy?”

2. How does it relate to the concept “2nd-Order Change?”

3. Are there different definitions of transformative therapy?

4. What are some contemporary versions of psychotherapy and how

do they bring about transformative change?

5. What constitutes evidence that a client has undergone a

transformative change?

6. What would be examples of transformative one-to-one talk-therapy in the three dominant psychotherapy approaches that inform my theory?

#### The Origin of the Term “Transformative Psychotherapy”

Let’s begin with the origin of the term. In the 19th century, academia’s view of the mind shifted from theological and philosophical explanations to the physiologists’ explorations of psychology. The overarching questions for the physiologists were:

1. Is there a biological basis for conscious and unconscious thought?

2. What is the connection to behavior?

Therapeutics developed by the physiologists focused on altering biological functioning to induce recovery from symptoms. ("Historical context for the writings of Sigmund Freud," n.d.; "History of psychology" 2014; Malone, 2021; Psych.rutgers.edu, n.d.)

It turns out that independently, two physicians arrived at a similar approach to resolving symptoms; that was verbalization of unconscious injury. Freud introduced his ideas about talk-therapy in a paper about repressed memories of childhood sexual assault ("Freud, "Aetiology of hysteria"," n.d.; "Young Dr. Freud . Theories: Seduction | PBS," n.d.) He developed the method and ideas while working with patients who were the adult daughters of society’s rich-and-powerful. The powerful, male elites responded with hostility; Freud continued his experiments in talk-therapy but replace his theory of childhood sexual assault with a theory of the mind (conscious development and unconscious conflicts.) I said there were two physicians developing talk-therapy independently of each other. Who was the other doctor? Georg Groddeck (1977, 2012; Grossman & Grossman, 1965) asserted that an individual’s physiology communicated in code about the nature of the illness and if decoded correctly the symptoms would diminish or vanish. Groddeck did not give a brand name to his approach to talk-therapy, Freud coined his “psychoanalysis.”

Freud (1938, p. 442) discussed the transformation of affects, “The dream-work is able to dispose of the affects of the dream-thoughts in yet another way than admitting them or reducing them to zero. *It can transform them into their opposites.”* [Italics in the original]. Freud considered transformation a result from the resolution of unconscious conflicts through talk therapy. Jung (1968, p. 179) considered individual transformation to result from developmental maturation which could be facilitated by talk-therapy:

\* To establish a really mature attitude, he has to see the *subjective value* of all of these images which seem to create trouble for him. He has to assimilate them into his own psychology; he has to find out in what way they are part of himself; how he attributes for instance a positive value to an *object*, when as matter of fact it is he who could and should develop this value. And in the same way, when he projects negative qualities and therefore hates and loathes the object, he has to discover that he is projecting his own inferior side, his shadow as it were, because he prefers to have an optimistic and one-sided image of himself.” [Italics in the original.]

In summary, I gave a brief summary of the early history of the development of a theory of the mind during the historical period that came to be known as Modernism: a theological and philosophical emphasis was supplanted by physiologists who pioneered the field of psychology. A major theoretical divergence emerged associated with the concept of transformation: the resolution of unconscious conflicts versus developmental maturation which requires integration of unconscious motivations. From its inception, there has been skepticism and rejection of the theory of the unconscious.

#### Transformative Talk-Therapy and “2nd-Order Change”

Pioneers introduced talk-therapy 120 years ago. Since then, there has been experimentation and thinking for the common good as well as intellectual battles for power and glory. I will focus on the common good.

The subtitle of Fraser and Solovey’s *Second-Order Change in Psychotherapy* (2007) is “The Golden Thread that Unifies Effective Treatments”. The quest to understand treatment efficacy connects their work with the efforts of the talk-therapy pioneers. One implication is a desire to lay to rest the intellectual battles for power and glory. They state, “First-order change is related to stability; second-order change is related to transformation (p. 15).” We can see the knowledge has been disseminated in statements such as this:

\* Second order change is creating a new way of seeing things completely. It requires new learning and involves a nonlinear progression, a transformation from one state to another. The aim would be to enable the individual to behave, think, or feel differently (Hanson, 2016, para. 4).

\* Second-order change implies a fundamental or significant break with past and current practices. This type of change represents a dramatic difference in current practices. Second-order changes require new knowledge and skills for successful implementation. A change becomes “second-order” when it is not obvious how it will make things better, it requires people to learn new approaches, since it conflicts with prevailing values and norms (Parmenidou, 2011, p. 3).

As I read the book by Fraser and Solovey, I thought, “This is useful for the education of people entering the field because it is non-partisan.” The authors explain therapeutic action associated with second-order change (p. 95):

\* [As] meaning-making machines, we develop assumptions about every aspect of our life experience… [Therapists] can ascertain the faulty assumptions for intervention by understanding the commonality in the client’s first-order solutions… Second-order change predicts further those solutions to psychological problems lie in opposites.

While they give a nod to the theory of the unconscious and the theory of healing through the clinical relationship, their methodology emphasizes a cognitive-behavioral approach: Analyze the patterns of first-order change and the nature of their insufficiencies, then try things in the territory of opposites.

There is common sense expressed by the notion of opposites. But I wonder: When the commonality of observable first-order solutions (i.e., thoughts emanated and derailed, behaviors committed and omitted) is understood and the repetition of problems continues, what’s a body to do?

Practitioners and researchers who gravitate toward the cognitive-behavioral approach have embraced the order-of-change framework (Bartunek & Moch, 1987; Ellis, 1992; Lutz, 1975; Lyddon, 1990). Murray (2002, p. 172). emphasized experiential change in self-concept, "increased self-acceptance, a sense of personal power, and a feeling of inner peace."

In summary, second-order change refers to a personal transformation that can also be manifested in social relationships and the transformation is such that cycles, repeating patterns of problems, are put to rest.

#### Different Definitions of Transformative Psychotherapy

Transformative psychotherapy is the subject of ongoing scholarship. Castonguay and Hill (2012) focused on three major approaches to psychotherapy: psychodynamic, relational and cognitive-behavioral. These definitions have changed over time and the history is inconsistently transmitted through the generations. Why is that relevant? Jacoby (1975, p. 4) states:

\* The general loss of memory is not to be explained solely psychologically; … it is a *social* amnesia – memory driven out of the mind by the social and economic dynamic of this society. The nature of the production of *social amnesia* … would have to draw upon the Marxist concept of reification [which] refers to an illusion that is objectively manufactured by society. This social illusion works to preserve the status quo by presenting the human and social relationships of the society as natural – and unchangeable – relations between things. What is often ignored in expositions of the concept of reification is the psychological dimension: amnesia – a forgetting and repression of the human and social activity that makes and can remake society. [Italics in the original.]

Jacoby’s treatise is about the loss of social memory and its impact on individual psychology. To explain, I need ‘a little help from my friends’:

\* Dialogue and the notion of praxis (the dialectical interweaving of theory and practice) cultivates Freire’s concept of conscientização (conscientization) which is an unfolding process that is filtered through a contextual framework that intersects the psychological– political– theological– social milieu in the awakening of critical awareness ... The notion of conscientization is not static or formulaic, but rather is situated in historical spaces and times (Kirylo, 2013 , p. 51).

\* Today, under the conditions of repressive integration, the change within individual emancipation may be the task of small education groups, political and psychological in one, practicing self-education, in and against the official education... In short: internal transformation of psychological into political, of therapy into political education. (“Kent State Lecture”, Herbert Marcuse, 1976, in “Introduction”, Kellner, et al., 2009, p. 15)

An orthodoxy of symbols and constructs turn people and their activities into things, relegated to alienated labor and self-alienation. Fortunately, resistance and creativity cannot be suppressed or repressed among all of the people, all of the time.

During and after World War II, the Postmodernist movement flowered. As it pertains to transformative psychotherapy, the question was, in so many words, “What good is personal growth if the relentless injuries caused by societal oppression are not opposed?” The theorists and practitioners became loosely known as post-Freudians. One of the best known is Erich Fromm. In the chapter “Mechanisms of Escape'' (*Escape from Freedom*, 1941, pp. 155-156) Fromm states:

\* By becoming part of a power that is felt as unshakably strong, eternal, and glamorous, one participates in its strength and glory. One surrender’s one’s own self and renounces all strengths and pride connected with it, one loses one’s integrity as an individual and surrenders freedom; but one gains a new security and a new pride in the participation in the power in which one submerges. One gains also security against the torture of doubt.

A Jesuit, parish priest and psychologist was assassinated by a Salvadoran death squad which was financed by the U.S. government. He was murdered in 1989. His name: Ignacio Martín-Baró. In the chapter “Toward a Liberation Psychology” (Martín-Baró, 1994, p. 27) states:

\* Psychology has always been clear about the need for personal liberation; that is, people’s need to gain control over their own existence. Psychology has believed that, were it not for unconscious mechanisms or conscious experiences holding them back from their existential goals and personal happiness, people would turn their lives toward a pursuit of those objectives which they consider worthwhile. Nevertheless, psychology has been for the most part not been very clear about the intimate relationship between an unalienated personal existence and unalienated social existence, between individual control and collective power, between the liberation of each person and the liberation of a whole people. Moreover, psychology has often contributed to obscuring the relationship between personal estrangement and social oppression, presenting the pathology of persons as if it were something removed from history and society, and behavioral disorders as if they played themselves out entirely on the individual plane.

### Contemporary Psychotherapies can be Transformative

There is a growing body of literature about three modern versions of three dominant approaches (psychodynamic, relational, cognitive-behavioral) and transformative results (Caviglia, 2021; Fok et al., 2021; Giovanardi & Spangler, 2021; Kellogg & Garcia Torres, 2021; Lüdemann et al., 2021; Mende & Schmidt, 2021; Minulescu, 2015; Peräkylä, 2019; Prot-Klinger, et al., 2019):

1. What constitutes evidence that a client has undergone a transformative change?

2. What would be examples of transformative one-to-one talk-therapy in the three dominant approaches that inform my theory?

Let’s start with the two derivative questions represented by the bullet points. The first one asks for evidence. “Empirical evidence supports the efficacy of psychodynamic psychotherapy” (Shedler, 2011, p. 1). “Our data suggest that [Long-term Psychoanalytic Therapy] is effective treatment for a large range of pathologies, with moderate to large effects” (de Maat, et al, 2009, p.1). "There is evidence that both psychodynamic therapy and cognitive behavior therapy are effective treatments of personality disorders" (Leichsenring & Leibing, p. 1, 2003). Similar comparability is found for relational therapies (Ghaffer, et al., 2020; Magnavita, 2005; Shapiro, et al. 1994). “[Cognitive Therapy] is effective in patients with mild or moderate depression” (Gloaguen, et al., 1998, p. 1).

#### Feminist Psychotherapy

From a feminist perspective, Longino (1993) asked, “What evidence is valued?” A WISR scholar answered the question this way:

Science has historically claimed its authority through its claim to universality. This universality derives from its assertions of "objectivity". "Objective" is defined as having reality independent of the mind, "of, relating to, or being an object, phenomenon, or condition in the realm of sensible experience independent of individual thought and perceptible by all observers (Pruitt, n.d., p. 1).

A practitioner defined it this way:

\* I define feminist therapy as the practice of therapy informed by feminist political philosophies and analysis, grounded in multicultural feminist scholarship on the psychology of women, men and gender, which leads both therapist and client toward strategies and solutions advancing feminist resistance, transformation and social change in daily personal life, and in relationships with the social, emotional and political environments. (Brown, n.d., para. 1)

The theory and practice have been developing for decades, the heritage extends back generations ("16 ways you can stand against rape culture," n.d.; Collett, 2014; Enns, 1993; Gray & Desmarais, 2014; Halo, et al., 2021; Kaschak, 2018; Marcus-Mendoza, 2010; Mathy & Schillace, 2003; Morrow & Hawxhurst, 2012; "Putting politics into practice: Feminist therapy as feminist praxis," 2013; Sparks, 1995). Two other WISR scholars discussed the issue from an overarching perspective:

\* Thomas Kuhn has used the term "paradigm" (broadly, a pattern, or model) to describe such complexes of basic concepts, assumptions, ways of studying a thing, examples of proved conclusions, etc., which he says characterize all "normal science," and a lot of other people have picked up the term and popularized it. (See Kuhn, The Structure of Scientific Revolutions, 2d ed., 1970) The basic point about it here is that our choices of such "paradigms" make a lot of difference to the course and content of our inquiries afterwards It is worth remembering that, just as there is no great Scientific Method in the sky, that is the correct one, so there is no one way to describe or categorize what you want to study, or the conclusions you want to reach. So, you choose these, for each inquiry, whether you do it consciously or not. (Lunsford & Bilorusky, 1981, pp. 3-4)

#### Liberation Psychology

Progress can be compromised, predictably by systemic oppression. The problem with the concept of evidence for individual transformation is that it neglects the synthesized Marxian and Freudian critique of modern society. The critique predicts the rise of authoritarianism in the liberal democracies, and the critique demands a *Great Refusal* on all levels at all times to resist the destruction of liberal democracy. One way to view transformative personal growth is the individual’s orientation to oppression. Transformative psychotherapy responds to manifestations of “internalized oppression”[[27]](#footnote-27) as well as actively engaging in action to create social justice (Brown, 1973; Freire, 1998; Jacoby, 1975; Martín-Baró, 1996).

#### Intersectional Psychotherapy

Imagine the joy I felt when I came across the New School for Social Research “Frantz Fanon Lab for Intersectional Psychology” (n.d.) They state, “Here you will find information about our current projects and how to collaborate with us in our scholarship and research. … We complement Fanon’s thinking with perspectives drawn from intersectionality and queer of color critique, in particular the works of Kimberle Cremshaw, Roderick Ferguson, and the Combahee River Collective. This involves examining how inequality manifests itself across lines of race, ethnicity, class, gender, gender identity, sexual orientation, ability, citizenship status, age, and religion.” Intersectional psychotherapy is a growing field (Acharya, 2010; Adames, et al., 2018; Denton, 2016; Faramelli, 2020; "Intersectionality in psychology" n.d.; Kassan & Moodley, 2018; McKenzie-Mavinga, 2018; Nayak, 2020; Robcis, 2019; Rogers-Sirin, 2017; Rutherford & Davidson, 2019; Walker, et al., 2012; Witten, 2016; Wright & Wright, 2017) Another great website, in addition to the New School for Social Research is the Australian Psychological Association’s “Intersectionality in psychology: A rainbow perspective” (n.d.)

#### A View from a Philosopher and Theologian

Another way to understand transformative change is to go entirely outside the fields of psychology and psychotherapy. In his seminal treatise, Buber provides a nuanced explanation that informs my understanding.

\* 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)

Buber’s “world of value” is similar to Cognitive psychology’s concept of beliefs, schemas.I have chosen three theories: Psychodynamic Psychotherapy, Interpersonal Psychotherapy, and Cognitive Behavioral Therapy to understand Telehealth psychotherapy. My choices were supported by literature:

\* [Although] there is empirical support for delivering cognitive behavioral therapy through telehealth services, there is still limited information about which therapy modalities are most amenable to telemental health care delivery [Berryhill et al., 2019]. Additional data are needed to assess clinicians’ and patients’ satisfaction with more relationally focused interventions, such as psychodynamic and interpersonal therapy [Jenkins-Guarnieri et al., 2015]. (Chiauzzi et al., 2020, p. 2)

Next we take a quick look at these three historically dominant psychotherapeutic approaches that support transformative personal growth: psychodynamic, relational and cognitive-behavioral.

#### Psychodynamic Psychotherapy

“Psychodynamic” is a term used by clinicians who are not trained by a psychoanalytic institute, their theory and methods deviate from psychoanalysis, even as they use key psychoanalytic principles. Psychodynamic theory and methods developed from psychoanalysis.

Psychoanalysis is aligned with ideas and practices established by Sigmund Freud (Brandell & Schechter, 2014). Psychoanalysis relies on the interpretation of transference. The interpretation is focused on repression that is indicated by resistance. Interpretation is a way of surfacing conflicts in the unconscious; free association is a cornerstone method.

\* A psychoanalyst who might be asked to give very briefly the essential principles of psychoanalysis could say that the recognition of the significance of childhood history for personality development, the teachings of transference and resistance, and above all, the establishment of the unconscious as an integral part of the human mind constitute the essence of psychoanalysis. (Fromm-Reichmann & Bullard, 1960, p. 105)

Karen Horney, a founder of the Berlin Psychoanalytic Institute, provided some of the earliest formulations that deviated from Freud (Horney, 1967). She focused on the emotions of an individual which have conflicting characteristics and the person’s adaptation to the conflicting impulses which occur beyond the conscious awareness of the person (Horney, 1939, pp. 23-25). Psychodynamic methods retain that focus.

There are two early psychoanalysts who I see as bridges to psychodynamic psychotherapy. They posit conflict between unconscious impulses and the conscious self. But their methods do not rely on interpretation of resistance. They are Carl Jung and Harry Stack Sullivan.

Carl Jung parted ways with his mentor Sigmund Freud, partly over the purpose of psychoanalysis. Freud was interested in resolving symptoms caused by a patient’s unconscious conflicts (e.g., neurosis). Carl Jung began to work with awareness as a means to mobilize the unconscious for creative purposes, he introduced the method *active imagination* (Jung & Bennet, 1968, p. 192):

\* [Everybody] gets at it in his own way… imagination is active, purposeful creation… [Active] imagination, as the term denotes, means that the images have a life of their own and the symbolic events develop according to their own logic – that is, of course, if your conscious reason does not interfere.

Jung considered the four functions of consciousness to be sensation, thinking, feeling and intuition. These serve a person’s interactions and understanding of the external world. He posited features of “personality which is still unconscious, which is still becoming; we are unfinished; we are growing and changing” (p. 22).

Harry Stack Sullivan was a psychoanalyst who described the relationship between patient and doctor to be the basis of treatment. The interpersonal experience is inseparable from the nature of transformative psychotherapy; the clinician is a “participant-observer” (Morgan, 2014; Sullivan, 1953). “What one observes is a situation, ‘integrated’ by two or more persons. The situation is an interaction, an integration, or rather an integrated interaction of two or more people” (Sullivan, 2018, p. 280). It’s my view that Sullivan laid the path that became psychodynamic psychotherapy, because interpretation became focused on the relationship not as a manifestation of resistance but rather as an experience of personal growth. Unconscious conflicts begin with the individual’s origin story, thereafter personal development is bound by the conflicts. Interpretation of the relating (rather than the transference) loosens the bindings.

Next, I briefly discuss Interpersonal Psychotherapy. Jung’s concept of *active imagination* and Sullivan’s focus on relating are consistently expressed – even though the language varies.

#### Interpersonal Psychotherapy

Humanist Psychotherapy firmly established the interpersonal approach. It focuses on a person’s individuality. The emphasis is on a person’s ability to use strengths to find wisdom, growth, healing, fulfillment (*Humanistic Therapy*, n.d.) Therapy is “person-centered” and therapeutic results are achieved in the context of the relationship (Rogers, 1995; Rogers, 2012.) Authenticity, empathy, and “unconditional positive regard” manifest effective use of self in the psychotherapy. Rogers published his ideas about client-centered therapy in the aftermath of World War Two (Rogers, 1946; Rogers, 1951).

Unlike Rogers, Maslow connected his theory with the heritage from psychoanalysis (Maslow & Murphy, 1954; Maslow, 1968). Maslow, in *A Theory of Human Motivation* (1943), discussed human suffering in terms of thwarting essential needs; the needs engaged by interpersonal psychotherapy are safety, love, esteem, self-actualization.

#### Cognitive Behavioral Therapy (CBT)

The psychotherapist who developed Cognitive Therapy, Aaron T. Beck, was a trained in psychoanalysis and (like Carl R. Rogers) he separated himself from it. His theory and methods are more widely known and practiced as Cognitive Behavioral Therapy (CBT) because clients became better emotionally and behaviorally when they “changed their underlying beliefs about themselves, their world and other people” (*Beck Institute,* 2015). CBT is closely related to Rational-Emotive Behavior Therapy (REBT) that “served as a sort of precursor to the widely known and applied Cognitive-behavioral therapy (CBT), and [it] is still commonly used as a treatment in CBT interventions” (*Albert Ellis' ABC model...*, 2021, para. 2).

CBT methods are specific to the diagnosis (Madewell & Shaughnessy, 2009). For example, the Veterans Administration provides training tailored for the treatment of depression, the manual’s core premise is that an event leads to an automatic thought which generates a reaction (Crane & Watters, n.d., p. 8).

## Psychotherapy and Telehealth

I conducted a traditional, narrative review (University of Alabama, 2007). I did not have a hypothesis per se. I cast a wide net to find publications and I used my judgment to assess relevancy. In other words, I made educated guesses. My criteria for inclusion in the literature review about Telehealth and psychotherapy were:

1. A focus on transformative effects rather than solely here-and-now adaptation,

2. An inquiry about the psychotherapeutic experience and/or

3. An inquiry about individual adult psychotherapy.

I usually excluded from my literature review articles about Telehealth psychotherapy that targeted specific diagnoses or populations. I mentioned a few such studies if they provided context or direction for my inquiry. The organization of material developed from the review itself; my process was inductive[[28]](#footnote-28). I cast a wide net.

I started with a simple query, “Telehealth psychotherapy” in the ProQuest Research Library: Health and Medicine. I also used ProQuest Central and ProQuest Psychology Database. I accessed each search engine through the Library and Information Resources Network. The query was not specific enough to focus on transformative change. I changed the query to “second-order psychotherapy”; there were plenty of results, but they did not include Telehealth. My next query was, “second-order psychotherapy Telehealth”. Results included two of three terms, but not all of them. Similar results occurred with the term “transformative” substituted for “second-order.”

My search of sites from professional associations yielded little about psychotherapy theory and methods in the context of Telehealth. My membership in the National Association of Social Work (NASW) provides me access to its discussion forums. I monitored (for several months) two forums, one is for all members and one is for mental health professionals. There were no discussions that compared modalities for psychotherapy (in-person and Telehealth)[[29]](#footnote-29) until I posted an announcement about my dissertation topic in May 2021. The California chapter of the NASW offers continuing education in Telehealth, a state-mandated course *Legal and Ethical Aspects of Telehealth* and *Telehealth Response to Covid-19*. A search of CAMFT (California Association for Marriage Family Therapists) focused on legal, ethical and business concerns as well as risk management, regulation, payment, etc.

There are a lot of articles about legal, ethical and business concerns (Baker & Bufka, 2011; Clark, et al., 2010; Maheu & Gordon; 2000). Attention is given to risk management, regulation, payment and so on (Kramer, et al., 2013; Maheu, 2001; 2006; 2020).

Dr. Karen Wall, WISR faculty, suggested the search term “telebehavioral health.”[[30]](#footnote-30) That search term yielded businesses that promote it.[[31]](#footnote-31) One had a bibliography and I’ve included some of the cited literature.

### Some Studies about Modalities

Richards & Richardson (2012) stated in their systematic literature review and meta-analysis, “The majority of literature reviews are targeted to support a hypothesis and may be vulnerable to author bias because of this, as they may not always explicitly comment on literature selection decisions or rationales” (p. 35).

According to Smith, et al. (2021) the evidence from research that is 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-centred, humanistic or integrative practices [British Association for Counselling and Psychotherapy, 2021, “2.1 CBT focus of evidence base”].

Some aggregated literature reviews were done to inform the policies of and expenditures by governmental agencies and corporate entities; academia is closely aligned with their efforts to define “evidence-based practices” (EBP)[[32]](#footnote-32).

EBP is one of seven core competencies that guide government policy and the healthcare industry (Maheu, et al., 2020). Along with the other core competencies, the impetus is a concern for quality as defined by patient outcomes. My own training in Health Information Technology emphasized risks to patients derived from health care processes that do not operationalize quality (Institute of Medicine, 2001). According to Maheu, et al., (2020), “[Telebehavioral Health] TBH has been demonstrated to be an effective mode of treatment for a variety of presenting problems, with outcomes comparable to therapy provided in-person when diagnoses and settings are controlled.”

EBP research commonly cites Cognitive Behavior Therapy (CBT). CBT is defined by policy-makers and the insurance industry as an EBP. One study of 33 patients at an intensive outpatient psychiatric treatment program found that internet-based CBT seemed efficacious as an adjunct to the in-person services (Fernandez, et al., 2021; Månsson, et al., 2017). “CBT seems to be effective when delivered online in real time by a therapist, with benefits maintained over 8 months” (Kessler et al., 2009). A study found that internet-based CBT was useful in support of in-person treatment of hoarders (Fitzpatrick et al., 2018) and children traumatized by family violence (Anderson & Cook, 2015). Another study found, “Internet and other computerized treatments hold promise as potentially evidence-based treatments of depression” (Andersson & Cuijpers, 2009).

Common concerns among TBH researchers, in addition to EBP, include: access to mental health service (Abney & Maddux, 2004; Backhaus, et al., 2012, Bee, et al., 2008; Chakrabarti, 2015; Warren & Smalley, 2020), reducing disparities associated with social injustice (Fore, 2013; Gone, 2004; Hays, et al., 2014; Hilty, et al., 2020; Human & Wasem, 1991; Panchal, et al., 2021) general cost-effectiveness (Bischoff, 2004; Berryhill, et al., 2019; Gros et al., 2013; Harwood et al., 2011; Hilty, et al., 2013; Langarizadeh, et al., 2017; Luxton, 2013; Marton & Kanas, 2015; Modai, et al., 2006; National Center for PTSD, n.d.; Whaibeh et al., 2020).

According to Hilty et al. (2019), “few studies literally discuss the therapeutic relationship… Additional evaluation/research is needed to ensure quality care, training and evaluation of the therapeutic relationship while preventing potential pitfalls.” A literature review of 844 studies yielded eleven (1.3%) which were concerned with the therapeutic alliance (Sucala et al., 2012).

"How do I create a therapeutic alliance using telehealth?" is one of the courses offered by Telehealth.org. Several of their other courses emphasize "telepresence."[[33]](#footnote-33) The organization’s bibliography listed 915 publications. I read through the listed publications and found ten (1.1%) which implied concern for transformative personal growth via Telehealth. In addition to the ten, I read any article with a title that pointed to inclusion per my criteria. Their bibliography gave me good leads.

### Client and Psychotherapist Experience

Telehealth affects the relational experience. As Roesler (2017, p. 372) put it:

\* [Internet-based] interactions produce new forms of social relationships that differ significantly from face-to-face-interactions… unconscious, nonverbal cues get lost… The loss of nonverbal cues has implications for psychotherapy in general and especially for the treatment of patients who have difficulties relying on a secure therapeutic relationship.

There is a need to broaden inquiry, according to Lesser (2021, p. 1):

\* Intersubjectivity [the] interplay between subjectivities in the clinician/client relationship and Intersectionality [the] internalized societal relations, unconscious accommodations to oppressive social structures, and inequalities that may be implicitly enacted in therapeutic practices [and connected to] telemental health during a pandemic [which has] underscored issues of power and privilege…The sudden move to telemental health provides the opportunity to examine the impact… of privilege related to work from home, exposure to illness, flexibility in scheduling, access to telemental health, mental health challenges, and resilience during a pandemic that is both personal and collective.

Psychoanalysis is an intersubjective approach and I assumed it would not be attempted in any setting other than in-person. I was wrong (Moses, 2005; Scharff, 2010). Scharff (2018, p. 59) observes, “Since teleanalysis occurs three to five times a week, those of us who practise it have an opportunity to study its pros and cons in depth over time.” In her discussion of literature about telephone psychoanalysis Scharff cites Mirkin (2011, p. 64), “[Teleanalysis] allowed intense effects to be expressed, tolerated and reflected upon.” Scharff concludes that psychoanalysis will be increasingly a blended psychotherapy. Psychoanalytic theory uses the concept “working alliance” (Greenson, 1965); it is now a widely accepted concept “therapeutic alliance”[[34]](#footnote-34).

#### Therapeutic Alliance

Studies have found that telephonic (Cukor et al., 1998) and Telehealth counseling does permit formation of the therapeutic alliance (Cook & Doyle, 2002; Glueck, 2013; Jenkins-Guarnieri et al., 2015; Lozano et al., 2014; Reese, et al., 2016; Simpson & Reid, 2014). The therapeutic alliance is vitally important in psychotherapy and it can be achieved telephonically (Ardito & Rabellino, 2011; Bordin, 1979).

\* Therapeutic alliance is important to the success of psychotherapy. It has been conceptualized as the bond between the psychotherapist and client as they work on the mutually agreed-upon tasks and goals of psychotherapy (Bordin, 1979). Some have argued that therapeutic alliance may be difficult to develop in a telephone-based relationship... Recent evidence, however, suggests that an effective therapeutic alliance can be established in telephone-delivered psychotherapy… Although differences in therapeutic alliance between face-to-face and telephone-delivered psychotherapy have not been examined fully, evidence suggests that a good therapeutic alliance can, in fact, be established in telephone-based psychotherapy. (Brenes, et al., 2011, p. 543)

According to Berger (2017, p. 511) regarding the therapeutic alliance in Telehealth psychotherapy, “Mixed results were found regarding the therapist-rated alliance and alliance-outcome associations.” What might account for the “mixed results?”

One systematic literature review and meta-analysis (skewed toward CBT) found that the therapeutic alliance was inferior for Telehealth as compared to in-person, but symptom reduction was superior (Norwood et al., 2018). Telehealth’s effects on the therapeutic alliance could be nuanced according to Hilty, et al., (2002) cited by Richardson (2011, p. 66):

\* Telepsychology appears to have both positive and negative effects on communication and the development of relationships (Hilty, Nesbitt et al., 2002). Non-verbal communication, which includes eye-contact, gestures, posture, proximity, fidgeting, nodding, facial expressions and lip reading (Fussell & Benimoff, 1995; Miller et al., 2003b), combines with verbal communication to enhance mutual understanding and achieve intervention goals.

Alvandi (2019) discussed scholarship about relational qualities in psychotherapy and how they are different when sessions are in-person versus online. He looked at cognition, therapeutic alliance, emotions, connectedness and empathy. He recommended:

\* The engagement of users should also be invited in the studies of mental health via virtual reality. That would not only account [for] the relativity and depth of physical and non‐physical receptivity for counselling presence via technology, but also satisfy the emotional module of their presence. (p. 39)

Smith, et al., (2021, p. 4) also recommended listening to providers:

\* More research— along with therapist and client recommendations— into strategies [are needed] to help improve the outcomes of video therapy. [We need to research] the expression and recognition of empathic responding (Grondin et al., 2019) and therapist presence, and ‘in the moment’ verbal and non- verbal responding and awareness (Geller, 2020).

“Therapist presence” has a special meaning in the context of Telehealth, according to Cataldo, et al., (2021, p. 2):

\* Therapists are not trained to conduct clinical treatments by videoconferencing (VC) as they normally rely on face-to-face interactions; thus, the establishment of a concept termed presence becomes essential. This term has been used in VC as a concept that encapsulates 2 elements: (1) the degree to which the web-based experience of another person is analogous to a real-world meeting and (2) the degree to which the user experiences agency and control that impacts the real world [Riva, 2009].

Cataldo, et al., (2021, p. 8) find that clients overall report greater satisfaction than psychologists, and then goes on to discuss psychologists’ evaluation of Telehealth psychotherapy:

\* [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) explain the basis for a clinician’s abovementioned “internal trust toward the whole process” this way:

\* According to the [polyvagal theory][[35]](#footnote-35), 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, that is closely linked with a sense of safety. Fletcher-Tomenius & Vossler (2009) 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 counselling. 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 internalising the other. ("Conclusion and Implications")

Summary: A therapeutic alliance is formed in order to achieve goals, be they here-and-now or transformative. It is possible through Telehealth.

#### Outcomes

Outcomes is a common term used to discuss the extent to which psychotherapeutic goals are achieved. Some researchers have found relatively few studies that compare Telehealth and in-person modalities for outcomes and effectiveness (Van Ballegooijen, et al. 2014). One literature review searched more than 3600 publications and found 13 randomized-controlled studies[[36]](#footnote-36) (Massoudi, et al., 2017). Another study reviewed 44 studies of blended treatment, two-thirds were randomized-control studies, for depression, anxiety and substance abuse; it found that blended treatment is not superior to in-person only (Erbe, et al., 2017). Blended psychotherapy refers to a mix of in-person and online modalities, and studies suggest it can be effective for individual and group treatment (Schuster et al., 2019; Titzler et al., 2019).

Regarding outcomes from psychotherapy, there is a growing body of evidence suggesting rough equivalency of in-person, Telehealth, and blended modalities (Day & Schneider, 2002; Hoge & Rye, 2015; Hubley, et al., 2016; Osenbach, et al., 2013).

An analysis of thematic content from interviews and follow-up focus-groups by Montero-Marín, et al. (2015, para. 1) found, “Those patients with symptoms of mild severity are seen as good candidates [for Telehealth mental health services], as well as those who take responsibility for the treatment and who attribute success to themselves, focusing on action”. The connection between less severe symptoms and acceptance of “digital treatment” for depression was supported by a survey of 175 organizations in Europe that represented government bodies, care providers, service-users, funding/insurance bodies, technical developers and researchers (Topooco et al., 2017). A cautionary note comes from Rozental, et al., (2015, p. 223):

\* Results emphasize the importance of always considering negative effects in Internet-based interventions, and point to several ways of preventing such experiences, including regular assessment of negative events, increasing the flexibility of treatment schedules and therapist contact, as well as prolonging the treatment duration.

According to Simpson, et al., (2021, p. 411) Telehealth psychotherapy improves efficacy for some clients as compared to in-person:

\* There is already some indication that [the Telehealth] modality may in fact enhance outcomes for some client groups, most notably, those with mood disorders and/or interpersonal avoidance, who may find in-person sessions overwhelming (Nelson, Barnard, & Cain, 2003, 2006; Richardson, Frueh, Grubaugh, Egede, & Elhai, 2009; Simpson, Bell, Knox, & Mitchell, 2005; Simpson & Slowey, 2011).

Mitchell (2020, p. 3) summarized her thematic review of literature this way:

\* [The] literature relating to clients’ perspectives on online therapy reveals a range of findings. Overall, studies suggest that clients appreciate enhanced confidentiality and convenience, along with substantial, satisfactory relationships with therapists. Clients report that they are less self-conscious, find online therapy less confrontational and intimidating, and emerge with higher levels of hope. However, findings also indicate that clients can find online work less personal. Online therapy appears to have little impact on life satisfaction or stress levels.

Mitchell (2020, p. 4) recommends listening to clinicians:

\* This literature review of research in the field of online therapy and counselling points to a major gap in the literature: the absence of qualitative research that seeks to capture subjective experience and explore the deeper meanings of a psychotherapist’s online experience.

According to Geller & Porges (2014, p. 3) the psychotherapist’s subjective experience is inextricably connected to psychotherapeutic outcomes when viewed through the lens of polyvagal theory:

\* The polyvagal theory emphasizes that there are strong links between the autonomic nervous system and behavior and explains that when a client feels safe with the therapist, the client’s physiological state can provide optimal conditions for both client and therapist to engage in effective therapeutic work.

## Summary and Analysis

My literature review was intended to map the landscape, related to my qualitative study about psychotherapy, in-person and Telehealth. In the main, I excluded literature about psychiatry because the variable of medication was beyond the scope of my inquiry. I included, briefly, literature about psychoanalysis and Telehealth because it revealed a bias error of mine. There is literature about online treatment that includes self-help, chat rooms, texting, and the like; that was excluded as separate and apart from psychotherapy. I included systematic reviews including those with a meta-analysis, but they were blunt instruments that included variables extraneous to my concerns or they had an emphasis from which I could not generalize (such as evaluation of CBT for specific populations or diagnoses). I excluded studies that were clearly focused on frames other than individual adult psychotherapy such as group therapy, family therapy, marital therapy, children, adolescents, etc. I was particularly interested in literature about qualitative research about the experiences of clients and clinicians, because conclusions based upon stories told to the researchers might help me evaluate the stories I was told.

I wanted to find out:

1. What does the literature address?

2. What are the strengths and limitations of the literature from my perspective ?

3. What is the significance of the knowledge that I gained from the literature in terms of the questions that guided my inquiry?

4. What are the gaps in knowledge which need further research?

I cast a wide net using general search terms in research databases. I followed leads and built upon them. The first pass at the search yielded articles about legal, ethical and business concerns as well as risk management, regulation, payment and so on. The consequences of the current focus during the pandemic-induced, massive expansion of Telehealth adoption were summed up by a respondent in my inquiry:

\* I just want to comment that I took a 2-day training in Telehealth which gave me a certification. I spent 2 days learning how HIPAA works on the Internet. It did nothing to enhance my therapeutic skills and I was so glad to have had the background of theory of the mind. I think Telehealth education has got to find a way to teach psychotherapeutic theory, as well as being so protective of privacy. (#15-20210323)

My iterative review process allowed me to satisfy my curiosity and answer the questions listed above. Let’s proceed.

### What does the literature address?

I categorized the literature by means of inductive reasoning. The categories were:

1. Comparison of modalities

2. Client and psychotherapist experience

3. Therapeutic alliance

4. Outcomes

Numerous studies addressed all three broad psychotherapy approaches[[37]](#footnote-37) that I’ve selected and addressed the modalities (in-person and Telehealth). Some scholars are focused on the impact of technology on communication and information exchange per se and effects on psychotherapy in particular.

When the focus was information needed by participants (clients and clinicians), the qualitative studies noted a big difference between in-person and online. Even in person, the information sent and the information received is not lined up neatly – and that is useful, essential knowledge. Telehealth amplifies the likelihood that interpersonal signals sent are not received; and if unnoticed, such interpersonal disconnect cannot become therapeutic. In this vein, there are some qualitative studies that include the clinician’s experience as an outcome. These studies discussed psychodynamic and relational approaches.

Some of the literature discussed client satisfaction with Telehealth psychotherapy. Common themes were convenience, comfort, safety and trust. These were associated with not being present in an office.

A lot of the literature that discusses outcomes is focused on “evidence-based practices” (EBP). It makes sense in terms of the scarcity of dollars, caused by tax policies that concentrate wealth and corporate policies that emphasize profits without regard to the “Triple Bottom Line.”[[38]](#footnote-38) It makes sense as a strategy to reduce disparities caused by injustices in a way that promotes quality.

Literature across the three broad approaches explored the experience of psychotherapy, most often in terms of the therapeutic alliance. There is use of the concept “presence” (originally developed to understand the experience of communications technology), to Telehealth psychotherapy. The term often used is “Telepresence.” Telepresence and therapeutic alliance were commonly discussed in tandem.

In addition to the therapeutic alliance and telepresence, literature that was expressly psychodynamic or relational were more likely to be qualitative studies that looked at the client-clinician interpersonal experience, comparing in-person and online. Some discussed the subjective experience of each person in the dyad. Disparities as a reflection of injustice was discussed by one author who made a connection between intersubjectivity and intersectionality in the context of mass adoption of Telehealth psychotherapy due to the pandemic.

Some literature connected the discussion of outcomes in terms of whether or not the modalities (in-person and Telehealth) are equivalent. Outcomes were at times discussed in terms of efficacy in the therapeutic alliance and telepresence. Clinician concerns about efficacy were discussed and some authors concluded that training needs to be developed for these topics as well as real-time evaluation of effects. Efficacy variables routinely discussed were safety and trust. Diminution of efficacy was explained in one article in terms of polyvagal theory. Some authors discussed variances in reports of efficacy in terms of diagnoses and severity of symptoms. Discussion of goal variances (here-and-now adaptation or transformative change per se) were pointed out by some authors.

### Strengths and Limitations of the Literature

There is a dominance in the outcomes literature of research on approaches related to CBT and EBP. Is that a strength or a limitation? In my view it is a limitation, because it represents a distinct paradigm[[39]](#footnote-39) that is dominant in the United States, but such studies often do not acknowledge their implicit bias. There is an alternative paradigm, relevant to my inquiry. The distinct paradigms are:

1. The most valuable knowledge results from structured inquiry.

2. Transformative knowledge flows from reflection grounded in experience and participation.

(Please see my brief discussion of Modernism in “The strengths of my qualitative research design” – Chapter Three.)

A strength of the literature is that it defined terminology. The literature is being generated worldwide. There is great diversity of language and cultures. As long as the reader knows what the authors mean when they say this or that, we can use and interpret their findings.

But misleading terminology has implicit bias. In my opinion this is very important, so I will give you an example. An article asserted that telephonic CBT is superior to telephonic “emotion-focused therapy,” but further reading revealed that the study is talking about something called “supportive emotion focused therapy” (Mohr, et al., 2005). I could not interpret the findings because the terminology did not hold up under scrutiny. Supportive-Expressive and Emotion-Focused therapies are distinct (Sharpless, 2019; University of Haifa, 2020.) Supportive-Expressive is a psychodynamic methodology developed at the Menninger Clinic in the 1940s (Luborsky, 2002). Emotion-Focused Therapy is a brief treatment model that is expressly an alternative method to cognitive and behavioral approaches (McDonald, 2015). There is also “Emotion-Focused Cognitive Therapy” (Power, 2010). It is beyond the scope of my inquiry to slog through all of that. Many titles do not reveal the model of psychotherapy that has been evaluated, and that made it more difficult to find research related to psychodynamic and relational models.

It was seldom that studies comparing the modalities (in-person and Telehealth) explicitly distinguished the goals or purpose of the psychotherapy. I had to guess. Were the goals here-and-now adaptation, transformative change per se, a mix? Did the clinicians view the difference as a continuum, one-and-the-same, an iterative back-and-forth or something else? Not knowing the goals and purposes limited the understanding that I gained from reading the reports.

### The Significance of the Literature for My Inquiry

My inquiry had three broad interests:

1. A focus on transformative effects rather than solely here-and-now adaption;

2. Inquiry about the psychotherapeutic experience and/or

3. Inquiry about individual adult psychotherapy.

I had intended to completely exclude psychoanalysis, in part because I did not expect anyone whom I would interview would be a practitioner. I was right about that. But I found discussions about psychoanalysis and “teleanalysis.” While I didn’t dive into the topic, I included a little of it, because some psychoanalytic theory influences psychotherapies that are referred to as psychodynamic and relational or interpersonal.

The lack of discussion about the goals of here-and-now adaptation or transformative change per se is significant, because it tells us the theme is under-considered.

The qualitative research about the experience of psychotherapy in the two modalities and blended therapy indicates that inquiry is advanced rather than nascent. The explanations by authors suggest to me that there is significant insight in this area and practitioners would benefit from it.

Individual psychotherapy from psychodynamic and relational approaches is a smaller subset of the studies that I found. That might mean that enhanced focus could benefit the many practitioners of these approaches.

### Gaps of Knowledge which Need Further Research

In the broadest terms, more qualitative studies are needed that listen to clients and clinicians. There is a lot of literature about the therapeutic alliance which is essential, but it is not determinative for results from psychotherapy. If it were, there would not have been a proliferation of psychotherapeutic theories and methods for more than 120 years. We would have figured it out nicely and left it at that, whatever that was, a long time ago. Psychotherapy, if it does nothing else, provides relational experience that is distinct from ordinary, common interactions. It would be beneficial to expand inquiry into the subjective and relational aspects of psychotherapy in terms of the two modalities, in-person and Telehealth.

My view is that we are an artisanal profession and there are limits to what can be accomplished through an evidenced-based paradigm. We need more qualitative studies that listen to clients and clinicians.

Hopefully, as the overall disruptions caused by the pandemic recedes, scholarship can focus more on the strengths and limitations of Telehealth and blended psychotherapy for psychotherapy which is focused on transformative personal growth. My study contributes to filling in that gap. I listened to clinicians. I am pleased to share their experiences and reflections with you.

### Concluding Thoughts from the Literature Review

A final observation about the challenge of a literature review in these modern times. Thirty-eight years ago when I began my Master’s degree, the literature review was done in a physical library using a card catalogue. Librarians helped me. I was limited by the journals and books selected by the college. Now, the library is overwhelmingly internet-based. But I was frustrated by the profit motive of publishing houses. I had hundreds of dollars to spend on access to full articles, but I thought about scholars who are less fortunate. WISR provided access via no-cost and low-cost subscription services, I am grateful for that social justice policy. Nonetheless, my literature review inspired me to plan a free, web-based dissemination of my study. I’m concerned about people who can’t pay to play. Please see Appendix D.

# Chapter 3: Research Methods and Findings

The chapter has two main parts: Methods and Findings. In “Methods,” I present the research questions which were given to respondents and my rationale for questions. I discuss how I got my data, whom I interviewed and why. You might wonder, “How did the interviews go, well or not?” My answer to that question might help others interested in qualitative research. I discuss the validity of information from respondents by looking at results from the literature review. I share the story of how I analyzed the data and made sense of it. It is the story of how my insights emerged and my viewpoint evolved. I touch on limitations imposed by the sample size, twenty-three. I make some methodological recommendations based upon the strengths and limitations of the research. “Methods” sets up my discussion of “Findings.” As you read, keep in mind the main themes, lenses through which I view the findings:

1. The impact of emotional injury on a person.

2. How a psychotherapist helps that person.

3. How healing happens.

4. Telehealth effects on healing.

There were findings that did not fit the focus of my dissertation. A person can be injured repeatedly by oppression; my dissertation identifies that as an issue for ongoing activity.

## Research Methods

My career has been built on the premise that listening to people tell their stories is a great way to learn. Why not listen to clinicians tell their stories? Then I thought, given my interest in transformative personal growth, it would be a good idea to listen to psychotherapists with a lot of experience. I used the content analysis approach to arrive at a portion of my findings.

But there is something peculiar about people who have achieved expert proficiency; by the time they can do their thing super well, their mastery is part of them (Dreyfus & Dreyfus, 1987; Dreyfus & Dreyfus, 1989). Sometimes they have a hard time describing what they do or how they do it. To solve this problem, I created a list of questions which would focus the conversation and used my know-how to draw out “tacit knowledge”[[40]](#footnote-40) (Polanyi, 2015). A respondent said, “Good question. I think sometimes I’m not even sure how it works. I see it and I know it’s working.” (#32-210420)

## The Research Questions

The full set of questions is contained in Appendix A. The interview questions were provided ahead of time. Each respondent was able to read them before our conversation. In my email to prospects who might be interviewed, my goal was to be succinct and clear as I summed up my questions.

My dissertation explores the perceptions of psychotherapists, regarding transformative psychotherapy for a change in a person’s view of their self or solution-focused, problem-solving psychotherapy for improved adaptation in a situation. The question for clinicians, broadly framed, is what works well or not, why? Is that different when the therapy is in-person or via Telehealth?

We all understood that enhanced strength in coping with daily living can change a person’s view of their own self and vice versa. That baseline understanding might have been a benefit of talking with experienced psychotherapists.

The questions served different ends. We began by discussing in-person psychotherapy; this provided a basis to compare or contrast with Telehealth. I tried the language of first-order change and second-order change, the respondents and I found that unwieldy.

Instead I used the language of the clinicians themselves. I do the same when I talk with clients, use their own words and experience. Then we talked about Telehealth for transformative psychotherapy. Telehealth questions were: What works well? What are the problems? Can you tell a story about transformative results? In his review of my first draft, Dr. Gerrard stated:

\* Your position that solution-focused and problem-solving therapies are not transformative is I think untenable. I recommend you rethink this. When a client changes their behavior and becomes more effective in dealing with a problem, their self-efficacy and sense of self is profoundly altered. That is the essence of second-order change.

He is, of course, correct that solution-focused and problem-solving therapies can be transformative. I share the professor’s misgivings with you, because he likely gives a voice to the thoughts of some readers. Why do I say it is likely? A subtle purpose of mine is easy to miss: Each question of the interview and the explanation that I gave along with it was meant to get a conversation going. My approach worked! I elicited expansive responses. Respondents confirmed Dr. Gerrard’s main point. Here’s the way one put it:

\* It’s not so black and white, I firmly believe that the most important aspect of how therapy heals is the relationship between me and the person I’m working with. I try very hard... to understand how a persons’ responses to various situations in life have served or not served them. What do they want to keep, what do they want to let go of?... When you talk [how transformative psychotherapy works] I think about my individual clients… and how each person has different needs... With some people, I don’t talk very much. They just need to talk and be listened to. Some people have a problem to solve, so we talk together about what’s available to them, and share ideas… Sometimes people just want to talk about what they notice about their feelings. I try very hard to slow it down and do the age old, “What triggers that? Then what happens? Oh, and then what happens when you have those thoughts? What does that remind you of?”

For some people, their history is important, because it helps me understand how they got to where they are. For some people, it doesn’t matter how they got to where they are. They just want relief in the present time. (#23-210402)

A different respondent described the back-and-forth of emphasis that is common for psychotherapy:

\* It starts with the first phone call. I ask, “What is it you are looking for? What is it you want to achieve by coming to therapy?” We go from there. Sometimes they are not feeling very stable, maybe there’s been a death or there’s an acute issue. [Sometimes they] say, “Well, I’m not really happy. I’d like to look at why and explore that.”

[What] is the problem from the client’s perspective? My perspective comes in a little, but not initially. After that is thoroughly understood by both of us, then we come up with solution-oriented plans. That’s when I say, “Have you thought about this? Do you think this might help?”

[We’re looking] at times when they were happy and what’s changed. What is getting in the way? [We’re looking] at belief systems and bringing in their past, their experiences. What’s making it difficult for them, what’s getting in the way for them to be happy? Identifying what happiness would look like for them. (#14-20210323)

My plan was to enhance the ability of clinicians to discuss transformative psychotherapy before we talked about Telehealth. The plan generated rich answers like this one about transformative work:

\* It’s always really amazing to me that people change because they forgive themselves. They can love themselves. It starts with the therapist’s empathy towards the person’s dilemma. And I explain it back, supporting that part of them that was hurt or mistreated, and that they haven’t shut off themselves… [The] therapist needs to be able to know where the patient is stuck or hurt in their development, and then to gently focus on that. Make it more meaningful, change the meaning of it, and the experience of it for the person. So like lots of abused women will start to feel badly about their inner child, they start to feel sorry for the little girl that used to be, and then slowly they can empower the woman they are now. (#11-20210315)

The questions were threads woven together. I did not ask, “How can methods be adjusted for Telehealth?” Rather, the series of questions served as a foundation with a frame of posts and beams upon which the house takes shape. The questions guided our conversations while leaving space to speak expansively. In this way, unexpected elaboration flowed freely.

## Strengths of My Qualitative Research Design

There is another strength of my qualitative design. The Western Institute for Social Research (WISR) intends education to be “transformative” (WISR, 2014). WISR intends that their process supports learners “competencies in critical inquiry, curiosity and creativity.” “Transformative” as used by WISR points to an observation by Kuhn (1996) that consensus around a paradigm[[41]](#footnote-41) itself limits inquiry and imagination:

\* [Novelty] ordinarily emerges for the man who, knowing with precision what he should expect, is able to recognize that something has gone wrong. Anomaly appears only against the backdrop provided by the paradigm. (p. 65)

The dominant paradigm for much of the literature is that a client’s improved adaptation to status quo conditions is a key measure for outcomes, effectiveness. Yet, resistance and rebellion are necessary (Lamas et al., 2017; Traister, 2019). My analytical challenge was to review literature about research conducted through a paradigm that is misaligned with my worldview. Paradigm matters and if it is not acknowledged then bias is masked. My hope is that you will appreciate my bias so as to better understand my analysis of the data.

My challenge has been a long time in the making. Not so long ago there was an epoch of blossoming, new paradigms across the board.

\* Modernism refers to the momentous eruption within Western culture, roughly between 1890 and 1930, of utterly novel and singularly powerful ideas… The main impact of the university process is to minimize the historical and dramatic contexts within which formal theories of modernism were developed and thus deprive them of their human meanings. It does this by asserting value neutrality and by stressing classification as against participation, creation and response… The insights of [Modernist] founders were systematized, facilitating their incorporation into the university process at the expense of their radical content and purpose. (Stein, et al., 1970, “Elementary Instructions”)

My father aligned himself with the second-wave of upheaval, disruption in academia that followed in the wake of Modernism. The second wave emphasized academia’s participation, engagement to create justice in society. The living legacy is manifest in the theory and practice of participatory action-research[[42]](#footnote-42) (Baum, et al., 2006; Bilorusky, 2021; Dunne, et al., 2018). The moral of the paradigm story: The overwhelming proportion of published literature manifests categorization and quantification as a method of study, it represents a paradigm at odds with Modernism and second-wave participation to create social change; my dissertation attempts to straddle worldviews.

I elicited stories from clinicians about transformative change and here-and-now adaptation. This opened the possibility to develop a sensitizing concept. “Whereas definitive concepts provide prescriptions of what to see, sensitizing concepts merely suggest directions along which to look” (Blumer, 1954, p. 7). The method can provide a bundle of illustrative examples from which the efficacy of the concept is derived. The bundle of examples conveys the significance, relevance, nuance.

My design draws upon principles outlined by Howard S. Becker (1958). The credibility of respondents was a criterion. The frequency of statements among respondents was evaluated. As Becker explained, conceptualizations can fruitfully guide analysis of respondents’ comments.

\* [A] well-formulated hypothesis makes possible a deliberate search for negative cases, particularly when other knowledge suggests likely areas in which to look for such evidence. This kind of search requires advanced conceptualization of the problem, and evidence gathered in this way might carry greater weight for certain kinds of conclusions. (p. 659)

My knowledge of psychotherapy theories is background guidance for the questions. I had a guess about where they would lead. The respondents’ stories showed my bias was wrong. I like it when I find out that I’m wrong. It means that I’ve learned something.

## My Data

I selected psychotherapists through snowball sampling, explained in “Overall Research Design” in Chapter 1. I sent a letter with the questions before the interview. (See Appendix A.) The letter provided definitions for first-order change (adaptation to stabilize the status quo) and second-order (transformational) change. Terminology and the intent of any given question was discussed before and during the interview. The concepts of the clinicians themselves became the language of the interview. This made sense because the qualitative research design was inductive and constructivist. In other words, I went from the particulars of their experience to generalizations.

Data was gathered through interviews conducted with individuals. None were done in person. All were done using telecommunication. One was not recorded; I wrote notes during the interview. All others were recorded as a means of taking notes; the consent for recording is in Appendix A. In all, there were twenty-five recordings for twenty-two respondents. Each recording was edited for cogency and then transcribed using the computer’s speech-to-text software. (See Appendix B for discussion of the process). All recordings were deleted.

Each respondent was sent the transcript of their interview, for review and approval. There were two purposes for that. First was to make sure that privacy and confidentiality was respected in terms of the stories that were told. The question of confidentiality came up even to the point of requests not to include certain stories. All such requests were honored. Second was to make sure that the intent and nuance of the psychotherapist’s comments were represented well. The written record from each interview is in Appendix C, identified only by a serial number that I gave for it. I chose not to include the entire interview of each respondent, but rather I have presented those portions that expand on segments used in the body of the dissertation. My decision further enhanced privacy and confidentiality, it improved the overall readability of my dissertation.

The data is primarily qualitative, the information is contained in the stories told by respondents. I used my skills in eliciting reflection to help respondents share their experiences.

### Whom I Interviewed and Why

My study explored the qualities of psychotherapy that provide transformative potential. I did not pre-screen for theoretical orientation, but rather organized some data in this way retrospectively. My approach was validated by results, which is to say that most clinicians could be sorted into a few theoretical orientations (with most clinicians combining approaches). For this inquiry, I chose only three theories (approaches): psychodynamic, relational and cognitive. I chose them based upon my prior knowledge of their widespread influence in the profession. It was a way to analyze respondents’ comments. As I had anticipated, there was diversity of theoretical orientation among the clinicians whom I interviewed.

I did not pre-screen for any characteristics such as location of practice, gender identification, ethnicity, etc. While these characteristics might be of interest to some researchers and could be relevant to future studies, they were not my primary concern. With that said, my flexibility in terms of the criterion of number of years licensed allowed for greater diversity in terms of culture, gender identity, languages spoken, and ethnicity (among the respondents and the communities whom they serve).

The focus of my study is whether or not, to what degree and under what circumstances might transformative change be achieved through psychotherapy provided via Telehealth. In order to get at that, I looked for clinicians experienced in both modalities, with significant clinical experience, in-person, as defined by 5 years licensed. I made a few exceptions to the 5-year criterion because several persons had extensive pre-licensure experience, their background offered the possibility of nuance or novelty in their perspective. This is described fully in this chapter’s section, “Findings.”

### How Well the Interviews Went

An indication that the interviews went well is the sample achieved through snowball sampling. I had wondered if I could get the minimum target of eight to ten interviews. I conducted twenty-three interviews, because the interview itself inspired respondents to introduce me to additional persons. Another indicator that interviews went well were comments made during the interview by respondents (identified by serial number). Here are a few:

\* Let me think about that. (#11-20210315)

\* This is a hard question. (#14-20210323)

\* I was surprised because I hadn’t done Telehealth before [the pandemic]. (#19-210330)

\* I really liked this question when I read it in the package that you sent me. (#27-210409)

\* That’s a great question, because I’ve thought about that so many times. (#29-210412)

\* I wrote these answers down, I thought, “That’s a really good question.” (#30-210413)

There is another indicator that the entire interview process went well and that is the overall volume of answers by the respondents. Some of the answers and stories were short, others were extensive. The respondents were engaged in the interviews.

The main problem encountered during interviews reflects an aspect of the study itself, connectivity. A couple of respondents talked to me on a mobile device while in their car, one drove through a dead-zone and the connection ended. We completed the interview later. Sometimes there was electronic feedback and distortion. We worked through all of the glitches.

### Respondent Data Viewed from the Lens of the Literature

Some of the findings from the literature review[[43]](#footnote-43) speak to the validity of respondent information. Here I share three literature review findings that speak to the validity of respondent information:

1. Telehealth has been demonstrated to be an effective mode of treatment for a variety of presenting problems, with outcomes comparable to therapy provided in-person.

\* This person has a narcissistic orientation, this person would dominate the [Telehealth] sessions with talk, and I could not feel this individual coming into an alliance with me. Highly intellectualized, cogent, certainly not crazy… I’ve been using mentalization approaches… a balance of empathy and teaching somebody how to feel... Over time, I can really feel what this individual is telling me, which is greatly enhancing my ability to focus on her… [She’s] begun to send me beautiful poetry that illustrate some of the depth that she has, that’s been awfully coiled up in defensive intellectualization. So what has shifted is a sense of closeness in our bond, her ability to take her talent which is writing to find some emotional content to make poetry. I consider that a big step. (#15-20210323)

\* A young woman said to me, “I’ve decided that I need to respond more maturely.” She was back home from college because of COVID. The family’s from [Country.] So there’s a lot of cultural issues... There’s a lot of cultural factors which she had stepped away from when she was in college.

So she came home and she started acting like a child, of course. ... Something her mother did, and the client chose not to react the way she had before. The idea of change came from her… She said, “When my mother did that, I would’ve in the past yelled at her, gone into my room and had a tantrum. I chose not to respond. Mom is Mom and that’s the way it’s going to be when I’m back home.”

We had been working on that. She had some depression at home, some anxiety. As we were working, she was able to integrate and make it her own. I've had that with several, all Telehealth clients. (#19-210330)

There are two distinct presenting problems contained in the above short stories: 1) A person uses their intellectual powers to ward off emotions and intimacy, and 2) a child of immigrants grows up and becomes acculturated while away at college and returns home to face conflict with a parent who asserts the culture of their origin. Telehealth Psychotherapy helped each client a lot.

2. Blended psychotherapy refers to a mix of in-person and online modalities, studies suggest it can be effective for individual treatment.

\* When you were talking about whether or when we choose to meet or not to meet in person, it’s more about what works for the client. So if the client doesn’t want to drive and prefers Telehealth, that’s okay. That’s how I did it prior to the pandemic. I had the option for people. (#30-210413)

\* Another person I saw in-person had a palsy. During the time that we met during Telehealth, she improved more and more and more. Until she felt like she was good enough. We had gone over some of her history and what she had interpreted as to why she developed an immune response to some of her behavior. I think that if I hadn’t seen her in-person it would not have been the same, because it was a physical manifestation of her psychic injuries. (#23-210402)

Clinician (#30) has been using Telehealth to provide individual psychotherapy for 9 years and all along has also provided services in-person. Clinician (#23) has been in private practice for 37 years, began to use Telehealth because of the pandemic and found it to work well.

3. Studies have found that Telehealth permits formation of sustainable psychotherapeutic alliances.

\* It was out of necessity. A patient was reassigned to the east coast by the military. We would have had to stop transformative work right in the middle of the game. It started out with trauma, PTSD work. And then it transcended to ego development type work. The person had to leave and go to the other end of the country. We were able to keep our alliance, to keep our bond, to keep our work going thanks to Telehealth. It would have been very disruptive to both of us if we had to break up so to speak. So that was really a gift, to be able to continue the work. (#15-20210323)

\* I was surprised because I hadn’t done Telehealth before. I’ve had over forty clients over the past year. At first, I wasn’t sure how they were going to react to it. For the most part, I have found that clients like it. They like being at home. If they don’t have privacy, some go to their cars. And I was surprised at how well we can connect, that emotional connection and form the therapeutic relationship, even those clients I’ve never seen. There have been clients who have done tremendous changes in their lives that I discharged. They’ve gone way beyond, they’ve done transformative. I've never seen them [in person]. (#19-210330)

The first story shows that a person moved from in-person to Telehealth and the bond continued, as did the work on PTSD issues continued and it was fruitful. The second story tells of many clients who started psychotherapy via Telehealth and a therapeutic alliance was established for each.

To sum up: Three literature findings speak to the validity of data gathered through interviews. Telehealth and in-person modalities show comparable efficacy for an array of presenting problems. The blended model seems to work for individual psychotherapy. Telehealth can support a therapeutic alliance that is necessary for psychotherapy.

### How I Analyzed the Data

I reviewed the interviews numerous times prior to analyzing the content. All but one interview was recorded. I edited each recording through several passes to get it ready to be transcribed. I listened again to transcribe it. I rearranged interview segments to fit the sequence of questions. Next, I sent it to the respondent who sometimes edited. All of this before analysis, which was better for it. The process sensitized me to patterns and interesting nuances or novelties.

Appendix B shares some of the lessons I learned about the creation of audio clips from a streaming conversation. This could be useful to a person or group that imagines using recordings to create educational material, but who do not have money to hire professionals. Video clips, I quickly realized, could not be used because people had not prepared themselves for that.

I edited each video recording down from roughly an hour to about 20 minutes. It was a lot of work, for several reasons. A conversation goes back-and-forth and sometimes loops back to an earlier part to add a thought. The first thing to do was put thoughts that belong together in the right place in terms of the interview sequence and to remove almost all of my comments.

Audio might be useful for educational material, were there a clear purpose, adequate quality, a new permission from any respondent whose comments might be used that way. I chose not to explore that, because my to-do list was sufficient without adding to it.

There was a time-consuming frustration connected to my use of low-cost, low-end technology. Unlike online transcription that can use machine-learning to build a dictionary and even learn context, my computer’s built-in speech-to-text does not learn words or context.

I used a spreadsheet to notate nominal variables such as apparent gender, bilingualism, etc. These, along with years of experience in the modalities (in-person and Telehealth) were counted. The inductive, constructivist method did not test assumptions or a hypothesis framed by nominal variables.

There were two outliers that affected findings. One respondent did not want any stories cited in the body of the dissertation (to protect privacy and confidentiality) and therefore even though the stories sensitized me, the information is not available to you. One respondent categorized their approach as “complex systems” (Richardson et al., 2017). The complexity was too great for me to use at this time.

I developed approximate profiles of clinicians and their theoretical orientations by using the guideposts described in “Transformative Psychotherapy, Theories Relevant to Mine” in Chapter Two. My process was deductive reasoning.

I used general principles to interpret specific data. I grouped the approaches used by respondents: Psychodynamic Psychotherapy, Interpersonal Psychotherapy, and Cognitive Behavioral Therapy. The deductive reasoning approach helped me interpret their answers, because the respondents used language and terms in very different ways.

The aggregated profiles did not include theories of psychology.[[44]](#footnote-44) My understanding of psychology was applied to the interpretation of the findings in Chapter Five.

The analysis of data for descriptive purposes differed from analysis about Telehealth and its efficacy for transformative psychotherapy. For the guiding questions, I sorted and sifted narrative data to arrive at generalizations. Such inductive analysis draws conclusions based on recurring patterns or repeated observations (LibreTexts, 2021). The content analysis is presented in a few tables. For those of you who wish to mull over the findings, please use the serial numbers, look up the interview in Appendix C. Content analysis is creative, like art.

### The Twenty-Three Interviews

There were a lot of steps taken to complete the interviews and prepare the data for analysis. The process could be described as a campaign that identified prospects from trusted sources, evaluated the prospects by criteria and communicated with prospects to help them evaluate their interest and availability. After informed consents were secured, the campaign required coordination of calendars – theirs, mine, and the college’s teleconferencing platform. I kept track of all steps with multiple spreadsheets.

Communication was refined as I learned-by-doing. Email was used a lot, but it became evident that words that made sense to me can confuse a reader, especially a very busy person. Academic language was a turn-off for some clinicians who had valuable experience to share. Respondents interpreted instructions with varying degrees of concern for adherence to details such as completing checkboxes, signatures needed in several places, etc. The solution for these variances was to use different ways to communicate (i.e., text, emails, telephone calls) and different ways to document informed consent (i.e., forms, emails, verification at the outset of the interview).

Each interview followed the list of questions, so there was a complete set of answers for each respondent. The goal was to elicit stories that revealed nuance and novelty, that required a relaxed, conversational style. Answers to questions often were given without regard to the question at hand, because good conversation often weaves back-and-forth. Respondents, thinking as they spoke, changed the volume of their voice; as they became excited their voice was louder and as they became reflective their voice softened. I used editing software to delete irrelevant portions (such as my part of the conversation) and even out the sound, before transcribing. Then I emailed the transcript to each respondent for their review. Some edited it, others did not.

### How My Insights Emerged and Viewpoint Evolved

I was skeptical when I began the study that transformative psychotherapy is possible via Telehealth. I entered this study with a well-formed theory about the nature of change through talk-therapy. The model, which I’ve been teaching and using for years, relies on my experience and the scholarship of others. It has always been about the in-person process. I’ve supervised via Telehealth and have served a few clients that way during the pandemic, I could not tell if my ability to work through difficulties were the basis for any generalizations. I needed the perspectives of experienced clinicians to add to mine.

The conversations from interviews as well as editing recordings and transcribing them led me to a clear impression. “Impression”, as I am using the word, is analogous to a visual art process of carving into a block, coating it with pigment, pressing it into paper, forming an indelible mark. Here is the image. My theory of therapeutic action applies to clinical experience regardless of the modality, in-person or Telehealth. In other words, my theory can explain the efficacy of both modalities, in-person and Telehealth, for transformative change.

### Limitations Imposed by the Sample Size

The sample size did not permit my explanation of the effectiveness of Telehealth for transformative change to be presented as a “grounded theory” (Glaser & Strauss, 1967). But the results can be considered a step towards a “constructivist grounded theory” (Singh & Estefan, 2018), because co-construction of knowledge by myself and respondents occurred. Not yet done is a dialogue with participants about the findings. I plan to send an invitation for us to continue thinking together. I would like to do that.

"Diversity" in the sample was of two kinds: 1) Characteristics of the respondents and the clients whom they serve, and 2) theoretical and methodological approaches in their practice of psychotherapy. Descriptive characteristics were relatively easy to code. But the approach was not.

My analysis of respondents’ approaches was primarily deductive. Some respondents said in effect, “I’m this that or the other.” I used my understanding of theory, exercised judgment for the purpose of categorization. I thought about their answers and determined an approach.

I simplified the categories for approaches, because my inquiry was exploratory. Each category for approach could be differentiated, adherents could be invited through institutes and associations. We could learn from stories of psychotherapists explicitly aligned with particular theories, methods. Please see Chapter Six “Future Inquiry and Activity.

### Methodological Recommendations

**1. An Iterative Inquiry with Staff Support**

I had imagined cycles of inquiry, an iterative process of sharing findings, posing new questions and then engaging another round of conversation. I did not do this for a number of reasons, all pragmatic. One reason was the priority of completing the dissertation with the understanding that it could become a pathway for future activity.

Another factor was witnessing the constraints of time and resources; these constraints affected me and the respondents. It was immediately apparent to me the gift of time and attention given by each respondent. They gave their time to understand the purpose of the study and the meaning of the questions, to tell their stories, to read the transcript in order to protect privacy and confidentiality, to evaluate the representation of their meaning which often was nuanced. To ask for more time and attention would not have been the right thing to do.

For me, it was grueling to do all of the steps of a campaign, even a relatively simple one, without staff support. Such support is available if one is part of an organization and the campaign is one of its projects. Or if a person has money to pay independent contractors to do things, that would be wonderful.

**2. Further Address Disparities in Mental Health Services**

I barely scratched the surface in the literature review about disparities in mental health services. There is a lot, because it has been a widespread policy concern for a long time. A guiding question could build on a preliminary finding of my study. Transformative personal growth through talk-therapy via Telehealth is possible.

**3. Gather Data from Distinct Communities of Clinicians**

I did not invite clinicians on the basis of identification with a community nor intersectional identification. This limits confidence in the findings. The stories gathered by my study suggest that my findings could have cross-cultural and intersectional applicability. But we really do not know. For example, more than one respondent told a story about intergenerational conflict within an immigrant family – a college educated offspring returns to live with their parents who maintain the “old ways.” At college there was micro-aggression from non-immigrant cisgenders[[45]](#footnote-45) that required the formation of assertiveness by a student from an immigrant family, but at home the adult offspring needed to demur. Could blended psychotherapy offer access to the adult offspring of an immigrant family such that there is less friction in the household, because utilization of psychotherapy is not as noticed? Could in-person sessions be more beneficial for the same client’s expression of emotions related to intersectional microaggressions? These are examples of questions for future study.

**4. Expand Sample, Include Less Experienced Clinicians**

The selection of experienced psychotherapists, as measured by years licensed, was a limitation that could be loosened or jettisoned. What are the experiences and reflections of clinicians who have recently been licensed, associate clinicians earning hours of supervised practice, or trainees in Master’s degree programs? The current generation of clinicians grew up acclimated to online technology, streaming content and communication. I wonder if their familiarity and comfort with it might give all of us insight and understanding that I missed.

**5. Seek Clinicians with Different Views**

My analysis of respondents’ views was primarily inductive, constructivist. I started with the particular and generalized from that. There could be value in seeking stories from communities of psychotherapists who align themselves with particular theories and methods. For example, it would be informative to reach out to Gestalt psychotherapists. Psychotherapists who practice within faith communities were not part of the study. It might be very useful to reach out to them; we could learn a lot from their reflections on the use of the theologian Martin Buber’s views. Family therapists and their use systems theory were beyond the scope of my inquiry, even though their work is very relevant to the issue of transformative work via Telehealth. These are just a few of many psychotherapists who identify themselves with particular communities, theories, methods.

## Findings

I organized this section into three parts. First, I present some general observations that give you context to think about specific findings. Think of “General Observations” as foreshadowing in a story, a play or movie. Don’t be concerned that my bias skewed findings. After all, I have been up front with you. My bias was skepticism about the efficacy of Telehealth psychotherapy for transformative change, my headline finding is that my doubts were wrong.

After “General Observations,” I provide some statistics about the sample. The information points to paths for further inquiry. For example, there were a couple of outlier occurrences of “one” which are intriguing.

It is more common for these statistics to be in the “Methods” section. But my inductive, constructivist approach (which I explained in “Methods”) did not seek to answer any question with statistics. Rather, the statistics point to tentative answers and future inquiry. One of my questions was whether a theoretical or methodological approach might be a factor in the efficacy of Telehealth for transformative work. Some of the statistics provide a basis to tentatively answer that question, hence their placement in “Findings.”

Finally, I’ll take you through findings organized by each question which was answered by the respondents. So here we go: general observations, a few statistics, and what I learned by listening to stories told by experienced psychotherapists!

### General Observations

Language matters and shared meaning of terms can be a challenge. For example, “first-order and second-order change” confused many respondents, even though they had read the definition given to them ahead of time. Verbal explanation at the outset of the interview helped, but I scrapped using the terms because explaining them chewed up valuable, limited, irreplaceable time given to me, generously, by practitioners. With that said, a couple of respondents were familiar with the terminology. One was a professor and practitioner, the other had among the fewest years licensed experience. It’s possible the language has gained circulation in the last decade or so. Anyways, here’s what the pair said about it:

\* First order change is change without change. Basically, the client continues with what they are doing, adjusting it, fine tuning it. It’s more in the realm of counseling, coaching and problem solving. Second order change, the depth of that is real change. Substantial change comes from having some kind of epiphany, an interpretation of a point of view that is truly illuminating. It helps people adjust their sense of self… The premise is that it was always there to be seen, but it wasn’t necessarily noted and integrated consciously. “Your dad always did that,”… amplifying what they already see. Getting closer to the picture. That’s the first order, a lot of interactions can be about that and be extremely useful. (#12-20210319)

\* Yes, it does. On my website description I say, “Some people come in for communication skills and problem-solving.”… Then I say, “Some people continue, they like to go on with their therapy, and get to the root of the problem… When I meet in-person, I [say], “First-order change is fixing the problem and second-order change is fixing the underlying things that caused the problem.” Most clients come in for first order-change, that’s where their focus is. That’s certainly where we start. Then as we go along, we can talk about the possibility of going a little bit deeper and addressing those issues that really cause the problem in the first place. #27-210409

The term “transformative” was applied in different ways. Some respondents identified “first-order change” as transformative, others did not. Here’s how some respondents put it:

\* When I’m talking to clients and other non-professional folks, they don’t need theory or jargon. They need plain talk. I don’t think, “Oh we’re doing intrapsychic psychotherapy.” It’s much more interpersonal. I do think transformative work can happen at all levels. In transformative work we are not shifting around environmental pieces. We’re more rooted in who you are no matter who is around you, and no matter where you’re living, no matter what you’re doing... When we go into an intrapsychic role, I feel less overt, more subtle, so as not to introduce or lead with as much input as I would otherwise... The transformative mode, in that more intrapsychic level, I am there but my presence is subtler. I’m in a quieter space. I’m shifting into a place of being there.

The client is like a child who initiates what they need to do if you let them. The kid often knows more about what they need than the parents do. It’s a quieter sense of therapy for me. It’s a more client led conversation. It is less about suggestion and intervention; it is more about feeling, joining their sense of self in the cleanest of therapeutic ways... It’s much more feeling based. It’s much more an identity-based phase of change. It’s about the action of joining them in a phase of processing through far more of their emotional experience. (#24-210402)

My findings suggest that if the psychotherapist is good at what they do, they figure out how to do it (e.g., effective use of self) through Telehealth, whether it is streaming video or audio-only. The client’s experience of the therapeutic alliance[[46]](#footnote-46) is central to the potential for transformative personal growth; this is possible via Telehealth psychotherapy. The client’s ability to choose Telehealth modality as well as the type, two-way video or audio-only, might have a positive effect on the therapeutic alliance.

\* When I meet a brand-new person, a brand-new patient, I ask them if they can come to the office so I can at least see them and feel them and begin the process of creating a bond with them. Then I give them the choice of coming online or coming to the office. I’d say about 50% of the people come online, and the others want to come in in-person. (#15-20210323)

\* Interestingly enough on Telehealth, there was an acknowledged awkwardness on their part. I didn’t feel it at all, but I could see it in them. We’ve talked about it. Once a client said, “This is the most ridiculous thing I’ve ever done. It’s like watching Star Trek.” And I understood. She argued with herself that it shouldn’t be this way. That it really shouldn’t. That the best way is always in person. That lasted about one session. And once she spilled it, she just marched right on. (#22-210402)

\* Some of the people I’ve met in person in my office and seen for years, they chose to do telephone therapy. There are people I have never met and we only do phone therapy. They don’t want to do it online. One woman doesn’t want me to see her messy house. People I’ve never met in person like online because it feels more connected to them. There’s no one answer. It’s different for everyone. What is consistent is how I am, because of my experience. (#23-210402)

The inference that choice around modality affects outcomes is supported by some pre-pandemic research. My study did not consider client choice of psychotherapeutic approach, nor did I consider the interplay of client choice and psychotherapist approach.

Psychotherapists in this study report that transformation can be achieved when the clinical focus is strength-based, solution-focused, problem-solving, in-person and via Telehealth. I use my theory of transformative psychotherapy to explain this finding:

The potential for transformative change during talk-therapy is realized through the recurring *I-Thou*[[47]](#footnote-47) experience of the client interacting with the clinician. Intersubjective[[48]](#footnote-48) *I-Thou* experience engenders an *emotion response cycle* and gains are consolidated in the client’s *I-Thou* orientation in relation to their own self.

My study finds that Telehealth increases the probability of transformative change by improving access for some clients who can be identified by characteristics such as isolation (geographical distance or inadequate transportation), clinical factors that keep them homebound due to physical and psychological reasons, financial constraints (the high cost of going outside of an insurance company’s panel or a clinician’s high fees). Psychotherapists could offer Telehealth strategically, combined with in-person. We could accept less money, not bill insurance on a case-by-case basis.

My findings suggest that psychotherapists could offer Telehealth strategically, combined with in-person. We could accept less money, not bill insurance on a case-by-case basis. Telehealth can engender transformative change by enhancing a client’s sense of safety which is needed for *I-You* experience and a therapeutic *emotion response cycle*.[[49]](#footnote-49)

### A Few Statistics

The sample size was 23. Six were clinical psychologists with doctorates. Seven were Licensed Clinical Social Workers (LCSW). Eight were Licensed Marriage and Family Therapists (LMFT). One was a Licensed Professional Clinical Counselor (LPCC). One was a National Certified Counselor (NCC). Three clinicians currently work with children and adolescents, all work with adults. My study focused on work with individual adults.

The average years of practice since licensure was 24.8. About half had more than 30 years licensed experience. The average number of years using Telehealth was 2.3.

Table 1. Licensed (Years) / Telehealth (Years)

|  |  |
| --- | --- |
| **LIC (YRS)** | **#** |
| > 40 | 3 |
| 30 … 39 | 8 |
| 20 … 29 | 4 |
| 10 … 19 | 2 |
| < 10 | 3 |
| **TEL (YRS)** | **#** |
| 6 … 7 | 2 |
| 4 | 2 |
| 2 | 1 |
| 1 | 18 |

I did not ask about gender identity, because it was not a central concern for my study. That is why I use the phrase “presents as”. By appearance, 4 presented as male and 19 as female. Through the content of conversation, there were other identifiable characteristics:

Table 2. Community Identifiers

|  |  |
| --- | --- |
| **COMMUNITY IDENTFIEER** | **#** |
| Accessibility-Aided | 1 |
| African-American | 1 |
| Asian-American | 2 |
| Jewish | 4 |
| LGBTQ | 4 |
| Spanish-fluent | 2 |

The sample’s diversity, in terms of life experience and professional practice, gives me confidence to trust that the stories have significance to ponder. Their stories are meaningful to me. I hope they are to you. Next, I will share the stories in two ways. Sometimes, I will quote them in brief and occasionally a little bit more. I will share some findings about themes derived from clusters of similar comments.

### What I Learned from Psychotherapists’ Stories

We all tell stories. In this context, the reason is to be seen, heard and understood.

In my role as an interviewer, I found that I listened in a way that was similar to my role as a clinician. I had my ear tuned for significance. But healing and building strengths weren’t the primary goals, in that way it was different from the clinical setting. We were talking for the pleasure of it and for the inherent goodness of learning together.

Is the distinction of first-order and second-order change relevant to your practice?

The question laid a foundation for evaluating the effectiveness of Telehealth. I thought when I began the study, “Maybe Telehealth is fine for problem-solving, but not for transformative goals.” As I have mentioned, the study did not support my doubt, skepticism.

The question also was a good way to begin a conversation with clinicians whom I did not know. A shared vocabulary had to be established quickly, I was alert to nuance and novelty which were cues for me to urge elaboration by the client.

Two respondents said “No” and 21 said “Yes.” The two who said “no” were clear that their clinical focus was fundamentally concerned with dynamics, be they within the individual or with others, that generate the client’s problems. All respondents said some version of, “It depends.” A clinician who said “Yes” continued:

\* So before the pandemic, the hope of psychotherapy with me was to be transformative with people. Since the pandemic it has massively switched to the first order, people needing direct support, health check-ins, and improved coping strategies. (#11-20210315)

The clinician’s wide-angle view for their clinical focus is mediated by their theoretical orientation, that is their approach to the work. As practiced among respondents: those with a psychodynamic view are very interested in a person’s history and its impact on current problems; those with a cognitive behavioral view were focused on mitigating current dysfunction; those with a relational view used problem-solving as a means to an end, transformative change. As I listened and encouraged elaboration by the respondents, I found no purists. We all respond to the client’s priorities.

\* What you describe as strength-based problem-solving versus transformative, I describe as the [continuum] between counseling and psychotherapy… focusing upon personal coaching improvement or on fundamental personal change. (#13-20210319)

Respondent (#13) describes their approach as “complex systems.” There was another outlier in terms of the three main approaches that I have identified:

\* I had to think about that for a bit. The answer was yes, because what I do is use transactional analysis as my primary method. Transactional analysis is flexible, that is you can help people at both levels. And I adapt how I use transactional analysis to meet the needs of the person and the readiness of the person. (#17-210325)

The use of language, the lifelong learning that it reflects, caused me and each respondent to “think about that,” as each interview progressed.

As I read the answers to this basic question about clinical emphasis (problem-solving and transformative change,) I coded the respondents for their reliance on the three approaches[[50]](#footnote-50), Psychodynamic, Relational, and Cognitive:

Table 3. Main Approaches

|  |  |
| --- | --- |
| **MAIN APPROACH** | **#** |
| Cognitive | 4 |
| Psychodynamic | 8 |
| Relational | 8 |
| Transactional Analysis | 1 |
| Complex Systems | 1 |

*Note*. n = 22

The categories for main approaches are oversimplified. “Cognitive” does not distinguish Cognitive Therapy from CBT nor REBT[[51]](#footnote-51) as taught in training or modified by a clinician. “Psychodynamic” does not distinguish among the various influences from the heritage of Freud, Jung, Kohut[[52]](#footnote-52) and Winnicott – all of these came up as well as others. “Relational” does not distinguish among influences such as Adler[[53]](#footnote-53), Maslow, Rogers, Sullivan, etc.

The array that I’ve represented does not capture the ability of clinicians to draw upon the approach that makes sense for a particular client at a given time. In a sense, all were eclectic[[54]](#footnote-54). The chart is derived from a content analysis which was deductive rather than inductive. I drew upon my knowledge of psychotherapeutic theory to paint with broad brushstrokes. The broad categories are presented in Table 3: “Main Approaches.”

I did this to get insight for one of the questions that I was pondering, “Does their approach seem to affect the experience of Telehealth psychotherapy?” The sample size was reduced by one, because a respondent marked all responses “Private and Confidential” and that precluded coding based upon the text. The sample size for the remainder of the study is 22.

What are your methods when the focus is improved stability in daily life? The purpose of the question was to find out what each respondent meant by psychotherapy for first-order change; few clinicians whom I interviewed use that term. And I wondered if the methods could be done via Telehealth. As I listened, it became clear to me that the training and supervision of people entering the field would be enhanced by exposure to stories of psychotherapists like those I interviewed.

Table 4. Beginning Methods for Improved Stability

|  |  |
| --- | --- |
| **BEGINNING METHOD FOR**  **IMPROVED STABILITY** | **#** |
| Attachment | 4 |
| Narration | 8 |
| Psychoeducation | 10 |

*Note*. n = 22

Clinicians have a set of tools, skills, techniques that they use based upon the client’s needs and readiness. Careers can have phases in which clientele characteristics shift. For example, when I first was licensed, I worked with a lot of families wherein a child had died or was dying. Thirty-years later, all of my clients are adults. Throughout these decades, grief has been a constant issue faced by my clients. My coding is a blunt instrument for a moment in time. It helped me think about and prepare my findings about here-and-now adaptation. One of the things I looked at after I coded was the combination of core therapeutic approach and initial methods to begin work for problem-solving. Among cognitive therapists, two began with the client’s narration, two started with psychoeducation. There was a distribution for psychodynamic therapists (three started with narration, three started with psychoeducation, two started with attachment). The relational therapists were also distributed across the methods (two started with narration, four started with psychoeducation, two started with attachment). Is there any significance for my inquiry about Telehealth? Respondents’ comments lead me to conclude that there’s nothing about Telehealth per se that impedes psychoeducational support, relationship modeling to form an attachment or client self-integration through narration.

A psychodynamic clinician who uses psychoeducation for strength-based change said, “People can’t deal with insight-oriented when they’re crying, so afraid they can’t leave their house [because of the pandemic]” (#11-210315, Psychodynamic). The clinician elaborated:

\* Let’s add mindfulness and personal self-awareness about all those daily habits that allow people to stay in the moment, reduce anxiety, teach deep breathing, progressive relaxation... You have got to be very flexible and listen very carefully to what the person needs at this time and give gentle, regular reminders to live the healthiest life that they can live... At times I thought, “What the heck am I doing here? You know this is not this is not psychotherapy.” But you know what? At this time it was, because without a daily check in with me, you know people went awry. So things changed.

A clinician who uses narration for problem-solving said:

\* [Assessment is] my roadmap to the treatment and to the interventions that I’m going to bring to them… And then I’m going to go back to my use of self, being empathetic and being supportive, allowing people to share, in a way that they feel supported… I want to know what they’ve done about [the issue]. Then from there, “What worked, what didn’t work?” From there we explore some interventions, some tasks. (#19-210330, Relational)

A different psychotherapist begins with attachment for solution-focused work:

\* [I am] just being present, transparent, honest, reliable. Sometimes I think it’s either what people truly believe that needs solving or it is the safer place to start so that they can get to transformative work. So I’m happy to begin there. (#28-210409, Relational)

These comments illustrate something that all of us (who are any good at what we do) know, even if we seldom say it. There is an experience central to talk-therapy. The client sees and feels that the therapist is paying attention and seeing them accurately in the moment. Without saying so directly, each clinician describes avoiding things that interfere with the sensations of safety and trust that the client needs: not missing the urgency of the moment, not putting up airs to impress, not imposing. These answers suggest tacit knowledge[[55]](#footnote-55) useful to understanding why Telehealth can be effective.

**What methods do you use for transformational change?**

Respondents indirectly and explicitly affirmed the perspective that strength-based problem-solving goes hand-in-glove with transformative personal growth. It could be represented by a Venn Diagram.[[56]](#footnote-56) One respondent said:

\* The problem-solving is the scaffolding of the work for the insight, especially being able to help her with her sense of herself and her depressive orientation. (#15-20210323, Psychodynamic)

A question that I routinely ask clients and interns, after I’ve made a qualitative remark (i.e., reflection, evaluation) is, “Do you have any objection or skepticism?” I did not have to ask clinicians who identified their approach as relational; they opened with their objection to the question about “methods”:

\* Really it is not so much of a matter of methods, but it’s more that it’s relationship-based. (#25-210406)

\* It’s more about who I am than what I do. (#26-210407)

\* I’m in the present moment. (#30-210413)

\* Psychodynamic therapists said similar things:

\* I don’t think of myself in terms of method. I think of myself in terms of relationships. (#23-210402)

\* It is less about suggestion and intervention; and it is more about feeling, joining their sense of self in the cleanest of therapeutic ways. (#24-210402)

A methodology question such as, “How do we achieve results?” is especially important for the education and training of clinicians. But if I were able to have more interviews, I might ask, “Aside from your methods or techniques, is your style of relating a reason that you can help clients achieve transformative change via Telehealth?”

My inquiry about the efficacy of Telehealth for transformative personal growth ran into interlocking branches of theory, methods, situations, experiences. It was a thicket.

\* [Transformation] often develops out of the first. Of course with both kinds of treatment you’re trying to maintain a good relationship. As you develop the relationship, it goes from being what would typically be thought of as a real relationship to an interpsychic relationship. (#29-210412, Psychodynamic)

\* Taking attachment theory and polyvagal theory and interpersonal neurobiology and putting them together to come up with an understanding about how we form relationships… Even when I’m working with them on first-order change, and that’s where their focus is, [that] starts to help… the implicit part of them, make a more accurate narrative… there begins to be some wiggle room for conceiving of themselves differently. (#27-210409, Cognitive)

A Venn Diagram cannot usefully represent these comments. Each represents a psychotherapist’s creativity in seeing, reflecting, thinking, doing, being.

There’s novelty in phrases sprinkled throughout the transcripts, such as “a real relationship to an interpsychic relationship.” I can imagine the nuanced meaning; I would need a follow-up conversation to find out for sure. The same is true for the phrase “implicit part of them,” it has specific and nuanced meaning for the clinician who said it.

**What is your theory about how transformative psychotherapy works?**

Psychotherapists learn formalized theories in school. Theory is part of life-long learning in the profession, each clinician develops their own model. There is nothing inherent in a theme that emerged from the respondents’ answers. Among them is a common view that strength-based solutions can be transformative. “It operationalizes that way, but I’ve never used those terms [first-order, second-order]” (#16-210323, Cognitive). The choice of methods is situational, but the effects can be global which is to say the results can cause generalized progress, growth. Respondent comments illustrate:

\* How does transformative therapy work? Okay, so you know, thank God, after 30 years I have my own thoughts about that. (#11-20210315, Psychodynamic)

\* I’m going to pull together two worlds now... [transactional analysis and] developmental experience. (#17-210325 – Transactional Analysis)

\* I really believe it goes back to parenting, although I’m not actually thinking of that when I’m doing it. I’m being... intuitive at the moment. (#20-210409, Relational)

\* It’s super complicated, so it’s complicated to actually try to put this into words. (#30-210413 , Relational)

\* Psychoeducational can be transformative. The transformative part is kind of like Archimedes said. If you give them a lever long enough and a place to stand, you can move the earth. (#12-20210319, Cognitive)

\* I think what works is that if the client really feels heard and that’s really modeled for them then they can really hear themselves. (#14-20210323 , Relational)

\* Very often I am using what I call transformational work when I am doing trauma work. I am very interested in the display of ego in problem-solving skills, but from the point of view of self and self-integration that is so well revealed. So I have found myself doing a great deal of that during the quarantine. (#15-20210323, Psychodynamic)

**What do you need from the client in order for you to fulfill your role?**

The implication of the question is that it takes two to tango. What might impede or enhance the client’s contribution on the dance floor? The dance floor is in-person psychotherapy.

The term “show up” was cited by eight clinicians. Trust was identified by five. “Talk” was mentioned by five, as well. Honesty was mentioned by four. Active participation was mentioned in different ways by 14 of the clinicians. It’s useful to share their actual comments, before I summarize the relevance.

\* I need them to be invested in the growth and change. (#12-20210319, Cognitive)

\* They have to have a certain level of commitment to their own growth. (#13-20210319, Complex Systems)

\* I need the client’s engagement. (#14-20210323, Relational)

\* They need an open attitude. (#16-20210323, Cognitive)

\* The person has to want to make change. (#18-210329, Psychodynamic)

\* And what I like to get is a willingness to join me in the exploration. (#23-210402, Psychodynamic)

\* Patience. We both need tolerance for the process. (#24-210402, Psychodynamic)

\* Their willingness to see and to process what’s coming up. (#25-210406, Relational)

\* It was clear that they had no real goals for therapy. And that’s not therapy. (#26-210407, Relational)

\* The more information that I have, the better equipped I am to help you. (#28-210409, Relational)

\* Stable enough and they have to be interested, curious. (#29-210412, Psychodynamic)

\* I need them to be curious about themselves [and] engage in conversation. (#30-210413, Relational)

\* The first thing I need from the client is commitment to the process. (#32-210420, Psychodynamic)

\* Some level of engagement. (#33-210426, Relational)

Most of my analysis of the narrative data yielded a distribution that is roughly half-and-half, thirds, and a bunch of overlap. What is the significance of the commonality among the comments and what about the stand-out comments? Always in my mind is, “What does any of this have to do with the efficacy of Telehealth?”

A cluster of responses grabbed my attention. Two-thirds of these experienced clinicians said that they need client engagement for psychotherapy to work. This is not a group of neophytes that need to learn how to elicit engagement. The question becomes, “Is there something about Telehealth that encourages or inhibits client engagement?”

Beyond engagement, the client’s commitment to the process is needed. The process can be exhilarating, but it also can get bogged down or become painful. Are there qualities of Telehealth that militate against or reinforce commitment to the process?

**What does the client need from you to move towards second-order change?**

I thought about how to give an overview of comments that have a lot of detail, nuances. Respondents used phrases like “empathic reaction,” “the realness,” and “some sort of relatability.” I think I know what they meant.

I wish it had been possible to have follow-up conversations about comments such as these:

\* What does the client need from me? I really believe that it is the empathy and the understanding of the patient. They’ll be talking about their life and maybe some maltreatment or abuse they suffered, but it’s my empathic reaction to what they experience that they stop and realize, “Oh, that was not normal.” (#11-20210315, Psychodynamic)

\* The client needs to be assured that I’m gonna be there where they’re at, that I’m not going to get ahead of them. Not going to tell them what to do. I’m not going to drag behind. They need to trust that. And they need to feel some sort of relatability. I think as a person they need to have some sort of relatability, whatever it is. (#14-20210323, Relational)

\* I have a humanistic tradition. Be authentic and real. So the realness. So what do they need from me? It’s kind of funny because it’s so damn obvious. They need me to care, want to care, to be interested in them. Which is why it’s a challenge when there’s a client that I don’t like. That speaks to issues that are much deeper. They need me to really care and be really interested, to be really honest and genuine. You could trust me to give honest feedback with compassion and sensitivity. The feedback will come without implicit or explicit judgment or condemnation. The trepidation that they bring into therapy is that they’ve been judged. They’ve been condemned. And they do it to themselves. They need me not to double down on that and at the same time not paralyze myself for fear of judging. (#12-20210319, Cognitive)

Instead, my solution was to identify words that have significance for our profession, count their occurrence among respondents, categorize the terms for sorting and stack them from least often to most often mentioned.

If I could, I’d ask to hear stories that illustrate what they meant. My thinking is that the most mentioned term for each category could be like a broad brush to paint a sign, “Qualities of a Clinician that a Client Needs.”

The first column lists categories of clinician qualities: conduct, feeling, knowledge. For each category, the second column lists what is needed by the client. The bold font draws your attention to the most mentioned:

Table 5. Qualities of the Clinician Needed by the Client

|  |  |  |
| --- | --- | --- |
| **QUALITY** | **CLIENT NEED** | **#** |
| Conduct | Authentic | 2 |
| Conduct | Consultation | 2 |
| Conduct | Boundaries | 3 |
| Conduct | Honest | 4 |
| Conduct | Patience | 4 |
| Conduct | Safety | 4 |
| **Conduct** | **Listening** | **7** |
| Feeling | Compassion | 2 |
| Feeling | Acceptance | 2 |
| Feeling | Empathy | 3 |
| **Feeling** | **Caring** | **6** |
| Knowledge | Understanding | 2 |
| Knowledge | Interested | 3 |
| Knowledge | Knowledge | 3 |
| Knowledge | Remember | 3 |
| Knowledge | Non-judgmental | 4 |
| **Knowledge** | **Experience** | **5** |
| **Knowledge** | **Feedback** | **5** |

To sum up the respondents’ views: The client needs a clinician who is good at listening, sends signals of caring and has sufficient experience to give useful feedback. You might ask, “So what?” After all, we learned that in graduate school. It may be universally accepted. That said, do these and other foundational qualities make it through Telehealth? You might wonder, what do the quality labels signify? Let’s give an example of each of the three qualities: conduct, feeling, and knowledge.

**Conduct**

I’ve identified seven measures. They are: Authenticity, Listening, Safety, Boundaries, Honesty, Patience, Consultation. With the exception of consultation with other psychotherapists and clinical supervision, all are directly observable by the client during the session.

\* I’m, from the past to now, really very different. I’m very flexible. I say what I feel to the client. Before I was a little bit more, not rigid, but I used to hold back more. I don’t anymore. If you don’t like it, tell me. There are some things that I can apologize for. And some things, I won’t. That statement alone puts just another great layer on treatment. A great layer that said, “How did that tap into something else? How did that manifest?” I kind of like it when that happens, because it just puts another layer on the treatment. (#31-210319, Psychodynamic)

Is it possible that the subtle, non-verbal cues that are exchanged in-person might be distorted or missed via Telehealth? Or it might be that Telehealth simply provides another arena through which the client can experience the clinician as a “Good Enough Parent”[[57]](#footnote-57) and interactions that go awry are an opportunity for optimal parental “failure”. The notion of failure having therapeutic potential is suggested by psychoanalytic theory: “[As] analysts we repeatedly become involved in the role of failure, and it is not easy for us to accept this role unless we see its positive value. We get made into parents who fail, and only so do we succeed as therapists” (Winnicott, 1989, p. 75).

**Feeling**

Let’s take a look at the quality of feeling. I have identified four measures: Compassion, Acceptance, Empathy, Caring. We know from in-person experience that those feelings, whether they be identified as bodily sensations and/or as emotions, are fundamental to each person’s evaluation of any social interaction. Talk-therapy is a social interaction, albeit a special kind. This is how one respondent said it:

\* Much of that is metaphoric to parenting. The parent gives you boundaries and guidance that’s difficult to hear sometimes. And as they know that it comes with caring and compassion, they tell you. They need that energy from you. They need to know that I’m real, that I care, I’m honest. They need to know that I won’t hold back. (#12-20210319, Cognitive)

I chose the above comment, because it shows the intersection of feelings and conduct. The next comment describes the clinical importance of feelings.

\* [What] I’m doing is using a great deal of empathy as I am listening to their narrative, I am establishing a bond. The bond is going to be critical to our work, for as long as it lasts. Now, of course, some patients will not let me do that. They are pushing me away. I can feel that and that’s diagnostic. And here’s how it’s diagnostic. An individual who is pushing me away is not going to let me be very explorative. So I have to stay on the surface with empathy for a while. (#15-20210323, Psychodynamic)

How do feelings flow when the interaction is mediated by technology? Under what circumstances is the bond, formed through shared feelings, either enhanced or diminished by Telehealth?

**Knowledge**

The third quality is knowledge. I’ve identified seven measures: Understanding, Interested, Knowledge, Remember, Non-judgmental, Experience, Feedback.

\* I’m pretty good at being able to confront something with a nurturing parent rather than a critical parent, and a lot of the adult mixed in there. And I have enough empathy and demonstrate enough empathy for the [inner] child so that I can give feedback in a way that creates a sense of safety. So people will very early in a treatment relationship open up about stuff that they don’t want anybody else to know. As more stuff emerges, more comes pretty quickly, the dirty laundry, that’s because they feel like I’m not going to misuse it or abuse them in some way. (#17-210325, Transactional Analysis)

The comment was made by a clinician with 45 years of experience. The experience is inseparable from the qualities of conduct and feeling. A clinician with 33 years of experience said it this way:

\* Nonjudgmental acceptance, professionalism, being able to hold their issues without imposing my own issues on them. My knowledge and expertise on personality styles and knowing realistic expectations for this person given the way they are wired. Knowing what is the reasonable goal for someone who’s wired the way they are. A consistent presence so they know what they’re going to walk into from one week to another. They probably have enough of not knowing what to expect in their lives with other people. (#26-210407, Relational)

So here we have a finding from the interviews. It is about the client’s need for qualities embodied in the psychotherapist. There are three qualities needed for transformative work and they are: conduct, feeling, knowledge. The question for my inquiry, “How are they manifested via Telehealth?”

**Do you modify methods for a Telehealth session?**

The interview questions were provided ahead of time. Each respondent was able to read the questions before our conversation. At the beginning, I would say, “The first set of questions are about your in-person work, that’ll give us the foundation to talk about Telehealth.” There were three Telehealth questions. Respondents jumped right in:

\* Our clients can’t give us what we need to fill this role when they are in crisis and it’s Telehealth. It is not clear that there can be transformative work done with Telehealth. I’m not ruling it out 100%... The pandemic has created all these kids that I see, in junior high, high school and college, their anxiety is so terrible. The way to treat anxiety is not some insight. It’s coaching, behavioral change, sometimes a medication consult, changing your daily patterns in life. The work is very different. (#11-20210315, 32 years, Psychodynamic)

\* I’m working with mommy and there’s no peace in the house. She goes out to the garage and finds a beach chair. She drags it out to the alley, gets out her iPad and we proceed to have our session. Well, a big black dog gives her a kiss and gives me one too. We just laughed for about 5 minutes and called it therapy… [When] you’re trained in psychoanalytic orientation, you are very careful about transference … Well I’ve gotten over that, big time, it’s made therapy so much more interesting to me, to really become not only a purpose but much more of a pleasure. … in terms of being more direct when you need to be, setting boundaries when you need to, and also being kind and careful with people’s feelings. (#15-20210323, 42 years, Psychodynamic)

I chose the two stories because the feelings that come through are so very different. One is very concerned and skeptical; the other finds Telehealth delightful. Both are very experienced and psychodynamic in their approach. There's a difference in clientele, adolescents and adults. The clinician who feels good about Telehealth and their changed use of self (as a therapist) suggests that, while necessity for Telehealth was the mother of invention, their personality and their stage of life (maturity) also might be drivers of a change in technique. Consider these preliminary musings to the next three questions that focus on Telehealth for transformative psychotherapy.

**What are the circumstances in which, or kinds of clients for whom, your use of Telehealth enhances transformative psychotherapy?**

First, I will share a few of the respondents’ stories. Then I will discuss the process of extraction of terms used by them as well as the themes and the significance. By this time in the interview, we had established that within a session and between sessions, there are distinct goals, stabilization and transformation. We shared an understanding that theory guides practice, but it is not practice itself.

**Selected Stories**

The first story shows that a person might very well say what they know and feel, regardless of the question or definitions. The question was about Telehealth and transformative goals. This clinician spoke of “supportive” work:

\* [Examples] are mostly women, not men so much, but women at home with their children. Their children are not in school. Somebody has to be in the house with them. And although we can really get interrupted by the kids coming and going, at least we get to do problem-solving things together thanks to Telehealth. They would not get therapy, I’m pretty sure, beyond their friendships, if we didn’t have Telehealth... She has to be there with her children and she can at least talk in a supportive way with me. (#15-20210323, 42 years, Psychodynamic)

If I were to follow up, I would ask the psychotherapist, “Did you intend to say that ‘talk in a supportive way with me’ is transformative?” I have my ideas, but I can’t assume mine apply. The other possibility is that the clinician did not respond to the “transformative” part of the question, but rather was thinking out loud about the efficacy of Telehealth in general. The next two comments refer to comfort within the physical space of psychotherapy, the effects of travel to get to the session:

\* And I think the clients are more relaxed. They don’t have to deal with traffic or parking, or the anxiety of being in someone else’s space. They are in their own space. They don’t have to get a babysitter. Those are the positive aspects of Telehealth. (#16-20210323, 39 years, Cognitive)

\* I think that they’re not having to worry about traffic, to have therapy in a place that they find comfortable. That helps in terms of what we were talking about earlier in terms of safety and in building rapport. It can be AOK from the get go, because 50%, now it’s more than that where I have my first connection with them through Telehealth. (#18-210329, 13 years, Psychodynamic)

There is so much in these comments. “Anxiety of being in someone else’s space,” can be something rife with therapeutic potential. But in this case, the psychotherapist sees a benefit in its mitigation. In a recent conversation, an intern of mine used the word “anxiety.” I asked, “Can you tell me more about what you mean by that word?” The intern defined it as a kind of thinking. That opened up supervision to the physiological experience and its social function. Keeping my dissertation within manageable boundaries and staying true to my compass, the purpose, has been a challenge. The details in the stories are fascinating!

The next two stories are about Telehealth and psychotherapy for trauma. The first story is about audio-only and the second is about streaming video on a phone.

\* I can think of a client, a woman who is divorced, mother of an adult child, late 50s. She has been struggling, she’s a Hispanic woman… She had real difficulty with boundaries. with her boss, with her friends. She tended to let herself be manipulated. She was not protective of herself. I had been talking to her for a while. And we do phone. A lot of my clients do phone, not video. It’s their choice. We were working on helping her recognize what she was doing. She had trauma in her past. She started to understand what she was doing, she started to understand how she was allowing people. She had feelings of being less than. She said to me [that] she had made some really significant changes in taking risks… She was challenging herself. Setting clear boundaries. (#19-210330, Relational)

“It’s their choice,” mentioned in the first story, resonates with my conclusion and my approach to healing through talk-therapy. “It’s their choice” might be a North Star for a blended psychotherapy model. As watchwords, they apply to healing through *I-You* experience.

\* [I’m] doing video on their phone, so I can actually see their face, but not as well as I can with video on the computer. In Telehealth, I’m so focused on people’s eyes and their expressions, as much as I can be. I think I’m more reflective with people on Telehealth because I’m watching so closely and so intently, there’s this smaller range to see on the screen. I have worked with a couple of people who are really doing a deep dive into how childhood trauma formed their unhealthy choices. I’m thinking of one person in particular. It seems to have really worked well doing that deeper, deeper, dive. But it could also be because there’s less opportunity to be out and about, they’re doing more writing. And I’m more reflecting. They come really prepared for the session. (#20-210409, 23 years, Relational)

I like the story because of the descriptive detail and the humility in reflection. It’s a challenge for an inductive, constructivist approach. My response to the challenge was to extract themes based upon words respondents used, even though the method is a blunt instrument. I continued inductive reasoning to build a general idea about this group of twenty-three psychotherapists. Experience was divided into years in practice and years using Telehealth and combined with main approach. Then I grouped their answers about conditions when Telehealth is effective.

**Extracted Themes**

I began by tagging text. Taken altogether, the most commonly mentioned factors for which Telehealth was specifically positive were “Improved Accessibility” and “Safe Personal Space.” A middle group were “Long-term Clients” and “Able to see the Person in their Environment.” The least mentioned: “Enhanced Visual Focus on Facial Expressions” and “Client who is Technology Fluent.” Mentioned once were “Caregiver at Home,” “Client in Crisis” and “None.” The counts do not provide much meaning to me. The following table represents the array of experience, approach and factors.

Among six clinicians who have been licensed between 10 and 29 years. One had seven years of experience in Telehealth, one had four, the rest had one. Seven factors were cited, none more than twice.

Among eleven clinicians whose experience ranged 30 years to 45 years, one had used Telehealth for six years, another had two, the rest had one. Eight factors were cited, fairly evenly distributed. There were outliers with a sole citation. One using Transactional Analysis, did not cite a factor. A psychodynamic clinician said that a client in crisis fits well with Telehealth psychotherapy. About half of the respondents gave a sole factor which enhances transformative psychotherapy via Telehealth.

Five clinicians were licensed under 10 years. One had nine years of experience in Telehealth, one had four, rest had one. Four of them cited “Safe Personal Space” as a factor through which Telehealth enhanced transformative psychotherapy.

Table 6. Experience, Approach, Factors

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **SN** | **YRS**  **LIC** | **YRS**  **TEL** | **APPROACH** | **FACTOR: 1** | **2** | **3** |
| 25 | 4 | 1 | Relational | Access-Geo. | Safe  Space | SafeSp |
| 30 | 4 | 9 | Relational | Access-Geo. | SafeSp |  |
| 27 | 6 | 4 | Cognitive | SafeSp |  |  |
| 28 | 7 | 1 | Relational | Access-Geo. | SafeSp |  |
| 32 | 7 | 1 | Psychodynamic | Person In Environ (PIE) |  |  |
| 18 | 13 | 4 | Psychodynamic | Access-Geo. | SafeSp | PIE |
| 14 | 19 | 1 | Relational | Access-Homebound |  |  |
| 24 | 21 | 1 | Psychodynamic | Long-Term Clients |  |  |
| 20 | 23 | 1 | Relational | Enhanced  Visual Focus |  |  |
| 12 | 27 | 7 | Cognitive | Access-Geo. | Tech Fluent |  |
| 13 | 29 | 1 | Complex Systems | Tech Fluent |  |  |
| 22 | 31 | 2 | Cognitive | Long-Term Clients. | PIE |  |
| 11 | 32 | 1 | Psychodynamic | Long-Term Clients. |  |  |
| 26 | 33 | 6 | Relational | Access-Geo. | SafeSp | PIE |
| 33 | 33 | 1 | Relational | Tech Fluent | Enhanced Visual Focus |  |
| 19 | 34 | 1 | Relational | SafeSp |  |  |
| 23 | 37 | 1 | Psychodynamic | Access-Geo. | SafeSp |  |
| 29 | 38 | 1 | Psychodynamic | Long-Term Clients. | Crisis |  |
| 16 | 39 | 1 | Cognitive | SafeSp |  |  |
| 15 | 42 | 1 | Psychodynamic | Access-Geo. | Caregiver |  |
| 31 | 43 | 1 | Psychodynamic | PIE |  |  |
| 17 | 45 | 1 | Transactional Analysis | None |  |  |

Here are two examples from clinicians using it for one year:

\* Access – Homebound: I can reach out to people who are homebound... going to the office wouldn’t have honored that deep feeling of loneliness they’ve always had, because they’ve always been homebound and somehow, they get to an office. (#14-20210323, 19 years, Relational)

\* Long-term Clients: I found that a lot of my patients were longer term and we then suddenly had to change from face-to-face to Telehealth, maybe it encouraged a little bit more independent functioning. (#11-20210315, 32 years, Psychodynamic)

Nine of the ten respondents who gave a single factor had one year of experience in Telehealth. One has been using it four years and said:

\* Safe Personal Space: 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 two-way video. We’ve explored that and he says, “No, the phone works for me better.” (#27-210409, 6 years, Cognitive)

A clinician who has used Telehealth for four years stated three factors:

\* Access – Geographic; Safe Personal Space; Able to see the Person in their Environment: When I first started doing Telehealth, it was to help people who are in remote areas that would otherwise not have access to therapy and counseling… to work with the most isolated people… so they can have well-being, health wise. Telehealth provides an opportunity for people who wouldn’t otherwise be receiving counseling. And that's the existential value of this profession, well-being. (#18-210329, 13 years, Psychodynamic)

It could be that, as experience grows, clinicians see more factors and nuance for which Telehealth is useful. Psychotherapists with more experience might view the unfamiliar as a puzzle to solve. A respondent with 34 years of experience, using Telehealth for one year said:

\* Safe Personal Space: 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).

**Under what conditions is your use of Telehealth less effective?**

Before I move onto the question of conditions in which their use of Telehealth is less effective, it is good to discuss a limitation that flows from my purpose and my method. This question brought clarity to me about my discomfort with reporting the findings. All of the clinicians were expansive with answers; the details of their stories contain nuance and novel perspective. For this question, I took a key sentence or two from each and placed the comments next to their identifiers (serial number, experience, approach). I saw patterns that I will share. But reducing their observations to a sentence or two and categorizing, for me, that felt disrespectful. I encourage you to read their full answers in Appendix C. For you who are not inclined to read all of the interviews, I’ll share a few selections. Then there is a chart with each serial number prefix and a line or two from the full answer.

\* You see less cues, you cannot see the whole body. On the other side, I can see their home. But I don’t see all of the nonverbal cues that I see from the body. I can’t see them shaking a foot or that nervous tension in the lower part of the body. I can’t see the posture as clearly. And, I can’t smell them. Sometimes smell is important. It could be body odors, perfume or whatever else. There’s therapeutic information from walking up to the waiting room and seeing what they’re doing, the magazine they’re reading, how they’re sitting. (#12-20210319, Cognitive)

The psychotherapist (#12) described the useful nonverbal clues and signals from the client that inform ongoing assessment. Other clinicians told similar stories. The next one talks directly about a Telehealth barrier to perception that can pose a significant challenge.

\* I can speak to this especially since this week I just had a client emergency. When there is a person who is withdrawing into depression or is hiding, unable to be honest about the severity of their mood or their risk factors or their use of substances or their suicidal ideations, it’s risky to be on Telehealth. At that point, I need to be able to see them. (#29-210412, Psychodynamic)

\* Safety issues are significant. Respondents also talked about domestic violence. In response, one psychotherapist took measures to see a client in the office, safely, during the pandemic. The limitations of Telehealth were discussed by a clinician in terms of substance abuse:

\* I have a lot of these actually. I work in substance use and I work with harm reduction, so I see a lot of people who are still using. And what I have found is that Telehealth, especially from home, was really problematic for my people who were not quite ready to stop yet. I had clients taking shots while on the session. I’ve had people who think that they are in their house so they just do whatever they want. Whereas when they would come into my office, they would have to get there, so they would often not drink before coming to session. Or they were coming to session, so they weren’t intoxicated for an hour, because they wouldn’t do that in the office with me. Now I was having a harder time, I had this client who was getting progressively more and more drunk. Then I had to figure out a way to keep him safe. I had to find someone because they’re alone in their house. So for me with a certain segment of the substance use population, people who are actively using and working on harm reduction, I think it was really unhelpful. It was definitely less effective. Also as a clinician, when my clients walk in the office, I smell them. I’m able to look at their pupils. On Telehealth, I had a client who was like, “No I haven’t been drinking.” But had it been in person I would have said, “I can smell it on you.” And they would have said, “Oh yeah, you’re right.” It just felt more accusatory through this computer screen when I couldn’t say, “I see it on you,” because I couldn’t really see it. I think there are pieces of my ability to be able to be a good clinician that was also lessened with Telehealth for substance abuse. I definitely think that population, Telehealth is much harder, much less effective. (#30-210413, Relational)

The comments by the psychotherapist (#30) speaks to the relational complexity beyond perception of clues and signals. Telehealth can affect the behavior of a client. It can constrain the psychotherapist, “It just felt more accusatory through this computer screen.” The next clinician describes other barriers.

\* There are a lot of concerns that I have. Not all the concerns are an absolute barrier. But what is a challenge can be used therapeutically over time. Some things are just challenges…

I’ve had more than one session where a client starts crying and I don’t realize that they’re crying because of the quality of the lights in the room where they’re at and the video connection. So I’m talking with a client and we’re going back and forth. At some point I do a reflection, 30 seconds or a minute... not realizing that the client has begun crying. If they were in the room and I saw them crying, probably my tone of voice may change, or something in me may shift to be with the client in a different sort of way. Not even recognizing someone’s crying doesn’t allow that to happen… I don’t think that’s as effective as being able to accurately gauge a client’s emotional state. Crying is one example. But when they go into sympathetic arousal in my office, I may notice when the client starts tapping their foot, when they really tense up or when the whole of their body freezes, I may notice changes in breath a bit more acutely. Changes in breath I do notice pretty well over video. But it’s even more noticeable through the in-person. So again, part of the way I practice is based on Porges’ polyvagal theory. (#27-210409, Cognitive)

Psychotherapist (#27) described barriers and adapting in the context of psychotherapeutic approach. The shared physicality of experience is very important to their method. Telehealth creates sensate isolation.

The following chart provides comments about conditions whereby Telehealth is less effective.

Table 7. Conditions Whereby Telehealth is Less Effective

|  |  |  |  |
| --- | --- | --- | --- |
| **SN** | **APPROACH** | **YRS** | **COMMENT** |
| 11 | Psychodynamic | 32 | |
| 8th graders to 12th grade girls who are depressed, isolated, lonely and then take it to something’s wrong with them. Do the video sessions just perpetuate where they’re at? | | | |
| 12 | Cognitive | 27 | |
| You see less cues, you cannot see the whole body. | | | |
| 13 | Complex Systems | 29 | |
| If their belief is that this modality won’t work, they’ll not use it. | | | |
| 14 | Relational | 19 | |
| In the last year many have expressed feeling less safe than in the office. | | | |
| 15 | Psychodynamic | 42 | |
| Where I have had difficulty with is when I am working with personality pathology, like narcissistic and I have a few borderline patients. I can’t see them well enough; I can’t feel them well enough when they begin their shifts, their abandonment worries and so on. | | | |
| 16 | Cognitive | 39 | |
| I can’t see the subtle changes in someone’s body language, | | | |
| 17 | Transactional Analysis | 45 | |
| Two things come to mind. One is two-chair work. The other is what we do with screens all day long. | | | |
| 18 | Psychodynamic | 13 | |
| EMDR, guided imagery is not really going to happen in Telehealth and be as effective as it could be in person. | | | |
| 19 | Relational | 34 | |
| I had someone with agoraphobia. I found that one harder to work with over Telehealth. | | | |
| 20 | Relational | 23 | |
| It’s been very difficult for one client had some depression, anxiety, her voice would drop off in a conversation, | | | |
| 22 | Cognitive | 31 | |
| I’m thinking of my clients who rely on medication. It’s to the good that these medicines are working. They’re having the most trouble. | | | |
| 23 | Psychodynamic | 37 | |
| There’s no one answer. It’s different for everyone. What is consistent is how I am, because of my experience. | | | |
| 24 | Psychodynamic | 21 | |
| There are high need people with chronic and difficult to resolve presentations, they don’t do well in Telehealth mode, because we lack energetically whatever we’ve got when we share space physically. | | | |
| 25 | Relational | 4 | |
| One concern that I have about Telehealth is the client who is at risk of self-harm, suicidal. | | | |
| 26 | Relational | 33 | |
| I had a client who was on the spectrum and also transgender and had difficulty with the video seeing themselves. | | | |
| 27 | Cognitive | 6 | |
| I’ve had more than one session where a client starts crying and I don’t realize it because of the quality of the lights in the room where they’re at and the video connection. | | | |
| 28 | Relational | 7 | |
| Couples work I think can be tricky... Safety when there is high acuity or potential destructive communication and escalation from there, that worries me. | | | |
| 29 | Psychodynamic | 38 | |
| When there is a person who is withdrawing into depression or is unable to be honest about the severity of their mood, risk factors or use of substances or their suicidal ideations, it’s risky to be on Telehealth. | | | |
| 30 | Relational | 4 | |
| I work in substance use and harm reduction, so I see a lot of people who are still using. And what I have found is that Telehealth, especially from home, was really problematic for people who were not quite ready to stop yet. | | | |
| 31 | Psychodynamic | 43 | |
| I’ve been working too much, looking at a screen is absolutely getting to be exhausting to me. | | | |
| 32 | Psychodynamic | 7 | |
| It’s not the same connecting with someone on video as it is in person. There’s an immediacy that is missing. | | | |
| 33 | Relational | 33 | |
| People will freeze up and you will miss some of what they are saying... There is something about the whole-body language. So what you gain by being this visually close, you lose the rest of the body language. | | | |

**Can you give an example (with attention to protection of privacy and confidentiality) where you helped a client make transformational change via Telehealth?**

Well, if I felt conflicted about skipping over nuance in the previous section, you can imagine the difficulty with these stories. It’s tempting to simply tell you to read the complete answers in “Appendix C” and see for yourself what you think. Actually, this is really tempting, because I think these stories are the foundation for future conversations that can help us educate and train new clinicians, as well as reinforce and support those of us who have a lot of years under our belts. I’ll share a couple of abridged stories, please accept my apology for not sharing them all. It would just be too much.

A clinician uses a relational approach, in practice 19 years, one year with Telehealth:

\* I have a young client. He and I used Telehealth while he was in his car. He always goes to the same parking spot where there’s not a lot of people and he’s not around his roommates. We talk an awful lot about how he was abused as a young boy and emotionally not respected as a young boy. I think there is more freedom to talk. I had seen him for a couple of years in my office and then we had a break. Then he requested support therapy on Telehealth. I notice the differences with him. He was not quite as safe in person. I wondered if it was a female to male dynamic, but I didn’t talk to him about that. I don’t know that, but I wondered. He really quickly gets to an understanding or an insight about why he is anxious when he’s around people. He didn’t have the opportunity to be relaxed and have fun around people when he was younger. He adjusted so negatively with the self-judgment because it is the old tapes of his parents. He gets to that quicker when he’s in his car in the parking lot in this spot where he always goes. He feels safer than when he was in the office while he’s talking on the phone. We are videoing on the phone. (#14-20210323, Relational)

The story shows clinical complexity and how it must be factored into an analysis of quality of Telehealth psychotherapy. The client is a young adult survivor of emotional abuse, a male with a female psychotherapist, suffering from harsh self-judgment and social anxiety. After a hiatus from in-person therapy, during the pandemic, he resumes therapy; he sits in his car and sessions are video calls. He shows enhanced emotional safety during the session, compared to before.

A relational clinician, licensed four years, providing Telehealth services for nine years:

\* The client who I’ve had for a while is depressed and says, “If things don’t get better, at some point I’m going to kill myself.” The client is very successful in their career, but incredibly lonely and unhappy. In sessions he was often telling me about their life, but kind of apathetic. I just felt like we were stalling. We were going in circles… There was mind awareness, but no heart awareness… I used Telehealth to push and push and push and push and push… And this is the person who got angry, screaming at me via Telehealth, “Why isn’t anything changing? I’m paying you. Why isn’t this changing? Why, why, why, why?” Just like crying and screaming. And I let them go and, of course, was trying to soothe them... I never felt connected to this person and I can connect with a lot of people via Telehealth, but can’t feel connected to this person. And they’re circling, not connecting and all of a sudden, I felt all of their emotions and they were connecting with me. We talked, “Why is it that you can’t connect in your relationships? What is it? What does it look like to connect with people?” And that was after working for this person for two years in-person… I honestly feel like they’re so guarded… I think it was really a safe way of doing it via Telehealth. And from there they are making a lot of changes in their life and how they connect with people and what they do… I’m looking forward to seeing where it’s going to go. (#30-210413, Relational)

One reason I chose this story is to caution the reader against assumptions about licensed experience. The respondent has four years, the least compared to any other study participant. But their Telehealth experience is at the top, nine years. Think of the amount of confidence and proficiency it requires to manage a client through Telehealth and the client is raging at you. Yet the clinician continues to “push and push and push and push and push.” The explanation offered by the psychotherapist is that Telehealth provided the relational safety for the self-binding to be loosened, self-binding was the root problem of the client’s suffering, an inhibition that blocks relating with other people. The relating happened via Telehealth, because it was safe and the relational crisis was understood by the clinician who knew how to enhance the odds of resolution.

A clinician who uses cognitive and cognitive-behavioral interventions has 31 years licensed experience and two years using Telehealth:

\* It was clear to me that the problem with her intrusive thoughts was the content actually. A bit of background, we’ve worked for years on this. Does the content mean anything? Are you really going to kill? And she’s adamant, “No.” She’s not going to do that.

But the thought is so troubling to her. We tried thought blocking. We tried a few little CBT things. We tried looking at the content. We did not make much headway. That was when I originally referred her to the psychiatrist... And [now] it’s COVID-19. The isolation is problematic for her. It’s necessary isolation. What do you suppose happens? There’s a big uptick in intrusive thoughts. She thinks it’s something she’s done wrong. I referred her back to the psychiatrist. There’s a very reasonable modification made in the meds. It doesn’t take her back to the place where she originally was before Telehealth. But it’s much more manageable. And she feels better. (#22-210402, Cognitive)

The clinician views medication management as an indispensable part of psychotherapy. The content of intrusive thoughts changed from “going to kill” to “something she’s done wrong.” That was transformative. I ask you, “Isn’t it a *Big Change* to move from living in terror to living with self-criticism?” In this case, the change in cognition precedes “she feels better” and medication management helped her get there.

A clinician who uses cognitive and cognitive-behavioral interventions has 6 years licensed experience and four years using Telehealth:

\* After switching to Telehealth and continuing to build our rapport, this person was able to talk about a childhood experience of being sexually abused and also later sexually abusing someone else... and over 20 years later, the client had never talked about it to anyone. Never talked about it in therapy or with family members or anyone else. It was part of their life that in some ways was important to their sense of self. So being able to discuss it really allowed them to start forgiving themselves. We didn’t talk about it after the two or three sessions focused on it. After that we focused on self-love, self-compassion, self-forgiveness… The client has experienced so much transformation in the relationships in their life and their career, their sense of self and their sense of self-care. Other compulsive behaviors have sharply declined… I don’t know if the client would have been able to share it if we had been in the same room just feet apart from each other. This is a client that chooses to use the phone. It may be that extra space of not having to see my face provided some level of spaciousness. The client didn’t say that themselves. But one thing I noticed about Telehealth is that some people find it much easier to open up when they don’t have to look at anyone. (#27-210409, Cognitive)

The client shares a secret story about their sexual abuse, as a victim and as a perpetrator. Soon thereafter the cognitive interventions are primarily on the level of schema, beliefs about self. Compulsive behaviors decline. Then the psychotherapist speculates about the role of Telehealth. There is a humility in the clinician’s tone that does not come across in the transcript.

I heard similar humility routinely throughout the interviews. Humility is a factor or quality of the clinician that could be crucial to the efficacy of psychotherapy, whether it is in-person or via Telehealth.

A psychodynamic psychotherapist with 32 years licensed experience, one with Telehealth:

\* Then there was a shift, “I need to make my life better.” She is a changed woman. She is not a victim. She asserts herself. She tells her husband what she needs. She asks things of him. She sticks with it. Her relationship with her children is much better, because she’s much calmer. She realized that she was becoming, acting like her own mother to her own little girls. And it killed her when she realized that. Telehealth came at the right moment. She was strong enough on her own to really start practicing and becoming the life she wanted. Yeah, it wasn’t even screen to screen. It was just a cell phone. That’s it. It’s been incredibly rewarding, and her life is better. The best outcome so far with Telehealth. (#11-210315, Psychodynamic)

The clinician said during the interview that she was trained by a child psychoanalyst and before the pandemic she was dedicated to “insight-oriented psychodynamic psychotherapy.” We did not delve into the topic. And she talked about a changed focus in her practice during the pandemic. The focus became alleviation of suffering caused by disruption within the family, social isolation related to COVID-19. And yet, she describes the formation of a client’s insight that drove *Big Change*; this was achieved with the use of audio-only Telehealth. My guess is that the clinician’s theoretical orientation framed pattern recognition and the clinician’s view of dynamics was woven seamlessly into pragmatic interventions, complex reflections. Whether or not my guess has merit, transformative personal growth happened.

A psychodynamic clinician with 38 years licensed experience, one with Telehealth:

\* I was trained in the Psychoanalytic Institute, but I also was getting supervision in Self Psychology which was a precursor to some of the attachment psychologies of today. And there was quite a split at the time I was being trained in the 80s and 90s, with looking at people with deficits or defenses versus looking at people trying to move towards more healthy ways of behaving and integrating their relationships, their ideals in their life. And for the social worker in me, it fit more for me to do the second one than the first.

One I worked with years ago. She was at a college teaching business law and in a relationship. 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, and many of her colleagues had passed on or she was isolated from some that moved away. What looked like a therapy focused on grief became a life review. Living with her mother and father, she was [from Country] living in [State]. Father went to an internment camp at one point. She had come to the US, with her sister to go to college, leaving her mother behind. There were all these hot points that we never talked about, ever. They were about life, letting go of what felt familiar, stable, and moving on from that part of her life which was more committed. Previously she had all of these ways of coping that were so, so strong. What was so remarkable about it, she was losing so much in this past year.

How Telehealth helped, I think, is that she sometimes would take her device to walk me through parts of her home and show me pictures of herself as a child, her mother, or show me things that she collected as she traveled or things that mattered to her, and just talk about that in a very deep way. Honestly, I don’t think that we could have done that in the office. 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, Psychodynamic)

I share this story with you because the psychotherapist lived through turf battles about theory and practice and knows the issues. Implied in the story is the use of a relational approach with the client years ago, the anticipation of situational adjustment for grief in the present, and the emergence of life review to integrate the experience of a first-generation child of immigrants who suffered from racism. The clinician reflects upon the role of streaming video, “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.”

The role of Telehealth “distance” was mentioned by a number of respondents. “Distance,” I had thought prior to listening to the clinicians, was something that would diminish therapeutic efficacy. Now, I think that consideration of “distance” might be a reason to recommend Telehealth for a client in an established psychotherapy. It seems to provide a form of safety. I discuss safety in Chapter Four. Turn the page and we’ll dive right in.

# Chapter 4: My Theory of Transformative Psychotherapy

Thirty years ago I opened my private practice, a newly-minted licensed psychotherapist, seven years after earning my Master’s degree which began my pivot from artist-laborer to employed professional. I felt nervous, because of my limited experience and knowledge. I sought out every conference and training opportunity that had two features: affordable and nearby. I was a single parent of modest means. I could see positive results for the clients whom I served, both through the jobs I had and my private practice. I could describe what I did. But I could not answer the question “Why does this work?”

Fast-forward nine years, I became a credentialed clinical supervisor; I could share the explanations of others about what happens through talk-therapy. But I was bothered by a few things. Academic battles about psychology were a turn-off, insurance companies enforced the primacy of diagnostic categories which undermines any holistic approach, public agencies driving mental health services demanded standardized clinical methods. My response to each area of dissatisfaction was to dive in, learn all that I could, become as proficient as possible. The strategy left me burnt-out. I became a Peace Corps Volunteer (2006-2008) to reinvigorate my community development and social justice roots. After my return to the United States, I decided that my clinical practice would be grounded in my values and experience.

## How and Why I Formed My Theory

I had learned from experience that a solution to a personal problem at a given time in life did not prevent its return. It can be like the “Whack-a-Mole” game. Psychotherapy interns would want to know how to help a client stop playing that game. Sometimes they called it the “hamster wheel.” I started using the image of getting on and off a merry-go-round.

One day an intern asked me, “You said that you don’t think in terms of curing an illness, but isn’t it sick to get back on the merry-go-round?” The question caused me to ponder my own personal growth. How do I explain my own necessity to persist, in order to maintain, consolidate, reclaim my own development? After all, progress is not a simple, one-way street to eternal wonderfulness.

I tried different ways to share my vision. I returned to art. I made an “art video” and I illustrated a couple of monographs that I self-published. The goal for each project was to show and say, with less jargon and more common references, what I had learned. The feedback I received can be summed up as, “I sort of get it, but not really.” That’s when I returned to school to earn a doctorate in education. I’ve been trying out different ways to share things with my professors, my colleagues, interns whom I supervise. This chapter of the dissertation is the result. I use it to discuss my findings about psychotherapy via Telehealth.

## Transformative Psychotherapy

I sometimes describe psychotherapy this way, “Talk-therapy can be focused on adaptation to daily life or transforming patterns of living that developed from past experience.” I use the image of Yin-Yang for adaptation-transformation. It’s not an either-or polarity. There often is a back-and-forth in the clinical emphasis. Here’s what a few respondents said about transformative work:

\* I think what works is that if the client really feels heard and that’s really modeled for them then they can really hear themselves. They can be okay and not so judgmental in their head. It allows them to not be so afraid. It affects change. It’s a relationship, the feel in the room. I always felt it meant you are in the room and there's safety and trust. Actually there was a feeling going on. There's safety and the client can start to relax. Trust in themselves grows. That affects change. (#14-20210323, 19 years, Relational)

\* She draws with Cray-Pas and then paints over it… blocks them out. And then she goes back in with the Cray-Pas. And not only is it rich and beautiful and textured, but there are layers and layers… and little by little her images have changed… she had always been drawing and painting these eyes. With her history it made sense to be vigilant. The eyes turned into fish swimming in the water with a beam of light shining down. Talk about a transformation! In this kind of process, the images often appear in the work before people acknowledge what it is. It’s an amazing thing. (#32-210420, 7 years, Psychodynamic)

\* The healing happens… because we develop, ideally, a safe attachment… That challenges a lot of what they believe about themselves. So there I am somebody who sees something other than what they see in themselves, ideally something more positive, strength-based, resilient. This relationship is trustworthy, it’s consistent and it's transparent. And I, client, feel valuable in it, I feel valued, I feel seen, I feel important. And when I have one of those experiences in my life, duplicating something is easier than creating from scratch. Now that I know what that feels like, I shift just a little bit in my belief about myself… And then they begin interacting in the world differently. (#28-210409, 7 years, Relational)

The clinicians’ descriptions ring all of the bells in the tower: Healing flows from a reliable experience of safety, trust and respect in service of the project. The project might be a situation in need of a solution, the project might be understanding patterns of thought or behavior and so on. A clinician described a way to recognize healing as it happens:

\* I give them an opportunity for reflection on their own journey… to sit with that realization and see how it settles in their body. I want them to have a little more body awareness of how they process things. Our lives, emotional and psychological, are not all in our head, it’s in our bodies as well. That is also a clue about where we’re at during various points in our lives, how our body is reacting. It’s all connected, mind, body, and I use the term spirit as that other awareness that isn’t as tangible. That is part of what being human is. (#26-210407, 33 years, Relational)

These clinicians have touched on qualities inherent in transformational personal growth. I have come to define personal transformation as ongoing learning that alters beliefs. The learning is necessary for a life dedicated to empowerment and emancipation from oppression (personal, social, societal).

Transformative psychotherapy seeks resolution of root causes for problems that recur, recede and intensify. Transformation is evidenced by new behaviors (ad hoc and routine) which maintain and promote the experience of self and others as persons rather than as things. There is an ever-present challenge, the *Thing-Person Swing*.

### What is “Thing-Person Swing”?

My theoretical perspective is that transformative psychotherapy mobilizes awareness of a *Thing-Person Swing*, regardless of whether or not the awareness is named as such. Buber (1970) describes a boundary that floats, fluctuates between *I-It* and *I-You.* My model, *Thing-Person Swing*, recognizes *I-It* as a source of problems and *I-You* as a resolution.

My view is that *I-You* is not a static achievement. There is oscillation once the developmental ability to see another as a person is achieved. An infant cannot perceive a parent as a person and a toddler can. The newborn senses the caregiver as a thing that satisfies or frustrates:

\* When mothers tell me about children, I usually get them to remember what sort of things happened at the very beginning… They tell me about all sorts of objects that become adopted by the infant… But this first object is established as part of the furniture of the cot or the pram before the word ‘ta’ can be said or could make sense, before the infant makes a clear distinction between the me and the not-me, or while the making of this distinction is in process. (Winnicott, 1993, pp. 15-16)

My theory recognizes that not all emotional events have the same significance. There is a unique quality of an emotional event which is essential for transformative effects. The unique emotional quality is available through, and only through, *I-You* experience. The client in psychotherapy can be helped out of their *I-It* orientation. Then, what happens?

### What is the “Emotion Response Cycle”?

I have introduced the concept of an *emotion response cycle* through which healing occurs and spasms through which emotional injuries are sustained.[[58]](#footnote-58) For the concept, I use the word “emotion” rather than “emotional”, because the latter has all sorts of implications from common uses that do not fit my concept.

Three critical factors drive healing versus injury. Two are safety and trust. The words “safe” and “safety” occur 62 times in the interviews, respondents used forms of the word “trust” 40 times. The third strand (imagine a triple helix) is respect. Respect is grounded in *I-You* experience. Psychotherapy nurtures respect through storytelling and emotional sharing that repeats in an iterative[[59]](#footnote-59) fashion. Interacting with the psychotherapist, unacceptable emotional pain is converted into meaningful experience, the path to satisfaction of motivational needs (Maslow, 1943) becomes imaginable for the client. The interacting, the sharing is iterative in the sense that meaning builds upon experience.

\* That helps to build trust. (#17-210325, Transactional Analysis)

\* You know there’s that feeling of safety, building that rapport. (#18-210329, Psychodynamic)

\* As the relationship goes on, getting a chance to demonstrate my genuine caring for them, then from there we build on that. (#19-210330, Relational)

\* So we weren’t directly talking about the experiences, but continuing to build on that theme. (#27-210409, Cognitive)

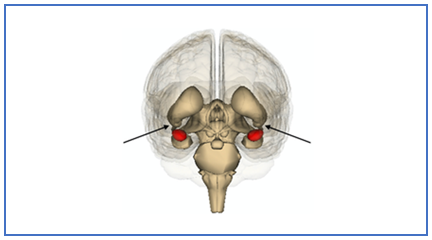
\* I think of it as this relationship that we’re building and we’re trusting in. (#29-210412, Psychodynamic)

\* We worked and were able to build that relationship. (#30-210413, Relational)

All of the respondents “build” regardless of the different approaches that they use. My view is that building occurs through a repeating *emotion response cycle*. What is it and what is actually happening?

Let’s start with emotion and its connection with thought. According to Ruud (2019, para. 1), “[The] amygdala (part of the limbic system of the brain) plays a large role in emotion and is activated before any direct involvement of the cerebral cortex where memory, awareness, and conscious ‘thinking’ take place].”

Figure 4. Amygdala

*Note*. From Wikimedia Commons (n.d.)

Emotions are physiological signals that we use to navigate interactions with others (Geller & Porges, 2014; Porges, 2011; Somatic Perspectives, 2011). And similar signals can flow from different reflexes. We all know that there are tears of sorrow and tears of joy.

The release of tears is not inherently healing. Acceptance (of the experience, the emotions, and their significance to one’s sense of self) is crucial to understanding whether released emotions injure or heal. My perspective builds on the work of Karen Horney (Ingram, Ed., 1967, pp. 97-99):

\* [There are] many patients who feel strong emotions… And these feelings, even though they are really felt, often have no therapeutic effect… There must be some difference in the value of such intense feelings, a value determined by whether or not such feelings were hitherto suppressed [and now they are felt] without embellishment, and without any interest in the reasons for the feelings – just the experience of the emotion itself… All of this – experiences of liberation and intense emotion – points to an aspect of therapeutic effect… Put in theoretical terms, it means accepting his ‘actual self.’ Nothing has changed… just the experience of such acceptance. (pp. 97-99)

Emotions are signal waves that signify something is important. Psychotherapy can, through the telling and re-telling of stories, open up emotional waves of varying degrees of intensity and duration, such that the experience heals rather than sustains the status quo or injures. The quality of emotional experience that heals is acceptance.

How is unacceptable pain converted into meaningful experience? *I-You* realm of relating is the key. Relating is grounded in safety, trust and respect; it supports the acceptance of the here-and-now which in turn builds the strengths needed for acceptance of the there-and-then. Such relating supports an *emotion response cycle* through which healing occurs.

My model is similar to a sexual response cycle (Cleveland Clinic, 2017). The sexual response cycle (excitement, plateau, orgasm, and resolution) provides insight into the waves of all emotions. The wave pattern is similar for laughing, crying, yelling, etc. The results of the waves differ radically based upon whether the experience is accepted or rejected. Metaphorically, acceptance yields an orgasm and rejection produces a spasm, regardless of the emotion.

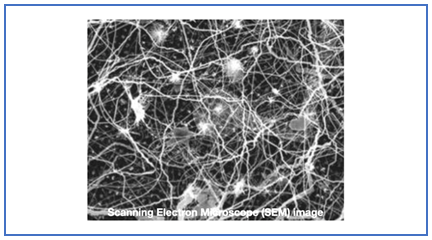
Neuropeptides are released after pleasurable sexual activity (Safron, 2016, “The neurophenomenology of orgasm”). These are also released after other activities that produce deep, intense satisfaction. Post reverie, all sorts of creative, integrative thoughts flow.

Think of a time when you cried and the person with you was supportive and safe. Afterward, you felt better and might have better been able to talk about it. This is an example of a completed emotion response cycle.

Now think of a time when you cried and the other person was aggressive or punitive or dismissive. Once the tears stopped there was not a feeling of well-being and talk was not desired. The tears flowed from spasms.

Neural nodes, synapses, can become inflamed (Bukalo et al., 2013; Gallego-Delgado et al., 2020; Uchizono, 1975). The inference that I draw from these observations is that spasms result from bio-electrical/chemical storms and they add to nodes of inflammation. When current upsets resemble past injury, spasms can be triggered. The waves of pain leave a wake as does a moving boat; the nodes can emit signals after the triggering event ends. There are nodes that contain hot-spots from past injuries which generate emotional signals.

Figure 5. Nodes-Synapses

*Note*. From “Emergent brain-like complexity…” Kuncic, et al., 2018).

Can anything be done about neural damage rooted in past trauma? Brain damage is located, at least in part, in its “white matter”. The structure of brain *white matter[[60]](#footnote-60)* can be changed through learning (Draganski et al., 2014; Nudo & Dancause, 2012; Scholz et al., 2009) and therein lies a hope provided by psychotherapy.

I am suggesting that psychotherapy can alter white matter through purposeful, safe remembrance. Psychotherapy provides real-time security that allows pain from past experience to surface, it prevents re-injury from shame, punishment, abandonment, betrayal and other forms of rejection aimed at the person and the experience. Acceptance as described by Karen Horney, allows and generates new meaning which is retained in the *white matter*.

One way to think about it is that nature and nurture gives each of us our start in life. Trauma causes damage. Healing is re-naturing through nurturing.

My model builds upon Gestalt psychology.[[61]](#footnote-61) It is a field theory of emotion that incorporates findings from neuroscience.

Talk-therapy invariably involves a client who tells their story. In the model that I have presented, the storytelling is iterative and the clinician’s responses elicit details through safe, trustful, respectful relating.

The transformative potential is manifest in the spontaneous sharing of emotions; the therapeutic action is expressed in the re-telling of the story. The re-telling modifies the explanation of events, self-identity of the client and their beliefs; altogether the changes allow the client to experience pain and pleasure as sources of healing, empowerment. This is a *Big Change* (i.e. transformation). A person who fundamentally sees self and others as persons can routinely reset the relationship through that perspective. Also it is possible to see the relationship from a communal perspective.

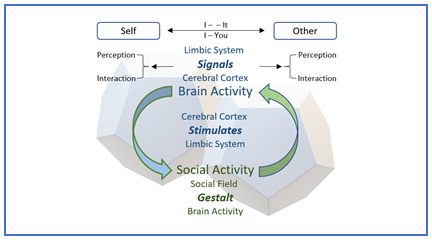
Figure 6. Field Theory – Emotions

The perspective, *I-You* in a community, can lift the veil of oppression (internalized and socialized). The concepts “internalized” and “socialized” might be grasped intuitively. But let’s address the duality directly.

Oppression defines some people as human and other people as subhuman *Things*. The racist can see a member of their group as a person, then swings to perceive others as *Things*. Do you think such a person is stable in *I-You* when among their kin, within their tribe? Might such a person view another in their close orbit as a *Thing* to dominate, control? Might that be a perversion of the Golden Rule: Do unto others that which has been done to you? I am describing internalized oppression. It begs the question, “Why is it so common?”

Oppression is internalized, incorporated into self-defining beliefs, because it resonates and is congruent with the individual’s earliest development. Winnicott formulated *Me/Not-me[[62]](#footnote-62)*; Buber formulated *I/It* and *I/You*. Infants are not born with a capacity for empathy. Empathy is learned; empathy is central to a communal ethos.

Figure 7. Intersubjectivity and-Mutuality

Throughout a person’s life, there is a back-and-forth of perception. I see the other person as a fellow human or not:

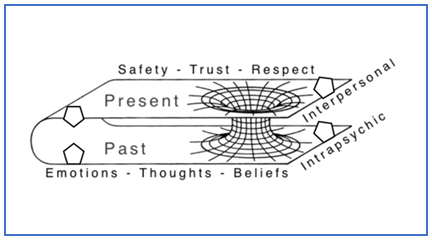
\* The market ideology demands the “objectification” of the people, who are to be treated as disposable objects easily replaced, which in turn facilitates their exploitation as labor that is increasingly devalued. This ideological stance requires a maximum of ephemeral human relations, fragile and poorly conducted... the disregard for other human beings evident in the violence plaguing the planet like an epidemic of horrific proportions. (Freire et al., 2014, p. 74)

The internalized oppression is inseparable from its socialized forms. After all, we are social creatures, primates. Each of our individual experiences occurs in the context of a social setting. An essential healing factor of psychotherapy is the mutuality of experience.

A transformative psychotherapy will rattle the client’s personal cage, because empowerment of an oppressed person releases emotions that were previously suppressed. Now here is the dilemma. How can disequilibrium or disruption, which is essential to empowerment, be created without causing new damage?

If disruption is created, it damages, but if it is co-created there is the possibility of empowerment. The determinative factor is collaboration that "embraces self-love as a force for emancipation" (Lawrence, 2020).

Figure 8. Therapeutic Action

The experience of psychotherapy engenders healing. It releases emotions frozen in time, when trauma originally occurred and thereafter were reinforced by re-traumatization. It works because the psychotherapist nurtures safety, trust and respect in service of healing. As emotional waves are released in the healing experience, the client can form fresh perspectives.

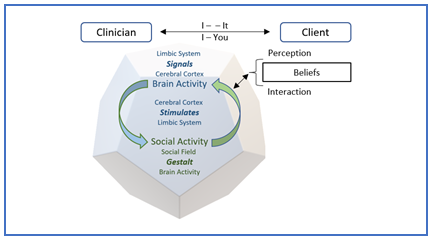
## Considerations for Telehealth

The core problem addressed by my dissertation was my uncertainty about the use of Telehealth to mobilize the client’s experience of the *Thing-Person Swing* in order to reclaim *I-You* when it is lost.

My findings suggest that 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. The client’s experience of the therapeutic alliance is central to the potential for transformative change. Psychotherapists in this study report that transformation can be achieved when the clinical focus is improved stability or adaptation in a situation, in-person and via Telehealth.

The modality, in-person or Telehealth, does not seem to be the fundamental factor. Nor is psychotherapeutic approach. Transformative results are explained by my theory.

Figure 9. Psychotherapy, In-Person and Telehealth

The potential for transformative change during talk-therapy is realized through a recurring *I-Thou* experience of the client interacting with the clinician. Intersubjective *I-Thou* experience engenders an *emotion response cycle* and gains are consolidated within the client’s *Self-Thou* orientation. The client is able to experience their own Self as a *Person* not a *Thing*. Their *Person-Thing Swing* favors *I-Thou*. The client becomes increasingly skilled at recognizing objectification in the here-and-now and in reflection which is essential to leave *Thing-Land* and return to the *Land-of-Humanity*.

# Chapter 5: Conclusion

I stated my goal at the beginning this way: I want to contribute to discussions about Telehealth psychotherapy among clinicians, educators and scholars. My dissertation considers whether the efficacy of a clinician’s theory and methods for in-person, transformative psychotherapy transfers to Telehealth, well or not.

My study finds that Telehealth increases the probability of transformative change by improving access for some clients who can be identified by characteristics such as isolation such as geographical distance or inadequate transportation, clinical factors that keep them homebound due to physical and psychological reasons, financial constraints such as the high cost of going outside of an insurance company’s panel or a clinician’s high fees. Psychotherapists could offer Telehealth strategically, blended with in-person. We could accept less money, not bill insurance on a case-by-case basis.

Transformation is defined as a change in a person’s self-image and perception about their own place in the world. Respondents said in a variety of ways, “Transformation can happen without it being a goal of therapy.” It can happen while a person improves their adaptation, their stability in a situation. Their transformation can be expressed as a reflection, like looking at oneself in a mirror, back-and-forth from where one has been even while moving further in a desired direction. Culturally-competent clinicians who serve marginalized communities might find this study to be useful, in terms of their decision to use online technology to extend the reach of transformative psychotherapy.

## Main Findings and Insights

My findings and insights are organized by four themes, lenses through which I view the topics.

1. The impact of psychological injury on a person.

2. How a psychotherapist helps that person.

3. How healing happens.

4. Telehealth effects on healing.

There is not much published about Telehealth for personal growth that changes beliefs about oneself; published literature reviews barely mention topics that infer transformative change. Nor is there much about the use of theory (psychology and psychotherapy) to evaluate the efficacy of talk therapy via Telehealth. I’ll briefly summarize the themes of injury and healing, and then return to Telehealth. Then I’ll be ready to discuss recommendations.

### The Impact of Psychological Injury on a Person

*I-You* denotes human encounter and *I-It* signifies objectification. A person is injured when they are treated like a *Thing*, whether by another or through oneself. The injury can be done to the bodily self, as when a worker is maimed or killed by employer disregard for safety. The injury can damage social relationships, as when a parent works multiple jobs that pay poverty wages and then has less time with their children. The injury can be psychological, as when emotional abuse causes unrelenting anxiety.

### How a Psychotherapist Helps an Injured Person

My theoretical frame posits that there is a polarity in the quality of emotional experience, an *emotion response cycle* versus a spasm. The *emotion response cycle* flows from safety, trust and respect (*I-You*); a spasm flows from insecurity, doubt and disregard (*I-It*). Transformative psychotherapy generates a recurring *emotion response cycle*.

Psychotherapy provides intertwined *I-You* encounters that release pain stored from prior injuries. The release of pain allows new perspectives, codified in stories that contain a different explanation for past events and new beliefs about oneself. When a person grasps for words that rise to the occasion, but those words are a little bit out of reach, the psychotherapist can offer words that fit the occasion.

### How Healing Happens

*I-You* is the experience of the client being seen as a person while relating with the psychotherapist, this opens the perception of the client to see their own self in the same way. The more regularly *I-You* occurs in session, the more *Self-Thou* (through which a person perceives and experiences their own humanity) becomes the norm.

Think of the *emotion response cycle* as a wave that occurs spontaneously when the present safety of *I-You* exists paradoxically while reliving a past *I-It* injury. The past injury is retained in a knot. The knot is a pain point in the brain, anywhere in the body; the pain is felt in thoughts, sensations, emotions. The knot is loosened by *I-You* relating, the energy is released spontaneously during the split awareness (past injury and present safety). Once the energy waves subside, the person can weave a new image, give a new explanation and different significance to the past injury.

### Telehealth Effects on Healing

Can the conditions associated with healing be achieved via Telehealth? Studies have found that Telehealth counseling does permit formation of the therapeutic alliance which is a foundation needed for psychotherapy. Psychotherapy, if it does nothing else, provides relational experience that is distinct from ordinary, common interactions.

More scholarship is needed about strengths and limitations of Telehealth and blended psychotherapy for transformative change. My study contributes to closing that gap. I listened to clinicians and shared their experiences, reflections with you.

## Recommendations

My inquiry considered whether or not, or under which circumstances, does a clinician’s theory and methods for in-person transformative psychotherapy transfer to Telehealth. My general finding is that it does transfer albeit with modification to Telehealth and that the model of blended psychotherapy might be widely efficacious. How might decisions be made to use in-person sessions or Telehealth?

### Improvements in Therapeutic Practice

My study suggests that psychotherapists could offer Telehealth strategically, combined with in-person. We could accept less money and on a case-by-case basis not bill insurance. Telehealth can engender transformative change by enhancing a client’s sense of safety; safety is needed for the *I-You* experience and the therapeutic emotion response cycle. How do feelings flow when the interaction is mediated by technology? Under what circumstances is the bond, formed through shared feelings and reflections, either enhanced or diminished by Telehealth?

Therapeutic practice could improve if a clinician considers these and other questions on a case-by-case basis. A respondent reflected:

\* Here’s another thing to do when you’re in a long-term psychotherapy relationship, it’s not a bad idea when people say, “You know, I think I need a break, I want to apply what I learned.” Developmentally, people need to practice and see how they do, based on where they are now. That’s always a good thing, So maybe in some weird way, Telehealth has thrust itself on the therapy experience in a very similar way. It’s like that the patient doesn’t have access to me or the process like they used to. It’s still there in a way, but it’s different. (#11-20210315, 32 years, Psychodynamic)

It might be a return to the office when Telehealth is less effective. A respondent shared some situations:

\* In the last year many have expressed feeling less safe than in the office. Their environment isn’t completely confidential. It’s harder for them to open up. It’s harder for them to do the work. That’s especially important if you work with domestic violence folks. I have a client who uses it because she is so lonely. She answers my call, but she doesn’t take it as seriously and isn’t as committed. Telehealth allows her to have more freedom in that area. Coming to my office is more of a commitment for her. (#14-20210323, 19 years, Relational)

Access to therapy is often discussed in terms of disparities suffered by communities. Some respondents talked about access in the context of psychotherapy with an individual. Here what one said:

\* The practicality is good for the continuity of therapy… it has actually been beneficial. From attachment theory, proximity, availability, nurturance, so we’re available. Somebody’s right there on their phone or computer, that is therapeutically very powerful. (#12-20210319, 27 years, Cognitive)

The psychotherapist could monitor the trade-offs when some senses are not used. The telephone prohibits sight and that could support a sense of safety. Video creates a close-up and that could enhance focus on fleeting changes in expression, but not show tapping of hands or feet.

### Training and Education of Psychotherapists

The swing between *I-You* encounters or *I-It* objectification was not addressed in my training or continuing education, nor the swing’s connection to injury or recovery associated with emotional expression. The *Thing-Person-Swing* and the *emotion response cycle* can be used to train and educate clinicians about the circumstances or conditions that support the use of Telehealth in a blended psychotherapy approach. The framework can support discussion about whether to see clients in-person or via Telehealth.

Here-and-now adaptation and transformative change are clearly related to all experienced therapists. What might not be as clear is the fluid connection with in-person and Telehealth modalities. It’s not simply a question about equivalence or efficacy, but rather it is about recognition. A respondent described it:

\* A lady patient is having postpartum depression. So first of all, I met her in person. And I listen to her story of the gestation of her baby, and the birth of her baby, 2 to 3 weeks of good health, and then she is socked with a pretty severe postpartum depression.

So we have got to problem-solve. How is she going to manage the baby enough to care for the other child? We end up working together with her husband who is now out of work and at home trying to help her with the children, but pretty depressed himself because he can’t work and bring home an income. They’re in a lot of distress. We’re doing problem-solving for organizing every kind of resource we can think of. We’re just resourcing. What would be helpful, where can she get it?... I’m working very hard to create a bond with her.

So during the course of our Telehealth work, daddy comes into the room with the baby. The new baby was crying and he said, “I cannot handle her,” and so she said to me, “Do you mind if I nurse her?” I said, “Heavens no, go ahead.” So we’re doing direct supportive psychotherapy, coping skills and she’s nursing the baby. And I’m enjoying this beautiful, beautiful child and getting reinforcement from her about how beautiful the baby really is…

She is nursing her baby and I am providing support to her kind of like grandma. We are admiring the baby and thinking about various resources for her so that she has a little more time for herself to do some very basic things like go walking, go to the grocery store, go to the doctor, this sort of thing. Now that is just problem solving.

She has a great deal of insight and so it doesn’t take very long for us once we create a bond to begin to talk about her internal world. And how she’s coping with this much depression, a new baby, and a 3- or 4-year-old, all at the same time. And her husband is so upset about work. And you meld the two together. The problem solving is the scaffolding of the work, for the insight, especially being able to help her with her sense of herself and her depressive orientation. The insight, she has the capability for that, so we can go there. (#15-20210323, 42 years, Psychodynamic)

The psychotherapist described the connection between problem-solving and forming insight. She described the intersection of maternal experience, complex social relations, economic stress, logistics and client-psychotherapist intersubjectivity. Imagine a clinical discussion group. Wouldn’t that be great?

Literature and my interviews brought up the topic of the clinician’s experience of Telehealth. It could be useful for education at all levels of the profession to hear and discuss stories such as this:

\* Maybe I’m having more trouble with Telehealth [because] my belief systems [are] getting in the way of my insight. How awesome to be able to validate someone who’s had this experience for a long time and now somebody else gets that [sense of isolation]… [Now they are] able to speak to that [whereas before] going to the office wouldn’t have honored that deep feeling of loneliness they’ve always had, because they’ve always been [mostly] homebound and somehow, they get to an office. Maybe I’m feeling more isolated. (#14-20210323, 19 years, Relational).

# Chapter 6: Future Inquiry and Activity

There were three significant limitations

of my dissertation:

1. There is not a lot of literature about Telehealth that is specifically focused on transformative psychotherapy.

2. My sample size was twenty-three.

3. The psychotherapy concept “transformative change” often neglects societal dynamics that are connected to an individual’s suffering.

I will discuss societal dynamics connected to individual suffering in the next subsection, “Activity.” For now, please consider this comment by C. Wright Mills (1959, p. 3), a sociologist who influenced activist academics like my father during the 1960s:

\* The sociological imagination enables its possessor to understand the larger historical scene in terms of its meaning for the inner life and the external career of a variety of individuals. It enables him to take into account how individuals, in the welter of their daily experience, often become falsely conscious of their social positions. Within that welter, the framework of modern society is sought, and within that framework the psychologies of a variety of men and women are formulated. By such means the personal uneasiness of individuals is focused upon explicit troubles and the indifference of publics is transformed into involvement with public issues.

## Inquiry

Now let’s return to future inquiry about transformative psychotherapy via Telehealth. How might we contribute to published scholarship on the topic, as well as increase the sample size of respondents who provide data?

I did not invite clinicians on the basis of identification with a community nor intersectional identification. This limits confidence in my findings. The stories gathered by my study suggest that blended psychotherapy could have cross-cultural and intersectional applicability.

Could blended psychotherapy offer enhanced access to an adult offspring of an immigrant family such that there is less friction in the parental household, because utilization of psychotherapy is not as noticed? Could in-person sessions be more beneficial for the same client’s expression of emotions related to intersectional microaggressions experienced at work or school? These are examples of questions for future study.

What about listening to clients? Client perceptions could be a future inquiry. This hearkens back to my Master’s Thesis “Ethnicity and Client Perceptions of Social Work Clinicians” (Bloomberg & Meyers, 1984, p. 1) “Operationally defined, client perceptions are evaluations (positive and negative) that develop from an interpersonal influence process in which counselor behavior indicates attributes in three dimensions: expertise, attractiveness, and trustworthiness.”

One way to approach clients is through academic inquiry which uses protocols for the protection of human subjects. A survey methodology could be developed that uses social media.

Social media managed by higher education and professional associations might be a way to scale up sample size and diversity. The platforms could reach less experienced clinicians. What are the experiences and reflections of clinicians who have recently been licensed, associate clinicians earning hours of supervised practice, or trainees in Master’s degree programs?

I’d like to reach out to clinicians with entirely different approaches. The practitioner of Transactional Analysis showed that there’s gold in those hills. I’d like to hear stories from Gestalt psychotherapists, especially those who align themselves with “relational embodiment.”

Psychotherapists who practice within faith communities were not part of the study. I’d love to hear their stories; we could learn a lot from their reflections on the use of the theologian Martin Buber’s views. The idea of reaching out to counselors in the faith community arose from Richard Lawrence (in a personal email, July 19, 2021):

\* When I saw a discussion on Martin Buber in your dissertation, I returned to my copy of “I and Thou.” It had a great impact on me during my days at the University of Chicago Divinity School. If we combine your presentation about transformation psychotherapy and dig deep into Buber, there is a world of exciting possibilities. We as pastors are called upon to counsel people with troubles. Our efforts would be immeasurably improved if we studied Buber and you.

A number of the psychotherapists whom I interviewed work with children, adolescents and families. I limited my inquiry to work with individual adults. Future studies could focus on settings such as School-Based Family Counseling. Inquiry into psychotherapy for couples and families could garner input about systems theory, methods. Narrative methods are unexplored by my study even though they reach populations disinclined to use talk-therapy (Dulwich Centre, n.d.; McCaleb, 1997; Puga, 2005).

Professional organizations might be interested in the topic. Institutions of higher education could see its potential. There are “think tanks” managed by non-profit foundations and entrepreneurs that might see value in developing grounded theory for transformative psychotherapy via Telehealth. Policy-makers could be interested.

## Activity

My concept of transformation includes society, but it was not in the scope of my dissertation to fully discuss that. I said that we must understand societal oppression in order to fully bear witness to an individual’s suffering. And I noted that individual transformation achieved through psychotherapy can lead to increased engagement in efforts to change society, such engagement sustains and amplifies personal healing. These are some of my reasons for hope that my dissertation might be useful to social justice activists. Let’s look at this in terms of possible future activity.

Here’s a little story with a big lesson: I listened as a member of the WISR Board of Directors, Richard Lawrence, was talking with his sister and founding faculty member of WISR, Dr. Cynthia Lawrence, about a recently published book, “Do Better” by Rachel Ricketts. (I have not yet read the book.) Cynthia asked Richard if during his participation in the 1965 marches in Selma, “Did you feel rage?” Richard was in his thirties back then, he replied, “No, because my students and I felt that we were on the winning side of history.” Then he referred to the attacks of police on horseback, “They went berserk.” Cynthia, a little later said, “I’m rethinking rage, I’m thinking about righteous rage.” Our conversation contrasted righteous anger and the history of violence by Whites in Cicero, Chicago.

Figure 10. Cicero-Chicago 1951

*Note*. From Moser (2015) –

Whites Riot and Burn Many Homes of Blacks.

I mentioned my personal experience with rage, when others have directed it against me and when I’ve expressed it; I’ve distinguished it from anger which retains awareness of humanity and hope. Cynthia said, “We’re using the word rage a little differently, you and I. The way you use it – I think of that as hate.”

If this mini-story were an Aesop’s fable, the moral would be, “Conversations matter.” I continually seek ways to say things clearly in order to help people struggling for personal growth. I’ve been saying for some time that rage removes humanity and turns people into *Things* to be destroyed. But, what about flashes of anger that look like rage and yet retain a sense of humanity for all? One way to tell the difference is to ask, “Is this hate?”

A future activity is to convert this dissertation into a series of mini-stories and use them to engage others to write “the moral of the story” and/or to tell their own story. Towards that end, I have designed a website, launched after the completion of my doctoral program (see Appendix D).

## Epilogue

I've resumed in-person private practice. While it doesn't change my conclusion that Telehealth is viable for effective psychotherapy, it reinforces my preference to see persons in my office. So my clinical practice is now “blended,” already clients and I have had conversations about when and why Telehealth might be useful. The same has occurred in my work as a clinical supervisor for a charitable nonprofit; California allows for HIPAA-compliant streaming video for that.

A few respondents made comments about clinical errors they had made during their career. I thought, "Wow, interns would benefit from hearing this from clinicians who are very experienced." I'm thinking about setting up a way for psychotherapists to tell their story, "Greatest Mistakes that I've Made."

# Definitions

*Andragogy* is an educational process through which the student engages in self-directed learning supported by a teacher. (Blaschke, 2012)

*Big Change* is intended from transformative psychotherapy; it is new resilience from relating with others such that emotion response cycles routinely militate against the Fight-Flight-Freeze response intensified by past events.

*Bigger Picture* is a term used in a special way by the Western Institute for Social Research to indicate that understanding human phenomena, problems, and solutions requires synthesis of societal dynamics and individual experience. (WISR, 2015)

*Blended care* is a combination of online and face-to-face therapy (Wentzel et al., 2016..

*Blended psychotherapy* (bPT) is a treatment that integrates internet- and mobile-based interventions into out-/inpatient psychotherapy. (Titzler et al., 2019)

*Cerebral cortex* is the part of the brain where memory, awareness, and conscious ‘thinking’ take place. (Ruud, 2019)

*Cisgender* refers to a person whose "sense of personal identity and gender corresponds with the sex put on their birth certificate." (The LGBTQ Experiment. 2018, para. 1)

*Code-switching* is reflected when a person speaks differently based upon the culture of the persons in the interaction. (Zainuddin, 2016)

*Cognitive Behavioral Therapy (CBT)* is one of the most common and best studied forms of psychotherapy. It is a combination of two therapeutic approaches, known as cognitive therapy and behavioral therapy... What we think, how we feel and how we behave are all closely connected – and all of these factors have a decisive influence on our well-being. (National Center for Biotechnology Information, 2016)

*Confidentiality* is the question of how personal data collected for approved social purposes shall be held and used by the organization that originally collected it, what other secondary or further uses may be made of it, and when consent by the individual will be required for such uses. It is to further the patient's willing disclosure of confidential information to doctors that the law of privileged communications developed. (Office of Assistant Secretary for Planning and Evaluation, 2016)

*Constructivist grounded theory* explains the co-construction of knowledge by a scholar and research participants, and it was developed by Kathy Charmaz. (Singh & Estefan, 2018)

*Countertransference* is transference manifested by the psychotherapist and it can usefully guide inquiry.

*Dialectical thinking* involves seeking out contradictions and being constantly open to an assumption being revised, repudiated, or overturned. (Roberts, 2000)

*Emotion response cycle* is a concept based on a model of the sexual response cycle. (Bloomberg, 2015)

*Emotions* are signals from the amygdala which is part of the limbic system of the brain. (Ruud, 2019)

*Evidence-Based Practice (EBP)*: Evidence based medicine is the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients. (Dotson, n.d.)

*Expert-level proficiency* uses feel and familiarity, does not require calculation, and can improvise in an unfamiliar moment to achieve success. (Dreyfus & Dreyfus, 1989, p. 50.)

*Family systems theory* “is concerned with family dynamics, involving structures, roles, communication patterns, boundaries, and power relations.” (Rothbaum, et al., 2002, p. 329)

*Field theory* is a method of exploring that describes the whole field of which the event is currently a part. (Yontef, 1993)

*Fight-Flight-Freeze* is a response to danger rooted responses associated with the amygdala. (University of Toledo, n.d.)

*First-order chang*e refers to solutions that do not change the problem but that create stability. (Fraser & Solovey, 2007)

*Generalization* is a form of inductive reasoning that draws conclusions based on recurring patterns or repeated observations. (LibreTexts, 2021)

*Gestalt psychology* provides a “[field theory] perception [that posits] neural… processes with which the perceptual facts are associated are located in a continuous medium [and] events in one part… influence events in other regions in a way that depends directly on the properties of both in relation to the other.” (Köhler, 1973, p. 55)

*Gestalt psychotherapy* “directs attention” to the “contact itself, the place where self and environment state their meetings and become involved with each other.” (Perls et al., 1994, p. 28)

*Great Refusal* “is based on a subjectivity that is not able to tolerate injustice and that engages in resistance and opposition to all forms of domination, instinctual and political.” (Lamas, et al., 2017, p. 86)

*Grounded theory* is the result of a research methodology which goes back-and-forth between data collection and analysis, and in the process builds a conceptual model. (Glaser & Strauss, 1967)

*Good Enough Parent*: “In order to be consistent, and so be predictable for our children, we must be *ourselves*. If we are ourselves our children can get to know us. Certainly if we are acting a part we shall be found out.” (Winnicott, 1993, p. 123) [Italics in the original].

*Health coaching* is a client-centric process to increase motivation and self-efficacy that supports sustainable lifestyle behavior changes and active management of health conditions. (Lawson et al., 2013)

*Health information technology (HIT)* involves the processing, storage, and exchange of health information in an electronic environment. (U.S. Department of Health & Human Services, n.d.-a)

*Heutagogy* is an educational process of self-directed learning independent of a teacher. (Blaschke, 2012)

*HIPAA* (Health Insurance Portability and Accountability Act) of 1996 was enacted in 1996, and it requires the Secretary of HHS to publicize standards for the electronic exchange, privacy and security of health information. (U.S. Department of Health & Human Services, 2013)

*Humanist Psychotherapy* focuses on a person’s individual nature, rather than categorizing groups of people with similar characteristics as having the same problems. The emphasis is on a person’s ability to use strengths to find wisdom, growth, healing, and fulfillment. (“Humanistic therapy”, n.d.)

*Inductive reasoning* draws conclusions based on recurring patterns or repeated observations. (“Inductive Reasoning”, 2021)

*I-It/I-Thou (I-You)* is a philosophical construct about the perception by one person of another as either an object or a human being. (Buber, 1970)

*Information and Communication Technology (ICT)* provides asynchronous messages and streaming connection. (National Assessment Governing Board, 2014)

*Informed consent* is a process that involves three key features: (1) disclosing to a potential research subject information needed to make an informed decision; (2) facilitating the understanding of what has been disclosed; and (3) promoting the voluntariness of the decision about whether or not to participate in the research. (U.S. Department of Health & Human Services, n.d.-b)

*Internalized oppression* "[obscures] the relationship between personal estrangement and social oppression" (Martín-Baró, 1994, p. 27).

*Intersectionality* [is the] internalized societal relations, unconscious accommodations to oppressive social structures, and inequalities that may be implicitly enacted in practices ... [and which underscore] issues of power and privilege Lesser (2021, p. 1).

*Intersubjectivity* is a shared meaning that emerges from and is enacted within the social fabric of interaction. (Garte, 2016, para. 1)

*Introception* is conscious and unconscious tracking of internal bodily functioning. (Porges, 2011)

*Intuition* is sensing something without being able to explain it with certainty.

*Iterative* is something that occurs in cycles wherein the last phase affects the next, it can be visualized as a spiral.

*Me/Not-me* consciousness is deduced from the observations of newborns and their subsequent development. (Winnicott, 1993)

*Mensch* can be [characterized as]"responsibility fused with compassion, a sense that one's own personal needs and desires are limited by the needs and desires of other people. A mensch acts with self-restraint and humility, always sensitive to the feelings and thoughts of others". (Rabbi Neil Kurshan, quoted by Rocker, 2015)

*Narrative therapy* seeks to be a respectful, non-blaming approach to counselling and community work, which [centers] people as the experts in their own lives. It views problems as separate from people and assumes people have many skills, competencies, beliefs, values, commitments and abilities that will assist them to reduce the influence of problems in their lives. (Dulwich Centre, n.d.)

*Neural node* is another term for synapse.

*Neuroception* is the subconscious totality of neural processes that facilitate adaptive defense behaviors such as fight, flight, or freeze. (Porges, 2011)

*Neuropeptides* activate and modulate signals in the brain. (Russo, 2017)

*Neuroscience* refers to the study of brain physiology and activity.

*Nominal variables* are characteristics, qualitative factors used to sort research findings and explain something or form, refine questions for study.

*Object relations theory* developed from psychoanalysis and it emphasizes the importance of infantile and early childhood interactions with the primary caregivers in formation of the Unconscious. (Winnicott, 1989)

*Optimal failure* is the idea that when a parent fails to satisfy a child’s developmental need in a given situation, it presents the child with the challenge to progress, as long as the failure is not catastrophic. The concept was developed by D.W. Winnicott. (1989, p. 445)

*Paradigm* is a philosophical and theoretical framework of a scientific school or discipline within which theories, laws, and generalizations and the experiments performed in support of them are formulated. (“Paradigm”, n.d.)

*Participatory action research (PAR)* differs from most other approaches to public health research because it is based on reflection, data collection, and action that aims to improve health and reduce health inequities through involving the people who, in turn, take actions to improve their own health. (Baum, et al., 2006)

*Pedagogy* is an educational process that transfers knowledge from a teacher to students. (Blaschke, 2012)

*Piaget’s theory* is that all cognitive development (including both intellectual and affective development) progresses towards increasingly complex and stable levels of organization. (UC Berkeley, n.d.).

*Polyvagal theory* proposes that a state of safety is mediated by neuroception, a neural process that may occur without awareness, which constantly evaluates risk and triggers adaptive physiological responses that respond to features of safety, danger, or life threat. (Geller & Porges, 2014)

*Presence*, as used in the context of Telehealth, encapsulates 2 elements: (1) the degree to which the web-based experience of another person is analogous to a real-world meeting and (2) the degree to which the user experiences agency and control that impacts the real world. (Riva, 2009 cited by Cataldo, et al., 2021)

*Privacy Rule* protects all "individually identifiable health information" held or transmitted by a covered entity or its business associate, in any form or media, whether electronic, paper, or oral. There are no restrictions on the use or disclosure of de-identified health information. De-identified health information neither identifies nor provides a reasonable basis to identify an individual. (U. S. Department of Health & Human Services, 2013)

*Psychodynamic (psychoanalytic) psychotherapy* refers to a range of treatments based on psychoanalytic concepts and methods that involve less frequent meetings and may be considerably briefer than psychoanalysis proper. (Shedler, 2011)

*Psychodynamic theory* attempts to explain human behavior in terms of intrapsychic processes and the repetition of interpersonal patterns that are often outside of an individual’s conscious awareness and have their origins in childhood experiences. (Deal, 2007)

*Psychology* refers to theories about the nature of the human mind and its connection to a person’s body, thoughts, emotions, behavior, relationships, etc.

*Psychotherapy* refers to theories about and methods used by trained professionals for interventions to improve a person’s functioning, using talking and reflecting in the process.

*Qualitative research* is used to understand people's beliefs, experiences, attitudes, behavior, and interactions. (Pathak et al., 2013)

*Randomized-controlled studies* are a subset of scholarship that structures knowledge, categorizes, quantifies and evaluates. (Yale University, 2020)

*Rational-Emotive Behavior Therapy (REBT)* “served as a sort of precursor to the widely known and applied Cognitive-behavioral therapy (CBT), and the [REBT] ABC Model is still commonly used as a treatment in CBT interventions.” (“Albert Ellis' ABC model...”, 2021, para. 2)

*Recessive trait* is an "inherited trait that is outwardly obvious only when two copies of the gene for that trait are present… The recessive condition is said to be masked by the presence of the dominant gene when both are present." (Gale Encyclopedia of Medicine, 2008)

*Relational Embodiment Gestalt* is a somatic and relational practice that has the view that our bodies are inextricably embedded and co-creating with the environment, and that we know our body and the world through our embodiment. (Clemmens, 2019)

*Relational schema* is a cognitive structure representing regularities in patterns of interpersonal relatedness. (Baldwin, 1992)

*Schema (core beliefs)* “[are different from] underlying assumptions (conditional beliefs) and automatic thoughts [that are temporary.]” (Padesky, 1994, p. 267)

*Second-order change* transforms the first-order solutions, resulting in a resolution of the problem. (Fraser & Solovey, 2007)

*Self-Thou* echoes the concept I-Thou, and emphasizes self-awareness through which a person perceives and experiences their own humanity.

*Sensitizing concepts* merely suggest directions along which to look, whereas definitive concepts provide prescriptions of what to see. (Blumer, 1954)

*Sexual response cycle* is a physiological wave pattern consisting of excitement, plateau, orgasm, and resolution. (Cleveland Clinic, 2017)

*Snowball sampling* is a recruitment technique in which research participants are asked to assist researchers in identifying other potential subjects. (Oregon State University, 2010)

*Stress response* involves the amygdala signaling to the hypothalamus leads to an endocrine cascade through the hypothalamic pituitary adrenocortical (HPA) axis, producing increased levels of circulating cortisol. (Kaiser et al., 2017)

*Surfing* flows from safety, trust and respect. It is synonymous with the emotion response cycle.

*Synapse* is sometimes called a neural node, and it releases signals in the brain. (Russo, 2017)

*Tacit knowledge* begins as personal intuition before it becomes easily communicated. (Polanyi, 2015)

*Telebehavioral health (TBH)* is another term for telemental health which uses videoconferencing technology to provide counseling and psychotherapy. (U.S. Department of Health & Human Services, 2021)

*Telehealth* is the use of electronic information and telecommunication technologies to provide care when the client and the provider aren’t in the same place at the same time. (U.S. Department of Health & Human Services, 2021)

*Telemedicine* is synonymous with telehealth.

*Telemental health* is synonymous with “telebehavioral health.”

*Telepresence* “is a phenomenon whereby technology creates an experience that allows the user to ‘feel as if they were present, to give the appearance of being present, or to have an effect at a place other than their true location’” (Hilty, et al., 2019).

*Telepsychotherapy* refers to mental health treatment provided via telehealth. (Rosen et al., 2020)

*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, 2015)

*Thing-Person Swing* is the oscillation between I-It/I-Thou (I-You).

*Transformative learning* is a fundamental change in perspective that transforms the way that an adult understands and interacts with his or her world. (Wang et al., 2016)

*Transference* is a psychoanalytic concept that explains out-of-place emotional reactions to the psychoanalyst flow from the Unconscious. (Horney, 1939)

*Triple Bottom Line* is a framework to evaluate business activities in terms of the impact on people, the planet, and profitability. (University of Wisconsin Sustainable Management, n.d.)

*Unconscious* is a concept from psychodynamic theory and enhanced by field theory, it can be visualized as nodes that contain hot-spots from past injuries which generate emotional signals, and the signals are emitted while a person is not cognizant of their origins.

*Venn Diagram* is a visual aid that uses overlapping circles to represent relationships. Some things are separate, but there's a space that is shared.

*Web 2.0* is used to refer to a new generation of websites that are supposed to let people collaborate and share information online in ways that were not possible before. (University of South Florida, n.d.)

*White matter* is a “vast, intertwining system of neural connections that join all four lobes of the brain (frontal, temporal, parietal, and occipital), and the brain’s emotion center in the limbic system, into the complex brain maps being worked out by neuroscientists” (Filley, 2005, para 5).

Wormhole is a metaphor, based on the Einstein-Rosen bridges, to represent an unconscious connection between past and present. (Bloomberg, 2015)

*Zone of Proximal Development (ZPD)* is a social interaction model whereby advances in learning occur through work and play among persons who are apart, but not too much, in understanding and skill. (Vygotsky, 1986)

# References

*16 ways you can stand against rape culture*. (n.d.). UN Women. <https://www.unwomen.org/en/news/stories/2019/11/compilation-ways-you-can-stand-against-rape-culture>

Abney, P. C., & Maddux, C. D. (2004). Counseling and technology: Some thoughts about the controversy. *Journal of Technology in Human Services*, 22(3), 1-24. <https://doi.org/10.1300/J017v22n03_01>

Acharya, B. (2010). Narrative foundations and social justice. *International Journal of Narrative Therapy & Community Work*. 2010 (3): 33-39.

Adames, H. Y., Chavez-Dueñas, N. Y., Sharma, S., & La Roche, M. J. (2018). Intersectionality in psychotherapy: The experiences of an AfroLatinx queer immigrant. *Psychotherapy, 55*(1), 73-79. <http://dx.doi.org/10.1037/pst0000152>

Adler Graduate School. (n.d.) *Alfred Adler: Theory and application*. <https://alfredadler.edu/about/alfred-adler-theory-application>

*Albert Ellis' ABC model in the cognitive behavioral therapy spotlight*. (2018, June 5). By Joaquín Selva in PositivePsychology.com. <https://positivepsychology.com/albert-ellis-abc-model-rebt-cbt/>

Alvandi, E. O. (2019). Cybertherapogy: A conceptual Architecting of presence for counselling via technology. *International Journal of Psychology and Educational Studies*, 6(1), 30-45. <https://doi.org/10.17220/ijpes.2019.01.004>

Anderson, K. M., & Cook, J. R. (2015). Challenges and opportunities of using digital storytelling as a trauma narrative intervention for traumatized children. *Advances in Social Work*, 16(1), 78–89. <https://doi.org/10.18060/18132>

Andersson, G., & Cuijpers, P. (2009). Internet-based and other computerized psychological treatments for adult depression: a meta-analysis. *Cognitive Behaviour Therapy*, 38(4), 196-205. <https://www.tandfonline.com/doi/abs/10.1080/16506070903318960>

Andrews, G., Cuijpers, P., Craske, M. G., McEvoy, P., & Titov, N. (2010). Computer therapy for the anxiety and depressive disorders is effective, acceptable and practical health care: A meta-analysis. *PloS one*, 5(10), e13196. Retrieved September 3, 2021 from <https://www.researchgate.net/>

Ardito, R. B., & Rabellino, D. (2011). Therapeutic alliance and outcome of psychotherapy: historical excursus, measurements, and prospects for research. *Frontiers in Psychology*, 2, 270. <https://doi.org/10.3389/fpsyg.2011.00270>

Backhaus A, Agha Z, Maglione ML, Repp A, Ross B, Zuest D, Rice-Thorp NM, Lohr J, Thorp SR. (2012, May).Videoconferencing psychotherapy: a systematic review. *Psychol Serv.* 9(2):111-131. doi: 10.1037/a0027924. PMID: 22662727. <https://pubmed.ncbi.nlm.nih.gov/22662727/>

Baillargeon, R. (2004). Infants' reasoning about hidden objects: Evidence for event-general and event-specific expectations. *Developmental Science*, 7(4), 391-414. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4215973/>

Baker, D. C., & Bufka, L. F. (2011). Preparing for the Telehealth world: Navigating legal, regulatory, reimbursement, and ethical issues in an electronic age. *Professional Psychology: Research and Practice*, 42(6), 405-411. <https://doi.org/.1037/a0025037>

Baldwin, M. W. (1992). Relational schemas and the processing of social information. *Psychological Bulletin*, 112(3), 461-484. <https://doi.org/10.1037/0033-2909.112.3.461>

Barak, A. & LaCrosse, M.B. (1975). Multidimensional perception of counselor behavior. Journal of *Counseling Psychology*. 22(6), 471-476 <https://eric.ed.gov/?id=EJ127348>

Bartunek, J. M., & Moch, M. K. (1987). First-order, second-order, and third-order change and organization development interventions: A cognitive approach. *The Journal of Applied Behavioral Science*, *23*(4), 483-500. <https://doi.org/10.1177/002188638702300404>

Baum F, MacDougall C, Smith D. Participatory action research. *J Epidemiol Community Health*. 2006;60(10):854-857. doi:10.1136/jech.2004.028662 <https://pubmed.ncbi.nlm.nih.gov/16973531/>

Beck Institute. (2015, October 27). *History of cognitive behavior therapy*. Beck Institute for Cognitive Behavior Therapy. <https://beckinstitute.org/about-beck/history-of-cognitive-therapy/>

Becker, H. S. (1958). Problems of inference and proof in participant observation. *American Sociological Review*, 23(6), 652-660 <https://www.sfu.ca/~palys/Becker-1958-ProblemsOfInferenceAndProof.pdf>

Bee, P.E., Bower, P., Lovell, K. et al. Psychotherapy mediated by remote communication technologies: a meta-analytic review. *BMC Psychiatry* 8, 60 (2008). <https://doi.org/10.1186/1471-244X-8-60>

Békés, V., Aafjes-van Doorn, K., Luo, X., Prout, T. A., & Hoffman, L. (2021). Psychotherapists’ challenges with online therapy during COVID-19: Concerns about connectedness predict therapists’ negative view of online therapy and its perceived efficacy over time. *Frontiers in Psychology*, 12. [https://doi.org/10.3389/fpsyg.2021.705699](https://doi.org/10.3389/fpsyg.2021.705699%20)

Berger, T. (2017). The therapeutic alliance in internet interventions: A narrative review and suggestions for future research. *Psychotherapy Research*, 27(5), 511–524. <https://doi.org/10.1080/10503307.2015.1119908>

Berryhill, M. B., Culmer, N., Williams, N., Halli-Tierney, A., Betancourt, A., Roberts, H., & King, M. (2019). Videoconferencing psychotherapy and depression: A systematic review. *Telemedicine and e-Health*, 25(6), 435-446. <https://doi.org/10.1089/tmj.2018.0058>

Berryhill, M. B., Halli-Tierney, A., Culmer, N., Williams, N., Betancourt, A., King, M., & Ruggles, H. (2018). Videoconferencing psychological therapy and anxiety: A systematic review. *Family Practice*, 36(1), 53-63. <https://doi.org/10.1093/fampra/cmy072>

Bettelheim, B., & Rosenfeld, A. A. (1993). The art of the obvious: Developing insight for psychotherapy and everyday life. Thames & Hudson

Bilorusky, J. A. (2021). Principles and methods of transformative action research: A half century of living and doing collaborative inquiry. Routledge.

Bischoff, R.J., Hollist, C.S., Smith, C.W. et al. Addressing the Mental Health Needs of the Rural Underserved: Findings from a Multiple Case Study of a Behavioral Telehealth Project. *Contemporary Family Therapy* 26, 179–198 (2004). <https://doi.org/10.1023/B:COFT.0000031242.83259.fa>

Blaschke, L. M. (2012, January). View of Heutagogy and lifelong learning: A review of heutagogical practice and self-determined learning. *The International Review of Research in Open and Distributed Learning*. <https://www.irrodl.org/index.php/irrodl/article/view/1076/2087>

Blaschke, L. M., Porto, S., & Kurtz, G. (2010). Assessing the added value of Web 2.0 tools for e-learning: The MDE experience. Proceedings of the *European Distance and E-learning Network (EDEN) Research Workshop*. <https://www.academia.edu/341690/Assessing_the_added_value_of_Web_2_0_tools_for_e_learning_The_MDE_experience>

Bloomberg, V. (2015). *KaBoom or kaching: E=MC2 or EM->2C*. Independently Published. ISBN 9-781515-919960

Bloomberg, V., & Meyers, R., (1984) *Ethnicity and client perceptions of social work clinicians*. [Unpublished master’s thesis]. San Diego State University.

Blumer, H. (1954). What is wrong with social theory? *American Sociological Review* 18 (1954): 3¬10. p. 6 (Retrieved September 3, 2021 from A Mead Project. <http://amser.org/>)

Bordin, E. S. (1979). The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy: Theory, Research & Practice*, 16(3), 252–260. <https://doi.org/10.1037/h0085885>

Brandell, J., & Schechter, K. (2014, February 25). *Psychoanalysis and psychodynamic theory*. Oxford Bibliographies. <https://www.oxfordbibliographies.com/view/document/obo-9780195389678/obo-9780195389678-0170.xml>

Brenes, G. A., Ingram, C. W., & Danhauer, S. C. (2011). Benefits and challenges of conducting psychotherapy by telephone. *Professional Psychology, Research and Practice*, 42(6), 543–549. <https://doi.org/10.1037/a0026135>

Brown, B. (1973). Marx, Freud, and the critique of everyday life: Toward a permanent cultural revolution. Monthly Review Press.

Brown, L. S. (n.d.) “What is Feminist Therapy?” Retrieved September 19, 2021 from <https://www.drlaurabrown.com/feminist-therapy/>

Buber, M. (1970). I and thou (W. A. Kaufmann, Trans.) (2nd ed.). Scribner Classics. (Original work published 1923)

Bukalo, O.; Campanac, E.; Hoffman, D.A.; Fields, R.D. (2013) Synaptic plasticity by antidromic firing during hippocampal network oscillations. *Proceedings of the National Academy of Sciences of the United States of America* 110:5175–5180.<https://doi.org/10.1073/pnas.1210735110>

Castonguay, L. G., & Hill, C. E. (Eds.). (2012). *Transformation in psychotherapy: Corrective experiences across cognitive behavioral, humanistic, and psychodynamic approaches.* American Psychological Association. <https://doi.org/10.1037/13747-000>

Cataldo, F., Chang, S., Mendoza, A., & Buchanan, G. (2021). A perspective on client-psychologist relationships in videoconferencing psychotherapy: Literature review. *JMIR Mental Health*, 8(2), e19004. <https://doi.org/10.2196/19004>

Cataldo F, Mendoza A, Chang S, Buchanan G. (2019). Videoconference in Psychotherapy: Understanding Research and Practical Implications. Paper presented at the *30th Australasian Conference on Information Systems*; CIS'19; May 6-9, 2019; Fremantle. 2019. Dec 9, pp. 656–662. <https://acis2019.io/pdfs/ACIS2019_PaperFIN_139.pdf>

California Association of Marriage and Family Therapists. (n.d.). *Attorney articles: Regulatory and legal considerations for telehealth*. Retrieved February 16, 2021, from <https://www.camft.org/Resources/Legal-Articles/Chronological-Article-List/regulatory-and-legal-considerations-for-telehealth>

Carl Rogers Foundation. (n.d.). *Resources for students, researchers and practitioners.* <https://carlrrogers.org/>

Carroll, K. M., Ball, S. A., Martino, S., Nich, C., Babuscio, T. A., & Rounsaville, B. J. (2009). Enduring effects of a computer-assisted training program for cognitive behavioral therapy: A 6-month follow-up of CBT4CBT. *Drug and Alcohol Dependence*, *100*(1-2), 178-181. <https://doi.org/10.1016/j.drugalcdep.2008.09.015>

Carter, K. (2020). Working during COVID-19: Therapists share their telemental health experiences. *PsycEXTRA Dataset*. <https://doi.org/10.1037/e503962020-001>

Caviglia, G. (2021). Working on dreams, from neuroscience to psychotherapy. *Research in Psychotherapy: Psychopathology, Process and Outcome*, *24*(2). <https://doi.org/10.4081/ripppo.2021.540>

Chakrabarti, S. (2015). Usefulness of telepsychiatry: A critical evaluation of videoconferencing-based approaches. *World Journal of Psychiatry*, 5(3), 286. <https://doi.org/10.5498/wjp.v5.i3.286>

Chavez, C. M., McGaugh, J. L., & Weinberger, N. M. (2009). The basolateral amygdala modulates specific sensory memory representations in the cerebral cortex. *Neurobiology of Learning and Memory,* 91(4), 382-392. <https://doi.org/10.1016/j.nlm.2008.10.010>

Chavooshi, B., Mohammadkhani, P., & Dolatshahee, B. (2017). Telemedicine vs. in-person delivery of intensive short-term dynamic psychotherapy for patients with medically unexplained pain: A 12-month randomized, controlled trial. *Journal of Telemedicine and Telecare*, 23(1), 133-141. <https://doi.org/10.1177/1357633X15627382>

Chiauzzi, E., Clayton, A., & Huh-Yoo, J. (2020). Videoconferencing-based telemental health: Important questions for the COVID-19 era from clinical and patient-centered perspectives. *JMIR Mental Health*, 7(12), e24021. <https://doi.org/10.2196/24021>

Chicago Magazine. (2015, April 29). *How White Housing Riots Shaped Chicago*. By Whet Moser. <https://www.chicagomag.com/city-life/April-2015/How-White-Housing-Riots-Shaped-Chicago>

Clark, P. A., Capuzzi, K., & Harrison, J. (2010). Telemedicine: medical, legal and ethical perspectives. *Medical science monitor: international medical journal of experimental and clinical research*, 16(12), RA261–RA272. [https://www.medscimonit.com/abstract/index/idArt/881286](https://www.medscimonit.com/abstract/index/idArt/881286%20)

Clemmens, M. (2019). Embodied relational gestalt: Theories and applications. Taylor & Francis.

Cleveland Clinic. (2017, October 1). *Sexual response cycle*. Health library articles. <https://my.clevelandclinic.org/health/articles/9119-sexual-response-cycle>

Collett, B. (2014). Current feminist issues in psychotherapy. <https://doi.org/10.4324/9781315804422>

Cook, J. E., & Doyle, C. (2002). Working alliance in online therapy as compared to face-to-face therapy: preliminary results. *Cyberpsychology & behavior : the impact of the Internet, multimedia and virtual reality on behavior and society,* 5(2), 95–105. [https://doi.org/10.1089/109493102753770480](https://doi.org/10.1089/109493102753770480%20)

Crane, K. L., & Watters, K. M. (n.d.). *Cognitive behavioral therapy strategies*. Medical Illness Research, Education and Clinical Center (MIRECC). <https://www.mirecc.va.gov/visn16/docs/cbt-strategies-guide.pdf>

Cukor, P., Baer, L., Willis, B. S., Leahy, L., O′Laughlen, J., Murphy, M., Withers, M., & Martin, E. (1998). Use of videophones and low-cost standard telephone lines to provide a social presence in Telepsychiatry. *Telemedicine Journal*, 4(4), 313-321. <https://doi.org/10.1089/tmj.1.1998.4.313>

Davanloo, H. (1999). Intensive short‐term dynamic psychotherapy—central dynamic sequence: phase of pressure. *International Journal of Intensive Short‐Term Dynamic Psychotherapy*, 13(4), 211–236. [https://doi.org/10.1002/ (sici)1099-1182(199912)13:4<211::aid-sho150>3.0.co;2-v](https://doi.org/10.1002/%20(sici)1099-1182(199912)13:4%3c211::aid-sho150%3e3.0.co;2-v)

Davey, M. P., Davey, A., Tubbs, C., Savla, J., & Anderson, S. (2010). Second order change and evidence-based practice. *Journal of Family Therapy*, 34(1), 72-90. <https://doi.org/10.1111/j.1467-6427.2010.00499.x>

Davidson, R. J., Putnam, K. M., & Larson, C. L. (2000). Dysfunction in the neural circuitry of emotion regulation--a possible prelude to violence. *Science*, 289(5479), 591-594. <https://doi.org/10.1126/science.289.5479.591>

Davis, M., Guyker, W., & Persky, I. (2012). Uniting veterans across distance through a telephone-based reminiscence group therapy intervention. *Psychological Services*, 9(2), 206–208. <https://doi.org/10.1037/a0026117>

Day, S. X., & Schneider, P. L. (2002). Psychotherapy using distance technology: A comparison of face-to-face, video, and audio treatment. *Journal of Counseling Psychology*, 49(4), 499–503. <https://doi.org/10.1037/0022-0167.49.4.499>

de Maat, S., de Jonghe, F., Schoevers, R., & Dekker, J. (2009). The effectiveness of long-term psychoanalytic therapy: a systematic review of empirical studies. *Harvard review of psychiatry*, *17*(1), 1–23. <https://doi.org/10.1080/10673220902742476>

Deal, K. H. (2007). Psychodynamic theory. *Advances in Social Work*, 8(1), 184-195. <https://doi.org/10.18060/140>

Denton, J. M. (2016). Critical and post-structural perspectives on sexual identity formation. *New Directions for Student Services*. (2016)154: 57-69.

DigitalHealth.net. (2019). *Blended care: A remedy for mental health provision*. Retrieved from <https://www.digitalhealth.net/2018/07/blended-care-a-remedy-for-mental-health-provision/>

Doran, J. M., & Lawson, J. L. (2021). The impact of COVID-19 on provider perceptions of telemental health. *Psychiatric Quarterly*. <https://doi.org/10.1007/s11126-021-09899-7>

Dotson, W. D.(n.d.) *Evidence-based practice: What is it and why it matters*. [Presentation slides]. Centers for Disease Control and Prevention. <https://www.cdc.gov/genomics/about/file/print/Evidence-Based_Practice_508.pdf>

Doran, J. M., & Lawson, J. L. (2021). The impact of COVID-19 on provider perceptions of telemental health. *Psychiatric Quarterly.* <https://doi.org/10.1007/s11126-021-09899-7>

Draganski, B., Kherif, F., & Lutti, A. (2014). Computational anatomy for studying use-dependent brain plasticity. *Frontiers in Human Neuroscience*, 8. <https://doi.org/10.3389/fnhum.2014.00380>

Dreyfus, H. L., & Dreyfus, S. E. (1987). From Socrates to expert systems: The limits of calculative rationality. *Bulletin of the American Academy of Arts and Sciences*, 40(4), 15. <https://doi.org/10.2307/3823297>

Dreyfus, H. L., & Dreyfus, S. E. (1989). *Mind over machine: The power of human intuition and expertise in the era of the computer.* The Free Press. Retrieved November 24, 2018 from <https://alpheus.org/TS_Open/SkillAcquisitionTableText.pdf>

Dulwich Centre (n.d.) *What is narrative therapy? A gateway to narrative therapy and community work.* <https://dulwichcentre.com.au/what-is-narrative-therapy/>

Dunne S, MacGabhann L, McGowan P, Amering M. Embracing Uncertainty to Enable Transformation: The Process of Engaging in Trialogue for Mental Health Communities in Ireland. *Int J Integr Care*. 2018;18(2):3. Published 2018 Apr 18. <https://doi.org/10.5334/ijic.3085>

Eclectic therapy. (2017, April 19). *Psychology Today*. <https://www.psychologytoday.com/us/therapy-types/eclectic-therapy>

Ellis, A. (1992). First-order and second-order change in rational-emotive therapy: A reply to Lyddon. *Journal of Counseling & Development*, *70*(3), 449-451. <https://doi.org/10.1002/j.1556-6676.1992.tb01636.x>

EMDR Institute. (n.d.). What is EMDR? Eye movement desensitization and reprocessing therapy. <https://www.emdr.com/what-is-emdr/>

Enns, C. Z. (1993). Twenty years of feminist counseling and therapy. *The Counseling Psychologist*, *21*(1), 3-87. <https://doi.org/10.1177/0011000093211001>

Erbe, D., Psych, D., Eichert, H. C., Riper, H., & Ebert, D. D. (2017). Blending face-to-face and internet-based interventions for the treatment of mental disorders in adults: Systematic review. *Journal of Medical Internet Research*, 19(9), [e306]. <https://doi.org/10.2196/jmir.6588>

Faramelli, A. J. (2020). The aesthetics of Decoloniality in psychotherapy: Institutional psychotherapy and fanon’s ethico-aesthetic paradigm. *PORTO ARTE: Revista de Artes Visuais*, *25*(44). <https://doi.org/10.22456/2179-8001.110120>

Fernandez, E., Woldgabreal, Y., Day, A., Pham, T., Gleich, B., & Aboujaoude, E. (2021). Live psychotherapy by video versus in-person: A meta-analysis of efficacy and its relationship to types and targets of treatment. *Clinical psychology & psychotherapy*, 10.1002/cpp.2594. Advance online publication. <https://doi.org/10.1002/cpp.2594>

Filley, C. M. (2005, January 1). Why the white brain matters. *Dana Foundation*. Retrieved January 16, 2021 from <https://www.dana.org/article/why-the-white-brain-matters/>

Fitzpatrick, M., Nedeljkovic, M., Abbott, J. A., Kyrios, M., & Moulding, R. (2018). “Blended” therapy: The development and pilot evaluation of an internet-facilitated cognitive-behavioral intervention to supplement face-to-face therapy for hoarding disorder. *Internet Interventions*, 12, 16-25. <https://researchbank.swinburne.edu.au/file/edc4dda3-7b37-4646-bd4e-2ae456410478/1/2018-fitzpatrick-blended_therapy_the.pdf>

Fletcher-Tomenius, Leon and Vossler, Andreas (2009). Trust in Online Therapeutic Relationships: The Therapist's Experience. *Counselling Psychology Review*, 24(2) pp. 24–34. <https://oro.open.ac.uk/17204/3/873EF4B0.pdf>

Fok, M., Lee, T., & Yakeley, J. (2021). Views on psychotherapy research among members of the medical psychotherapy faculty of the royal college of psychiatrists. *BJPsych Bulletin*, 1-9. <https://doi.org/10.1192/bjb.2021.39>

Fore, C. (2013). Telebehavioral health within Indian health service. *PsycEXTRA Dataset*. <https://doi.org/10.1037/e591332013-001>

*The Frantz Fanon lab for intersectional psychology — Manhattan (NYC) psychologist*. (n.d.). Manhattan (NYC) Psychologist - Individual Therapy for Social Anxiety and Self-Confidence - Daniel Gaztambide, PsyD. <https://drgpsychotherapy.com/new-school-culture-mental-health-lab-frantz-fanon-race-ethnicity-inequality>

Fraser, J. S., & Solovey, A. D. (2007). Second-order change in psychotherapy: The golden thread that unifies effective treatments. American Psychological Association.

Freire, P., Araújo Freire, A. M., & de Oliveira, W. F. (2014). *Pedagogy of Solidarity*. Taylor & Francis Group

Freire, P. (1998). Pedagogy of freedom: Ethics, democracy, and civic courage. Rowman & Littlefield.

*Freud, "Aetiology of hysteria"*. (n.d.). UW Courses Web Server. Retrieved from September 15, 2021. <https://courses.washington.edu/freudlit/Hysteria.Notes.html>

Freud, S. (1938). *The basic writings of Sigmund Freud* (A. A. Brill, Trans.) The Modern Library.

Fromm, E. (1941). *Escape from freedom*. Rinehart and Co.

Fromm-Reichmann, F., & Bullard, D. M. (1960). *Psychoanalysis and psychotherapy, selected papers*. (2nd ed.) (D. M. Bullard, Ed.) University of Chicago Press.

Frontiers for Young Minds. (2016, September 22). *What are neural stem cells, and why are they important?* Retrieved January 16, 2021, from <https://kids.frontiersin.org/article/10.3389/frym.2016.00020>

Gale Encyclopedia of Medicine. (2008.) *Recessive trait*. Retrieved from <https://medical-dictionary.thefreedictionary.com/Recessive+trait>

Gallego-Delgado, P., James, R., Browne, E., Meng, J., Umashankar, S., Tan, L., Picon, C., Mazarakis, N. D., Faisal, A. A., Howell, O. W., & Reynolds, R. (2020). Neuroinflammation in the normal-appearing white matter (NAWM) of the multiple sclerosis brain causes abnormalities at the nodes of Ranvier. *PLoS Biology*, 18(12), e3001008. <https://doi.org/10.1371/journal.pbio.3001008>

Garte, R. (2016). A sociocultural, activity-based account of preschooler intersubjectivity. *Culture & Psychology*, 22(2), 254-275. <https://doi.org/10.1177/1354067x15621483>

Geller, S. (2020). Cultivating online therapeutic presence: Strengthening therapeutic relationships in teletherapy sessions. *Counselling Psychology Quarterly*, 1-17. <https://doi.org/10.1080/09515070.2020.1787348>

Geller, S. M., & Porges, S. W. (2014). Therapeutic presence: Neurophysiological mechanisms mediating feeling safe in therapeutic relationships. *Journal of Psychotherapy Integration*, 24(3), 178–192. <https://doi.org/10.1037/a0037511>

Ghaffar Nasiri Hanis, Masoud Sadeghi, Simin Gholamrezaei et al. Comparison of the effectiveness of existential, cognitive-existential, and humanistic-existential group psychotherapy on psychosomatic complaints in women with type 2 diabetes mellitus, 07 July 2020, PREPRINT (Version 1) available at Research Square <https://doi.org/10.21203/rs.3.rs-38310/v1>

Ghosh, G. J., Mclaren, P. M., & Watson, J. P. (1997). Evaluating the alliance in videolink teletherapy. *Journal of Telemedicine and Telecare*, 3(1\_suppl), 33-35. <https://doi.org/10.1258/1357633971930283>

Giovanardi, G., & Spangler, P. (2021). Introduction to the special section on *Working on dreams, from psychotherapy to neuroscience*. *Research in Psychotherapy: Psychopathology, Process and Outcome*, *24*(2). <https://doi.org/10.4081/ripppo.2021.578>

Glaser, B. G., & Strauss, A. L. (1967) The discovery of grounded theory: Strategies for qualitative research. Aldine.

Glass, V. Q., & Bickler, A. (2021). Cultivating the Therapeutic Alliance in a Telemental Health Setting. *Contemporary family therapy*, 1–10. Advance online publication. <https://doi.org/10.1007/s10591-021-09570-0>

Gloaguen, V., Cottraux, J., Cucherat, M., & Blackburn, I. M. (1998). A meta-analysis of the effects of cognitive therapy in depressed patients. *Journal of affective disorders*, *49*(1), 59–72. <https://doi.org/10.1016/s0165-0327(97)00199-7>

Glueck, D. (2013). Establishing therapeutic rapport in telemental health. *Telemental Health*, 29-46. <https://doi.org/10.1016/b978-0-12-416048-4.00003-8>

Gone, J. P. (2004). Mental Health Services for Native Americans in the 21st Century United States. Professional Psychology: *Research and Practice*, 35(1), 10–18. <https://doi.org/10.1037/0735-7028.35.1.10>

Greenson, R. R. (1965). The working alliance and the transference neurosis. *The Psychoanalytic Quarterly*, 34(2), 155-181. <https://doi.org/10.1080/21674086.1965.11926343>

Gregory, S. (2015). Gestalt therapy's embodied styles. *British Gestalt Journal*, 24(1), 39-44. (Retrieved from Academia.edu, November 21, 2020) <https://www.academia.edu/30954572/Gestalt_Therapys_Embodied_Styles_docx>

Gray, A. & Desmarais, S. (2014) Not all one and the same: Sexual identity, activism, and collective self-esteem. *Canadian Journal of Human Sexuality*. 2014 (23)2: 116-122.

Groddeck, G. (1977). *The meaning of illness: Selected psychoanalytic writings*. International Universities Press.

Groddeck, G. (2012). *The book of the it*. SCB Distributors. (First published in 1923)

Grondin, F., Lomanowska, A. M., & Jackson, P. L. (2019). Empathy in computer-mediated interactions: A conceptual framework for research and clinical practice. *Clinical Psychology: Science and Practice*, 26(4), 17. <https://doi.org/10.1111/cpsp.12298>

Gros, D. F., Morland, L. A., Greene, C. J., Acierno, R., Strachan, M., Egede, L. E., Tuerk, P. W., Myrick, H., & Frueh, B. C. (2013). Delivery of evidence-based psychotherapy via video telehealth. *Journal of Psychopathology and Behavioral Assessment*, 35(4), 506-521. <https://doi.org/10.1007/s10862-013-9363-4>

Grossman, C. M., & Grossman, S. (1965). The wild analyst: The life and work of Georg Groddeck. Barrie and Rockliff.

Halo, D., Mrhálek, T., & Kajanová, A. (2021). Feminist and gender-sensitive psychotherapy: social construction of mental health. *E-psychologie,* 15(2), 43-53. <https://doi.org/10.29364/epsy.402>

Hanson, I. (2016, July 31). *First and second order change*. The Open University. Retrieved September 16, 2021 from <https://learn1.open.ac.uk/mod/oublog/viewpost.php?post=178202>

Harwood, T. M., Pratt, D., Beutler, L. E., Bongar, B. M., Lenore, S., & Forrester, B. T. (2011). Technology, Telehealth, treatment enhancement, and selection. *Professional Psychology: Research and Practice,* 42(6), 448-454. <https://doi.org/10.1037/a0026214>

Hays, H.; Carroll, M.; Ferguson, S,; Fore, C.; Horton, M. (2014, December). The Success of Telehealth Care in the Indian Health Service. *AMA Journal of Ethics* 2014;16(12):986-996. <https://doi.org/10.1001/virtualmentor.2014.16.12.stas1-1412>

Hilty, D.M.; Ferrer, D.C.; Parish, M.B.; Johnston, B.; Callahan, E.J.; Yellowless, P.M. (2013, May 22). The effectiveness of telemental health: A review. *Telemedicine and e-health* (19)6 Special section on telemental health <https://doi.org/10.1089/tmj.2013.0075>

Hilty, D. M., Gentry, M. T., McKean, A. J., Cowan, K. E., Lim, R. F., & Lu, F. G. (2020). Telehealth for rural diverse populations: telebehavioral and cultural competencies, clinical outcomes and administrative approaches. *mHealth*, 6, 20. <https://doi.org/10.21037/mhealth.2019.10.04>

Hilty, D. M., Randhawa, K., Maheu, M. M., McKean, A. J. S., & Pantera, R. (2019). Therapeutic relationship of telepsychiatry and telebehavioral health: Ideas from research on telepresence, virtual reality and augmented reality. *Psychology and Cognitive Sciences – Open Journal*, 5(1): 14-29. <http://doi.org/10.17140/PCSOJ-5-145>

*Historical context for the writings of Sigmund Freud*. (n.d.) Retrieved September 15, 2021 from <https://www.college.columbia.edu/core/content/writings-sigmund-freud/context>

*History of psychology – Psychology*. (2014, February 14). Open Text WSU – Simple Book Publishing. <https://opentext.wsu.edu/psych105nusbaum/chapter/history-of-psychology/>

Hoge, C. W., & Rye, C. B. (2015). Efficacy and challenges of in-home telepsychotherapy. *The Lancet. Psychiatry*, 2(8), 668–669. [https://doi.org/10.1016/S2215-0366(15)00226-6](%20https:/doi.org/10.1016/S2215-0366(15)00226-6)

Horney, K. (1939). *New ways in psychoanalysis*. W Norton & Company.

Horney, K. (1967). *Feminine psychology* (H. Kelman, Ed.). W.W. Norton & Co.

Hosch, W. L. (2017, September 7). Web 2.0. *Encyclopedia Britannica*. Retrieved January 3, 2021, from <https://www.britannica.com/topic/Web-20>

Hubley, S., Lynch, S. B., Schneck, C., Thomas, M., & Shore, J. (2016). Review of key telepsychiatry outcomes. *World journal of psychiatry,* 6(2), 269–282. <https://doi.org/10.5498/wjp.v6.i2.269>

Human, J., & Wasem, C. (1991). Rural mental health in America. *The American psychologist*, 46(3), 232–239. [https://doi.org/10.1037//0003-066x.46.3.232](https://doi.org/10.1037/0003-066x.46.3.232%20)

Institute of Medicine. (2001). *Crossing the quality chasm: A new health system for the 21st century.* Washington, DC: The National Academies Press. <https://doi.org/10.17226/10027>

Internet-delivered psychological treatments. (2016, March 28). *Annual Reviews*. <https://www.annualreviews.org/doi/abs/10.1146/annurev-clinpsy-021815-093006>

*Intersectionality in psychology | APS*. (n.d.). Australian Psychological Society | APS. <https://psychology.org.au/for-members/publications/inpsych/2020/april-may-issue-2/intersectionality-in-psychology>

Jacoby, R. (1975). *Social amnesia: A critique of conformist psychology from Adler to Laing*. Beacon Press.

Jenkins-Guarnieri, M. A., Pruitt, L. D., Luxton, D. D., & Johnson, K. (2015). Patient perceptions of telemental health: Systematic review of direct comparisons to in-person psychotherapeutic treatments. *Telemedicine and e-Health*, 21(8), 652-660. <https://doi.org/10.1089/tmj.2014.0165>

Jencks, C., & Riesman, D. (1968). *The academic revolution*. Doubleday.

Johansson, R. (2019). Internet-based psychodynamic psychotherapy. *Contemporary Psychodynamic Psychotherapy*, 337-347. <https://doi.org/10.1016/b978-0-12-813373-6.00023-4>

Joinson, A. N. (2007). Disinhibition and the internet. *Psychology and the Internet*, 75-92. <https://doi.org/10.1016/b978-012369425-6/50023-0>

Jung, C. G., & Bennet, E. A. (1968). *Analytical psychology: Its theory and practice (The Tavistock lectures)*. Pantheon Books.

Kaiser, R. H., Clegg, R., Goer, F., Pechtel, P., Beltzer, M., Vitaliano, G., Olson, D. P., Teicher, M. H., & Pizzagalli, D. A. (2017). Childhood stress, grown-up brain networks: Corticolimbic correlates of threat-related early life stress and adult stress response. *Psychological Medicine*, 48(7), 1157-1166. <https://doi.org/10.1017/s0033291717002628>

Kaplan, J. T., Gimbel, S. I., & Harris, S. (2016). Neural correlates of maintaining one’s political beliefs in the face of counterevidence. *Scientific Reports*, 6(1). <https://doi.org/10.1038/srep39589>

Kaschak, E. (2018). The next generation: Third wave feminist psychotherapy. *The Next Generation: Third Wave Feminist Psychotherapy*, 1-4. <https://doi.org/10.4324/9781315786131-1>

Kassan, A., & Moodley, R. (Eds.) (2018). *Diversity and social justice in counseling, psychology, and psychotherapy: A case study approach*. Cognella Academic Publishing

Kellogg, S., & Garcia Torres, A. (2021). Toward a chairwork psychotherapy: Using the four dialogues for healing and transformation. *Practice Innovations*. <https://doi.org/10.1037/pri0000149>

Kellner, D., Pierce, C., & Cho, D. K., (Eds.) *Marcuse's Challenge to Education*. Rowan and Littlefield (2009)

Kessler, D., Lewis, G., Kaur, S., Wiles, N., King, M., Weich, S., Sharp, D. J., Araya, R., Hollinghurst, S., & Peters, T. J. (2009). Therapist-delivered internet psychotherapy for depression in primary care: A randomised controlled trial. *The Lancet*, 374(9690), 628-634. <https://doi.org/10.1016/s0140-6736(09)61257-5>

Khan Academy. (2020). *Structure of the plasma membrane*. Retrieved January 16, 2021, from <https://www.khanacademy.org/science/high-school-biology/hs-cells/hs-the-cell-membrane/a/structure-of-the-plasma-membrane>

Kirylo, J.D. (2013). “13. Paulo Freire: ‘Father’ of critical pedagogy” in *Critical pedagogy of resistance: 34 pedagogues we need to know*. Steinberg, S. R. (Ed.) Sense Publishers, 2013

Knaevelsrud, C., & Maercker, A. (2006). Does the quality of the working alliance predict treatment outcomes in online psychotherapy for traumatized patients? *Journal of Medical Internet Research*, 8(4), e31. <https://doi.org/10.2196/jmir.8.4.e31>

Kramer, G. M., Mishkind, M. C., Luxton, D. D., & Shore, J. H. (2013). *Managing risk and protecting privacy in telemental health: An overview of legal, regulatory, and risk-management issues*. In K. Myers & C. L. Turvey (Eds.), Elsevier insights. Telemental health: Clinical, technical, and administrative foundations for evidence-based practice (p. 83–107). Elsevier. <https://doi.org/10.1016/B978-0-12-416048-4.00006-3>

Köhler, W. (1972). *The task of gestalt psychology.* Princeton University Press.

(Original work published 1969)

Köhler, W. (1973). *Dynamics in psychology: Vital applications of gestalt psychology*. W. W. Norton & Company. (Original work published 1940)

Kohut, H. (1977) *The analysis of the self*. International universities press.

Kohut, H. (1977) *The restoration of the self*. International universities press.

Kuhn, T. S. (1996). *The structure of scientific revolutions (3rd ed.)*. University of Chicago Press. <https://doi.org/10.7208/chicago/9780226458106.001.0001>

Kuncic, Z., Marcus, I., Sanz-Leon, P., Higuchi, R., Shingaya, Y., Li, M., Stieg, A., Gimzewski, J., Aono, M., & Nakayama, T. (2018). Emergent brain-like complexity from nanowire atomic switch networks: Towards neuromorphic synthetic intelligence. *2018 IEEE 18th International Conference on Nanotechnology (IEEE-NANO)*. IEEE. <https://ieeexplore.ieee.org/document/8626236/>

Lamas, A., Wolfson, T., & Funke, P. N. (2017). *The great refusal: Herbert Marcuse and contemporary social movements*. Temple University Press.

Langarizadeh, M., Tabatabaei, M. S., Tavakol, K., Naghipour, M., Rostami, A., & Moghbeli, F. (2017). Telemental health care, an effective alternative to conventional mental care: A systematic review. *Acta Informatica Medica*, 25(4), 240–246. <https://doi.org/10.5455/aim.2017.25.240-246>

Lawrence, R. (2020, May 12). *Self-love, love of others, and emancipation* [Video]. YouTube. <https://youtu.be/WZEkMQozgpg>

Lawson, K. L., Jonk, Y., O'Connor, H., Riise, K. S., Eisenberg, D. M., & Kreitzer, M. J. (2013). The impact of Telephonic Health Coaching on Health Outcomes in a High-risk Population. *Global advances in health and medicine*, 2(3), 40–47. <https://doi.org/10.7453/gahmj.2013.039>

LeDoux, J. E. (2000). Emotion circuits in the brain. *Annual Review of Neuroscience*, 23(1), 155-184. <https://doi.org/10.1146/annurev.neuro.23.1.155>

Lesser, J. G. (2021). Telemental health during a pandemic: Third space conversations. *Smith College Studies in Social Work*, 1-16. <https://doi.org/10.1080/00377317.2021.1927935>

LibreTexts. (2021, February 19). *Inductive reasoning*. Retrieved June 14, 2021, from <https://socialsci.libretexts.org/@go/page/17818>

Leichsenring, F., & Leibing, E. (2003). The effectiveness of psychodynamic therapy and cognitive behavior therapy in the treatment of personality disorders: a meta-analysis. *The American journal of psychiatry*, *160*(7), 1223–1232. <https://doi.org/10.1176/appi.ajp.160.7.1223>

Lindhiem, O., Bennett, C. B., Trentacosta, C. J., & McLear, C. (2014). Client preferences affect treatment satisfaction, completion, and clinical outcome: a meta-analysis. *Clinical psychology review*, 34(6), 506-517. <https://doi.org/10.1016/j.cpr.2014.06.002>

Longino, H. E. (1993). "5. Subjects, power, and knowledge: Description and prescription in feminist philosophies of science" in *Feminist Epistemologies*. (Alcoff & Potter, Eds.) Routledge.

Lozano, B. E., Birks, A. H., Kloezeman, K., Cha, N., Morland, L. A., & Tuerk, P. W. (2014). Therapeutic alliance in clinical videoconferencing: Optimizing the communication context. *Behavioral Telehealth*, 221-251. <https://doi.org/10.1007/978-3-319-08765-8_10>

Luborsky, L. (2002). Supportive-expressive dynamic psychotherapy. *Encyclopedia of Psychotherapy,* 745-750. <https://doi.org/10.1016/b0-12-343010-0/00214-2>

Lüdemann, J., Rabung, S., & Andreas, S. (2021). Systematic review on Mentalization as key factor in psychotherapy. *International Journal of Environmental Research and Public Health*, *18*(17), 9161. <https://doi.org/10.3390/ijerph18179161>

Lunsford, T. & Bilorusky, J. (1981). *Judging the evidence*. Western Institute for Social Research

Lutz, R. J. (1975). First-order and second-order cognitive effects in attitude change. *Communication Research*, *2*(3), 289-299. <https://doi.org/10.1177/009365027500200309>

Luxton, D. D. (2013). Considerations for planning and evaluating economic analyses of telemental health. *Psychological Services*, 10(3), 276–282. <https://doi.org/10.1037/a0030658>

Lyddon, W. J. (1990). First- and second-order change: Implications for rationalist and constructivist cognitive therapies. *Journal of Counseling & Development*, *69*(2), 122-127. <https://doi.org/10.1002/j.1556-6676.1990.tb01472.x>

Madewell, J., & Shaughnessy, M. F. (2009). An interview with Judith Beck about cognitive therapy. *North American Journal of Psychology*, 11(1), 29-36. <https://search.proquest.com/scholarly-journals/interview-with-judith-beck-about-cognitive/docview/198085826/>

Magnavita, J. J. (2005). Unified Relational Psychotherapy: Beyond Integration. In J. J. Magnavita, *Personality-guided relational psychotherapy: A unified approach* (pp. 3–22). American Psychological Association. <https://doi.org/10.1037/10959-001>

Mah, R. (n.d.). *Chapter 20. Second order change, Out of the monkey trap, Breaking negative cycles for relationships and therapy*. Retrieved September 16, 2021 from <https://www.ronaldmah.com/20.-second-order-change.html>

Maheu, M. M. (2001, January). *Telehealth: Practicing psychotherapy on the Internet. Risk Management and great opportunity.* <https://www.researchgate.net/publication/237035967>

Maheu, M. M. (2006). Exposing the Risk, yet Moving Forward: A Behavioral E-Health Model. *Journal of Computer-Mediated Communication*, 6(4), 0–0. <https://doi.org/10.1111/j.1083-6101.2001.tb00130.x>

Maheu, M. M. (2020). Telehealth: Risk Management in the Re-Tooling of Health Care. *Law & Governance*, 7(1). [https://www.longwoods.com/content/16422//telehealth-risk-management-in-the-re-tooling-of-health-care](https://www.longwoods.com/content/16422/telehealth-risk-management-in-the-re-tooling-of-health-care)

Maheu, M. M., Drude, K. P., Hertlein, K. M., Lipschutz, R., Wall, K., & Hilty, D. M.. (2020). Correction to: An interprofessional framework for telebehavioral health competencies. *Journal of Technology in Behavioral Science*, 5, 79–111. <https://doi.org/10.1007/s41347-019-00113-x>

Maheu, M. M., & Gordon, B. L. (2000). Counseling and therapy on the Internet. *Professional Psychology: Research and Practice*, 31(5), 484–489. <https://doi.org/10.1037/0735-7028.31.5.484>

Malone, John. (2021). 19th century science. Retrieved September 15, 2021 from <https://www.researchgate.net/publication/350682468>

Månsson, K. N., Klintmalm, H., Nordqvist, R., & Andersson, G. (2017). Conventional cognitive behavioral therapy facilitated by an Internet-based support system: Feasibility study at a psychiatric outpatient clinic. *JMIR Research Protocols*, 6(8), e158. <https://doi.org/10.2196/resprot.6035>

Månsson, K. N., Skagius Ruiz, E., Gervind, E., Dahlin, M., & Andersson, G. (2013). Development and initial evaluation of an internet-based support system for face-to-face cognitive behavior therapy: A proof of concept study. *Journal of Medical Internet Research*, *15*(12), e280. <https://doi.org/10.2196/jmir.3031>

Marcus-Mendoza, S. (2010). Feminist therapy with incarcerated women: Practicing subversion in prison. *Women & Therapy*, *34*(1-2), 77-92. <https://doi.org/10.1080/02703149.2011.532692>

Marcuse, H. (1960). *Reason and revolution*. Beacon Press.

Marcuse, H. (1969). *An essay on liberation*. Beacon Press.

Marcuse, H. (1972). *Counter-revolution and revolt*. Beacon Press.

Marcuse, H. (2002). *One-dimensional man: Studies in the ideology of advanced industrial society* (2nd Edition). (D. Kellner, Ed.). Routledge. (Original work published 1964)

Martín-Baró, I. (1996). *Writings for a liberation psychology*. (A. Aron & S. Corne, Eds.). Harvard University Press.

Marton, K., & Kanas, N. (2015). Telehealth modalities for group therapy: Comparisons to in-person group therapy. *International Journal of Group Psychotherapy*, 66(1), 145-150. <https://doi.org/10.1080/00207284.2015.1096109>

Maslow, A. H. (1943). A theory of human motivation. *Psychological Review*, 50(4), 370-396. <https://psychclassics.yorku.ca/Maslow/motivation.htm>

Maslow, A. H. (1968). T*oward a psychology of being. (2nd Edition)*. Litten Educational Publishing.

Maslow, A. H., & Murphy, G. (1954). *Motivation and personality: A general theory of human motivation based upon a synthesis of holistic and dynamic principles.* Harper & Brothers.

Massoudi, B., Blanker, M. H., van Valen, E., Wouters, H., Bockting, C. L., & Burger, H. (2017). Blended care vs. usual care in the treatment of depressive symptoms and disorders in general practice: Study protocol of a non-inferiority randomized trial. *BMC Psychiatry*, 17(1), 218. <https://pubmed.ncbi.nlm.nih.gov/30447572/>

Mathy, R. M. & Schillace, M. (2003). The Impact of Religiosity of Lesbian and Bisexual Women’s Psychosexual Development: Child Maltreatment, Suicide Attempts, and Self-Disclosure. *Journal of Psychology & Human Sexuality*. 2003, (15)2/3: p73-100.

Mayo, P. (2013). *Echoes from Freire for a critically engaged pedagogy*. Bloomsbury Academic.

McCaleb, S.P. (1997). *Building communities of learners: A collaboration among teachers, students, families, and community*. Lawrence Erlbaum Associates

McDonald, A. (2015). Emotion-focused therapy. In E. Neukrug (Ed.), The SAGE encyclopedia of theory in counseling and psychotherapy (pp. 342-344). *SAGE Publications, Inc*., [https://www.doi.org/10.4135/9781483346502.n121](https://www.doi.org/10.4135/9781483346502.n121%20)

McGaugh, J. L. (2004). The amygdala modulates the consolidation of memories of emotionally arousing experiences. *Annual Review of Neuroscience*, 27(1), 1-28. <https://doi.org/10.1146/annurev.neuro.27.070203.144157>

McKenzie-Mavinga, I. (2018). Addressing Racism in Therapeutic Practice. *Therapy Today*. Oct 2018 (29)8: 36-39.

Mende, M. A., & Schmidt, H. (2021). Psychotherapy in the framework of embodied cognition—Does interpersonal synchrony influence therapy success? *Frontiers in Psychiatry*, *12*. <https://doi.org/10.3389/fpsyt.2021.562490>

Millbank Memorial Fund. (n.d.) *Telebehavioral health: An effective alternative to in-person care.* Retrieved June 11, 2021, from <https://www.milbank.org/publications/telebehavioral-health-an-effective-alternative-to-in-person-care/>

Miller, E. A. (2003). The technical and interpersonal aspects of telemedicine: Effects on doctor–patient communication. *Journal of Telemedicine and Telecare*, 9(1), 1-7. <https://doi.org/10.1258/135763303321159611>

Miller, L., & Weissman, M. (2002). Interpersonal psychotherapy delivered over the telephone to recurrent depressives: A pilot study. *Depression and Anxiety*, 16(3), 114-117. <https://doi.org/10.1002/da.10047>

Millett, K. (1970). *Sexual politics*. Doubleday.

Mills, C. W. (1959). *The sociological imagination*. Oxford University Press.

Minulescu, M. (2015). Symbols of healing and transformation in psychotherapy: The bridge. *Procedia - Social and Behavioral Sciences*, *165*, 103-107. <https://doi.org/10.1016/j.sbspro.2014.12.610>

Mirkin, M. (2011). Telephone analysis: Compromised treatment or an interesting opportunity? The *Psychoanalytic Quarterly,* 80(3), 643-670. <https://doi.org/10.1002/j.2167-4086.2011.tb00100.x>

Mitchell, E. (2020). “Much more than second best”: Therapists' experiences of videoconferencing psychotherapy. *European Journal for Qualitative Research in Psychotherapy*, 10, 121–135. <https://ejqrp.org/index.php/ejqrp/article/view/111/74>

Modai, I., Jabarin, M., Kurs, R., Barak, P., Hanan, I., & Kitain, L. (2006). Cost effectiveness, safety, and satisfaction with video telepsychiatry versus face-to-face care in ambulatory settings. *Telemedicine Journal & E-Health*, 12(5), 515-520. <https://doi.org/10.1089/tmj.2006.12.515>

Mohr DC, Hart SL, Julian L, et al. Telephone-Administered Psychotherapy for Depression. *Arch Gen Psychiatry*. 2005;62(9):1007–1014. <https://doi.org/10.1001/archpsyc.62.9.1007>

Mohr, D. C., Vella, L., Hart, S., Heckman, T., & Simon, G. (2008). The effect of telephone‐administered psychotherapy on symptoms of depression and attrition: A meta‐analysis. *Clinical Psychology: Science and Practice*, 15(3), 243-253. <https://doi.org/10.1111/j.1468-2850.2008.00134.x>

Montero-Marín, J., Prado-Abril, J., Botella, C., Mayoral-Cleries, F., Baños, R., Herrera-Mercadal, P., Romero-Sanchiz, P., Gili, M., Castro, A., Nogueira, R., & García-Campayo, J. (2015). Expectations among patients and health professionals regarding web-based interventions for depression in primary care: A qualitative study. *Journal of Medical Internet Research*, 17(3), e67. <https://doi.org/10.2196/jmir.3985>

Morgan, J. H. (2014). The interpersonal psychotherapy of Harry Stack Sullivan: Remembering the legacy. *Journal of Psychology & Psychotherapy*, 4(6). <https://doi.org/10.4172/2161-0487.1000162>

Morrow, S. L., & Hawxhurst, D. (2012). Political analysis: Cornerstone of feminist multicultural counseling and psychotherapy. *Oxford Handbooks Online*. <https://doi.org/10.1093/oxfordhb/9780199744220.013.0018>

Moser, W. (2015, April 29). How white housing riots shaped Chicago. *Chicago Magazine*. <https://www.chicagomag.com/city-life/April-2015/How-White-Housing-Riots-Shaped-Chicago/>

Moses, I. (2005). Controversial discussions: Telephone analysis treatment by telephone: An uncanny attachment. *PsycEXTRA Dataset*. <https://doi.org/10.1037/e515992006-019>

Murray, R. (2002). The phenomenon of psychotherapeutic change: Second-order change in one's experience of self. *Journal of Contemporary Psychotherapy* 32, 167–177. <https://doi.org/10.1023/A:1020592926010>

Nagarajan, M., & S, Y. (2019). Mental health counsellors’ perceptions on use of technology in counselling. *Current Psychology*, 40(4), 1760-1766. <https://doi.org/10.1007/s12144-018-0104-4>

National Assessment Governing Board. (n.d.) *Information and communication technology (ICT)*. Retrieved July 3, 2020, from <https://www.nagb.gov/naep-frameworks/technology-and-engineering-literacy/2014-technology-framework/toc/ch_2/ict.html>

National Center for Biotechnology Information. (2016, September 8). *Cognitive behavioral therapy.* Retrieved January 5, 2021, from <https://www.ncbi.nlm.nih.gov/books/NBK279297/>

National Center for PTSD. (n.d.). *PTSD and telemental health.* <https://www.ptsd.va.gov/professional/treat/txessentials/telemental_health.asp>

Nayak, S. (2020). Intersectionality and psychotherapy with an eye to clinical and professional ethics. *Oxford Handbook of Psychotherapy Ethics*, 889-903. <https://doi.org/10.1093/oxfordhb/9780198817338.013.52>

Norwood, C., Moghaddam, N. G., Malins, S., & Sabin‐Farrell, R. (2018). Working alliance and outcome effectiveness in videoconferencing psychotherapy: A systematic review and noninferiority meta‐analysis. *Clinical Psychology & Psychotherapy*, 25(6), 797-808. <https://doi.org/10.1002/cpp.2315>

Nudo, R. J., & Dancause, N. (2012). Neuroscientific basis for occupational and physical therapy interventions. *Brain Injury Medicine*. <https://doi.org/10.1891/9781617050572.0068>

Office of Assistant Secretary for Planning and Evaluation. (2016, November 5). *Privacy, confidentiality, security.* <https://aspe.hhs.gov/report/privacy-and-health-research/privacy-confidentiality-security>

Olmstead, T. A., Ostrow, C. D., & Carroll, K. M. (2010). Cost-effectiveness of computer-assisted training in cognitive-behavioral therapy as an adjunct to standard care for addiction. *Drug and Alcohol Dependence*, 110(3), 200-207. <https://doi.org/10.1016/j.drugalcdep.2010.02.022>

Osenbach, J. E., O'Brien, K. M., Mishkind, M., & Smolenski, D. J. (2013). Synchronous telehealth technologies in psychotherapy for depression: A meta‐analysis. *Depression and Anxiety*, 30(11), 1058-1067. <https://doi.org/10.1002/da.22165>

Oregon State University. (2010, September 14). *Snowball sampling*. Research Office. <https://research.oregonstate.edu/irb/policies-and-guidance-investigators/guidance/snowball-sampling>

Padesky, C. A. (1994). Schema change processes in cognitive therapy. *Clinical Psychology & Psychotherapy*, 1(5), 267-278. <https://padesky.com/newpad/wp-content/uploads/2012/11/schema_change_article_permissions.pdf>

Panchal, N.; Kamal, R.; Cox, C. & Garfield, R. (2021, February 10). *The implications of COVID-19 for mental health and substance use.* Kaiser Family Foundation. <https://www.kff.org/coronavirus-covid-19/issue-brief/the-implications-of-covid-19-for-mental-health-and-substance-use/>

Paradigm (n.d.). Dictionary. *Merriam-Webster.com.* <https://www.merriam-webster.com/dictionary/paradigm>

Parmenidou, A.V. (2011, May 17) *Second-order change in psychotherapy: A necessary requirement? Remaining sane in insane places*. Paper presented at the 16th International Conference of A.P.P.A.C. on Neuropsychiatric, Psychological and Social Developments and Challenges, Athens-Greece. Retrieved September 16, 2021 from <https://www.academia.edu/>

Pathak, V., Jena, B., & Kalra, S. (2013). Qualitative research. *Perspectives in Clinical Research*, 4(3), 192. <https://doi.org/10.4103/2229-3485.115389>

Peräkylä, A. (2019). Conversation analysis and psychotherapy: Identifying transformative sequences. *Research on Language and Social Interaction*, *52*(3), 257-280. <https://doi.org/10.1080/08351813.2019.1631044>

Perls, F. S., Hefferline, R. F., & Goodman, P. (1994). *Gestalt therapy: Excitement and growth in the human personality*. ("Introduction to the Gestalt Journal Press”). Gestalt Journal Press. (Original work published 1951)

Prot-Klinger, K.; Szwajca, K.; Biedka, Ł; Bierzyński, K; Domagalska-Kurdziel, E.; Izdebski, R. (2019). Psychotherapy of holocaust survivors – Integration of traumatic experiences? *Isr J Psychiatry* 56(1) Retrieved September 16, 2021 from <https://researchgate.net>

Plutchik, R. (2001). The nature of emotions: Human emotions have deep evolutionary roots, a fact that may explain their complexity and provide tools for clinical practice. *American Scientist*, 89(4), 344-350. <https://www.jstor.org/stable/27857503>

Polanyi, M. (2015). *Personal knowledge: Towards a post-critical philosophy*. University of Chicago Press. (Original work published 1958)

Porges, S. W. (2011). *The Polyvagal theory: Neurophysiological foundations of emotions, attachment, communication, and self-regulation*. W. W. Norton & Company.

Power, M. (2010). *Emotion-focused cognitive therapy*. John Wiley & Sons.

Pruitt, D. (n.d.) *Some notes on feminist perspectives on science*. Western Institute for Social Research

Psych.rutgers.edu. (n.d.) *Chapter 2. Mental philosophy and psychology: The curriculum at Rutgers College in the 19th century.* Retrieved September 15, 2021 from <https://psych.rutgers.edu/docman-lister/history/19-chapter-2/file>

Puga, E. A. (2005). *Movilizando sueños: Encuentro nacional de educación popular*. Colectivo Ceaal Chile.

Putting politics into practice: Feminist therapy as feminist praxis. (2013). *Feminist Therapy as a Political Act*, 36-55. <https://doi.org/10.4324/9781315809649-8>

Rees, C. S., & Stone, S. (2005). Therapeutic alliance in face-to-face versus videoconferenced psychotherapy. Professional Psychology: *Research and Practice*, 36(6), 649–653. <https://doi.org/10.1037/0735-7028.36.6.649>

Reese, H. W. & Overton, W. F. (1970). “Models of development and theories of development”. In L. R. Goulet & P. B. Baltes (Eds.), *Life-Span Developmental Psychology* (pp. 115-145). Academic

Reese, R. J., Mecham, M. R., Vasilj, I., Lengerich, A. J., Brown, H. M., Simpson, N. B., & Newsome, B. D. (2016). The effects of telepsychology format on empathic accuracy and the therapeutic alliance: An analogue counselling session. *Counselling and Psychotherapy Research*, 16(4), 256-265. <https://doi.org/10.1002/capr.12092>

Richards, D., & Richardson, T. (2012). Computer-based psychological treatments for depression: A systematic review and meta-analysis. *Clinical Psychology Review*, 32(4), 329-342. <https://doi.org/10.1016/j.cpr.2012.02.004>

Richardson, Lisa (2011) "Can you see what I am saying?": An action-research, mixed methods evaluation of telepsychology in rural Western Australia. PhD thesis, Murdoch University. <https://researchrepository.murdoch.edu.au/id/eprint/7023/>

Richardson, M. J., Paxton, A., & Kuznetsov, N. (2017, February). Nonlinear methods for understanding complex dynamical phenomena in psychological science. *American Psychological Association*. <https://www.apa.org/science/about/psa/2017/02/dynamical-phenomena>

Riva, G. (2009). Is presence a technology issue? Some insights from cognitive sciences. *Virtual Reality,* 13(3), 159-169. <https://doi.org/10.1007/s10055-009-0121-6>

Robcis, C. (2019). Frantz fanon, institutional psychotherapy, and the decolonization of psychiatry. *Frantz Fanon’s Psychotherapeutic Approaches to Clinical Work*, 23-38. <https://doi.org/10.4324/9780429465307-2>

Roberts, P. (2000). Education, literacy, and humanization: Exploring the work of Paulo Freire. Greenwood Publishing Group.

Rocker, S. (2015, January 6). What is a mensch? *The Jewish Chronicle.* <https://www.thejc.com/what-is-a-mensch-1.64427>

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. (1946). Significant aspects of client-centered therapy. *American Psychologist*, 1(10), 415-422. <https://www.scribd.com/document/133028087/Client-Centered-Therapy-Rogers>

Rogers, C. R. (1951). *Client-centered therapy, its current practice, implications, and theory*. Houghton Mifflin College Division.

Rogers, C. R. (1995). *A way of being.* Houghton Mifflin Harcourt.

Rogers, C. R. (2012). *On becoming a person: A therapist's view of psychotherapy*. Houghton Mifflin Harcourt.

Rogers-Sirin, L. (2017) Psychotherapy from the Margins: How the Pressure to Adopt Evidence-Based-Treatments Conflicts with Social Justice-Oriented Practice. *Journal for Social Action in Counseling & Psychology*. Summer 2017(9)1: 55-78.

Rosen, C. S., Glassman, L. H., & Morland, L. A. (2020). Telepsychotherapy during a pandemic: A traumatic stress perspective. *Journal of Psychotherapy Integration*, 30(2), 174-187. <https://psycnet.apa.org/fulltext/2020-39749-003.html>

Rothbaum, F., Rosen, K., Ujiie, T., & Uchida, N. (2002). Family systems theory, attachment theory, and culture\*. *Family Process*, 41(3), 328-350. <https://doi.org/10.1111/j.1545-5300.2002.41305.x>

Rozental, A., Boettcher, J., Andersson, G., Schmidt, B., & Carlbring, P. (2015). Negative effects of internet interventions: a qualitative content analysis of patients' experiences with treatments delivered online. *Cognitive Behaviour Therapy*, 44(3), 223-236. <https://doi.org/10.1080/16506073.2015.1008033>

Russo, A. F. (2017). Overview of neuropeptides: Awakening the senses? Headache: *The Journal of Head and Face Pain*, 57, 37-46. <https://headachejournal.onlinelibrary.wiley.com/doi/abs/10.1111/head.13084>

Rutherford, A., & Davidson, T. (2019). Intersectionality and the history of psychology. *Oxford Research Encyclopedia of Psychology*. <https://doi.org/10.1093/acrefore/9780190236557.013.468>

Ruud, M. (2019, March 5). The four theories of emotion: What, why and how? *Owlcation - Education.* Retrieved December 1, 2020, from <https://owlcation.com/social-sciences/Emotion>

Safron A. (2016). What is orgasm? A model of sexual trance and climax via rhythmic entrainment. *Socioaffective neuroscience & psychology*, 6, 31763. <https://doi.org/10.3402/snp.v6.31763>

Scharff, J. S. (2018). Teletherapy and teleanalysis in training psychotherapists and psychoanalysts. *Psychoanalysis Online*, 227-239. <https://doi.org/10.4324/9780429478833-21>

Scharff, J.S. (Reporter) (2010) Telephone analysis, *The International Journal of Psychoanalysis*, 91:4, 989-992. <https://doi.org/10.1111/j.1745-8315.2010.00298.x>

Shapiro, D. A., Barkham, M., Rees, A., Hardy, G. E., Reynolds, S., & Startup, M. (1994). Effects of treatment duration and severity of depression on the effectiveness of cognitive-behavioral and psychodynamic-interpersonal psychotherapy. *Journal of consulting and clinical psychology*, *62*(3), 522–534. <https://doi.org/10.1037/0022-006x.62.3.522>

Sharpless, B. A. (2019). The supportive–expressive continuum. *Psychodynamic Therapy Techniques*, 52-61. <https://doi.org/10.1093/med-psych/9780190676278.003.0005>

Scholz, J., Klein, M. C., Behrens, T. E., & Johansen-Berg, H. (2009). Training induces changes in white-matter architecture. *Nature Neuroscience*, 12(11), 1370-1371. <https://doi.org/10.1038/nn.2412>

Schuster, R., Kalthoff, I., Walther, A., Köhldorfer, L., Partinger, E., Berger, T., & Laireiter, A. (2019). Effects, adherence, and therapists’ perceptions of web- and mobile-supported group therapy for depression: Mixed-methods study. *Journal of Medical Internet Research*, 21(5), e11860. <https://doi.org/10.2196/11860>

Shedler, J. (2011). The efficacy of psychodynamic psychotherapy. *American Psychologist*, 65(2), 98-109. <https://doi.org/10.1037/a0018378>

Singh, S., & Estefan, A. (2018). Selecting a grounded theory approach for nursing research. *Global Qualitative Nursing Research*, 5, 233339361879957. <https://doi.org/10.1177/2333393618799571>

Simpson, S. G., & Reid, C. L. (2014). Therapeutic alliance in videoconferencing psychotherapy: A review. *Australian Journal of Rural Health*, 22(6), 280-299. <https://doi.org/10.1111/ajr.12149>

Simpson, S., Richardson, L., Pietrabissa, G., Castelnuovo, G., & Reid, C. (2021). Videotherapy and therapeutic alliance in the age of COVID-19. *Clinical psychology & psychotherapy*, 28(2), 409–421. <https://doi.org/10.1002/cpp.2521>

Smith, K., Moller, N., Cooper, M., Gabriel, L., Roddy, J., & Sheehy, R. (2021). Video counselling and psychotherapy: A critical commentary on the evidence base. *Counselling and Psychotherapy Research*. <https://doi.org/10.1002/capr.12436>

Somatic Perspectives. (2011, November). *Stephen W. Porges: The polyvagal theory*. Somatic Perspectives on Psychotherapy podcast. <https://somaticperspectives.com/zug/transcripts/Porges-2011-11.pdf>

Sparks, E. (1995). Review of women in context: Toward a feminist reconstruction of psychotherapy. *Cultural Diversity and Mental Health*, *1*(1), 73-74. <https://doi.org/10.1037/1099-9809.1.1.73>

Spek, V., Cuijpers, P. I. M., Nyklíček, I., Riper, H., Keyzer, J., & Pop, V. (2007). Internet-based cognitive behaviour therapy for symptoms of depression and anxiety: A meta-analysis. *Psychological Medicine*, *37*(03), 319. <https://doi.org/10.1017/s0033291706008944>

Stein, M., Miller, L., & Heinrich, M. (1970). *Blueprint for counter education*. Doubleday & Co.

Stevens, A., & Price, J. (1996). *Evolutionary psychiatry: A new beginning.* Routledge.

Sucala, M., Schnur, J. B., Constantino, M. J., Miller, S. J., Brackman, E. H., & Montgomery, G. H. (2012). The therapeutic relationship in e-therapy for mental health: A systematic review. *Journal of Medical Internet Research*, 14(4), e110. <https://doi.org/10.2196/jmir.2084>

Sullivan, H. S. (1953). *The interpersonal theory of psychiatry*. W.W. Norton.

Sullivan, H. S. (2018). *Conceptions of modern psychiatry: The first William Alanson White memorial lecture* (2nd ed.). Pickle Partners Publishing.

Tao, Y., & Zhang, S. (2016). Neural subtype specification from human Pluripotent stem cells. *Cell Stem Cell*, 19(5), 573-586. <https://doi.org/10.1016/j.stem.2016.10.015>

TeleBehavioral Wellness. (n.d.) <https://telebehavioralwellness.com/>

TelebehavioralHealth.US. (n.d.) <https://www.telebehavioralhealth.us/>

Telehealth.org. (n.d.) <https://telehealth.org/>

The LGBTQ Experiment. (2018, October 28). *What does “cisgender” mean?* Retrieved September 13, 2021 from [https://lgbtqexperiment.com/2018/10/28/what-does-cisgender-mean/](https://lgbtqexperiment.com/2018/10/28/what-does-cisgender-mean/%20)

Thompson, R. & Ryan, N. (2007, April 2). *Managing the dynamics of second-order change: An Australian case study*. Paper submitted to the Eleventh International Research Symposium on Public. Retrieved September 16, 2021 from <https://www.researchgate.net/>

Management (IRSPM XI), 2-4 April 2007 Potsdam University, Germany. Retrieved September 16, 2021 from <https://www.researchgate.net/>

Tilliman, D. (2016). The effects of unconditional positive regard on psychotherapy outcome (Publication No. 10108864) [Doctoral dissertation, Institution]. ProQuest Dissertations and Theses Global.

Titzler, I., Egle, V., Berking, M., Gumbmann, C., & Ebert, D. (2019). Blended psychotherapy: Treatment concept and case report for the integration of internet- and mobile-based interventions into brief psychotherapy of depressive disorders. *Verhaltenstherapie*, 1-15. <https://doi.org/10.1159/000503408>

Topooco, N., Riper, H., Araya, R., Berking, M., Brunn, M., Chevreul, K., Cieslak, R., Ebert, D. D., Etchmendy, E., Herrero, R., Kleiboer, A., Krieger, T., García-Palacios, A., Cerga-Pashoja, A., Smoktunowicz, E., Urech, A., Vis, C., & Andersson, G. (2017). Attitudes towards digital treatment for depression: A European stakeholder survey. *Internet Interventions*, 8, 1-9. <https://doi.org/10.1016/j.invent.2017.01.001>

Traister, R. (2019). *Good and mad: The revolutionary power of women's anger*. Simon & Schuster.

Turner, B. M., Paradiso, S., Marvel, C. L., Pierson, R., Boles Ponto, L. L., Hichwa, R. D., & Robinson, R. G. (2007). The cerebellum and emotional experience. *Neuropsychologia*, 45(6), 1331-1341. <https://doi.org/10.1016/j.neuropsychologia.2006.09.023>

U. S. Department of Health & Human Services. (2013, July 26). *Summary of the HIPAA Privacy Rule*. <https://www.hhs.gov/hipaa/for-professionals/privacy/laws-regulations/index.html>

U. S. Department of Health & Human Services. (n.d.-a). *Health information technology.* <https://www.hhs.gov/hipaa/for-professionals/special-topics/health-information-technology/index.html>

U.S. Department of Health & Human Services. (n.d.-b). *Informed consent FAQs*. Office of Human Research Protections. <https://www.hhs.gov/ohrp/regulations-and-policy/guidance/faq/informed-consent/index.html>

U.S. Department of Health & Human Services. (n.d.-c). *Introduction to telehealth for behavioral health care*. <https://telehealth.hhs.gov/providers/telehealth-for-behavioral-health/>

U.S. Department of Health & Human Services. (2021, May 19). *What is telehealth?* [https://telehealth.hhs.gov/patients/understanding-telehealth/#what-is-telehealth](https://telehealth.hhs.gov/patients/understanding-telehealth/" \l "what-is-telehealth)

UC Berkeley. (n.d.) Cognitive constructivism. *GSI Teaching & Resource Center*. Retrieved December 12, 2020, from <https://gsi.berkeley.edu/gsi-guide-contents/learning-theory-research/cognitive-constructivism>

Uchizono, K. (1975). Mechanism of synaptic excitation. *Excitation and Inhibition*, 12-20. <https://doi.org/10.1016/b978-0-444-99872-9.50007-1>

University of Alabama. (2007). Reviews: From systematic to narrative: Narrative review. *Research Guides at University of Alabama - Birmingham.*

<https://guides.library.uab.edu/c.php?g=63689&p=409774>

University of Haifa. (2020, October 6). *Supportive-expressive and emotion-focused treatment for depression*. ClinicalTrials.gov. <https://clinicaltrials.gov/ct2/show/NCT04576182>

University of South Florida. (n.d.) *What is web 2.0?* Retrieved December 12, 2020, from <https://etc.usf.edu/techease/win/internet/what-is-web-2-0>

University of Toledo. (n.d.) *Fight/Flight/Freeze response*. Counseling Center. <https://www.utoledo.edu/studentaffairs/counseling/anxietytoolbox/fightflightfreeze.html>

University of Wisconsin Sustainable Management. (n.d.) *The triple bottom line.* Retrieved June 11, 2021, from <https://sustain.wisconsin.edu/sustainability/triple-bottom-line/>

Van Ballegooijen, W., Cuijpers, P., Van Straten, A., Karyotaki, E., Andersson, G., Smit, J. H., & Riper, H. (2014). Adherence to internet-based and face-to-face cognitive behavioral therapy for depression: A meta-analysis. *PLoS ONE*, *9*(7), e100674. <https://doi.org/10.1371/journal.pone.0100674>

*Young Dr. Freud. Theories: Seduction | PBS*. (n.d.). PBS: Public Broadcasting Service. Retrieved September 15, 2021 from <https://www.pbs.org/youngdrfreud/pages/theories_seduction.htm>

Vygotsky, L. S. (1986). *Thought and language (A. Kozulin, Trans.) (2nd ed.)*. MIT Press. (Original work published 1934)

Walker, M. D.; Hernandez, A. M.; Davey, M. (2012). Childhood Sexual Abuse and Adult Sexual Identity Formation: Intersection of Gender, Race, and Sexual Orientation. *American Journal of Family Therapy*. Oct-Dec 2012 (40)5: 385-398.

Wang, V. C. X., Keefe, D., & Sedivy-Benton, A. (2016). Transformative learning in adult and higher education: Confucius and Mezirow. In Wang, V. C. (Ed.), *Theory and practice of adult and higher education*. Information Age Publishing.

Warren, J. C., & Smalley, K. B. (2020, June 18) Using telehealth to meet mental health needs during the COVID-19 crisis. *Commonwealth Fund.* <https://www.commonwealthfund.org/blog/2020/using-telehealth-meet-mental-health-needs-during-covid-19-crisis>

Wentzel, J., Van der Vaart, R., Bohlmeijer, E. T., & Van Gemert-Pijnen, J. E. (2016). Mixing online and face-to-face therapy: How to benefit from blended care in mental health care. *JMIR Mental Health*, 3(1), e9. <https://mental.jmir.org/2016/1/e9/>

Western Institute for Social Research. (2014, August). *Learning the WISR way: The role of students and faculty in personalizing learning*. Retrieved from [https://www.wisr.edu/wp-content/uploads/2014/08/Learning-the-WISR-Way\_The\_Role\_of\_Students\_and\_Faculty\_in\_Personalizing\_Education. pdf](https://www.wisr.edu/wp-content/uploads/2014/08/Learning-the-WISR-Way_The_Role_of_Students_and_Faculty_in_Personalizing_Education.%20pdf)

Western Institute for Social Research. (2015, April). *WISR’s history, mission and the “bigger picture”– past, present and future*. Retrieved February 15, 2021, from <https://www.wisr.edu/about-2/wisrs-mission-and-the-bigger-picture-past-present-and-future/>

Western Institute for Social Research. (n.d.). *About WISR*. Retrieved March 3, 2021, from <https://www.wisr.edu/about-2/about-wisr/>

Whaibeh, E., Mahmoud, H., & Naal, H. (2020). Telemental health in the context of a pandemic: The COVID-19 experience. *Current Treatment Options in Psychiatry*, 7(2), 198-202. <https://doi.org/10.1007/s40501-020-00210-2>

What is a "Good enough mother"? (2016, May 3). By Marilyn Wedge in *Psychology Today*. <https://www.psychologytoday.com/us/blog/suffer-the-children/201605/what-is-good-enough-mother>

Wiederman, M. W. (1998). The state of theory in sex therapy. *Journal of Sex Research*, 35(1), 88-99. <https://doi.org/10.1080/00224499809551919>

Wikimedia Commons. (n.d.). *Amygdala.png [Image]*. Retrieved February 4, 2021, from <https://commons.wikimedia.org/w/index.php?curid=7894800>

Winnicott, D. W. (1989). *Psycho-analytic explorations.* C. Winnicott, R. Shepherd, & M. Davis (Eds.). Harvard University Press.

Winnicott, D. W. (1993). *Talking to parents*. Introduction by T. Berry Brazelton. C. Winnicott, C. Bollas, M. Davis, & R. Shepard (Eds.). Addison-Wesley Publishing

Witten, T. (2016). The intersectional challenges of aging and of being a gender non-conforming adult. *Generations*. 40. 63-70.

Wright, T., & Wright, K. (2017). Exploring the benefits of intersectional feminist social justice approaches in art psychotherapy. *The Arts in Psychotherapy*, *54*, 7-14. <https://doi.org/10.1016/j.aip.2017.02.008>

Yale University. (2020, August 11). *Systematic reviews and evidence synthesis: Review types.* Yale University Library Research Guides. <https://guides.library.yale.edu/searching/review-types>

Yontef, G. (1993). Gestalt therapy: An introduction. In Awareness, dialogue, and process. *Gestalt Journal Press.* Retrieved from <https://www.gestalt.org/yontef.htm>

Zainuddin, G. (2016). Levels of code switching on EFL student’s daily language: Study of language production. *Advances in Language and Literary Studie*s, 7(3). <https://doi.org/10.7575/aiac.alls.v.7n.3p.278>

# Appendix A: Safeguards

**Privacy**

The essence of the HIPAA[[63]](#footnote-63) Privacy Rule[[64]](#footnote-64) is that a client’s Personal Identifying Information (PII) and Personal Health Information (PHI) will not be disclosed without informed consent. My research did not collect PII or PHI. My research inquired about "effectiveness" of theory, methods, and modalities; it did not require discussion of confidential material from cases.

In order to guard against a breach involving inadvertent disclosure by a clinician during the discussion, the interview itself was conducted using the WISR Zoom service. Safeguards were used, in the form of strict permissions that block unauthorized access. While it is not HIPAA-compliant, any and all possible PII or PHI was scrubbed during the transfer from recording to written notes, and the recording was then permanently deleted from the WISR online storage.

The ethics of privacy was extended to respondents. No respondent was identified in the dissertation, nor their place of business, unless there was a signed Informed Consent[[65]](#footnote-65) that stated the permitted identification (i.e., the purpose, limitations, etc.)

**Confidentiality**

Confidentiality[[66]](#footnote-66) of information that was shared by a respondent (during an interview or a conversation) was assured in several ways. All respondents were experienced, licensed clinicians whose training, experience and required education (to maintain an active license) reinforced their understanding and ethics about confidentiality. All but one question avoided entirely any topic through which client confidentiality might be risked; and the one question which invited a clinical story was asked with a reminder to tell it in a manner that protected confidentiality. The interview and discussions via the WISR Zoom service included a signed Informed Consent, secured prior to the start, which specified adherence to the confidentiality principle. Respondent comments were not attributed, and inclusion of the respondent in the Acknowledgments section required documented permission by the respondent (and the agency, if applicable.)

**Full Disclosure**

The purpose of the study was fully disclosed in the letter which invited participation. The letter contained the planned questions. Each respondent was informed that quotes would not be attributed. All respondents were offered a copy of the dissertation as a token of gratitude, as well as a confirmation of integrity and fidelity. The letter explained these options about permission to record: declined, voice only, voice and video.

**Invitation to Participate in Dissertation Research**

[Name and Credential / Contact Information]

Thank you for your interest in participating in my dissertation research for a Doctorate in Education. After the disclosures are read and the informed consent is completed, we can schedule an individual interview. An hour for the conversation is planned.

**Background**

The COVID-19 Pandemic disrupted my psychotherapy practice, as it did for almost everyone, everywhere. I, like a lot of other psychotherapists who had not used video calls to provide services, had a stark choice. Close up shop or change my practice. Now I use Telehealth.

Informal talks with colleagues revealed a lot of “ifs, ands, and buts” to their assessment of psychotherapy done online. The terms used also varied greatly. Here are a few key terms, and a paragraph about the purpose of the study. The interview questions, disclosure and informed consent follow.

**Key Terms**

*First-order change* refers to solutions that do not change the problem, rather they create stability (e.g., strength-based problem-solving.) *Second-order change* transforms the first-order solutions, resulting in a resolution of the problem (e.g., schemas or beliefs change.)[[67]](#footnote-67)

*Transformative psychotherapy* is the term that I use for clinical work for second-order change. *Telehealth* is the term I use for online service, be it audio and/or video.

**The Purpose of the Study**

My dissertation explores the perceptions of clinicians regarding transformative psychotherapy, and differences between the in-person and Telehealth. The question for clinicians, broadly framed, is what works well or not, and why? The pandemic forced the issue to the forefront for many of us. The perceptions of early adopters and late-comers (like myself) could help all of us gain perspective and insight.

**Interview Questions**

1) What was the month and year you began as a licensed psychotherapist, and what was the month and year that you began to use Telehealth to provide psychotherapy?

2) Is the distinction of first-order and second-order change relevant to your practice?

3) Can the distinction be used to describe your methods?

a. What are your methods when the focus is improved ability in daily life?

b. What methods do you use for transformational change?

4) What is your theory about how transformative psychotherapy works?

5) During in-person, transformative psychotherapy:

a. What do you need from the client in order for you to fulfill your role?

b. What does the client need from you to move towards second-order change?

6) Do you modify methods for a Telehealth session?

a. What are the circumstances in which, or kinds of clients for whom, your use of Telehealth enhances transformative psychotherapy?

b. Under what conditions is your use of Telehealth less effective?

c. Can you give an example (with attention to protection of privacy and confidentiality) where you helped a client make transformational change via Telehealth?

7) Would you be interested in participating in a group discussion with clinicians who have been interviewed?

8) Could you introduce me to another licensed therapist, in private practice for five years or longer, for the purpose of being interviewed?

9) May I include you in the Acknowledgments section of the dissertation?

10) May I give you a copy of the dissertation?

Please do not hesitate to contact me with any questions.

I look forward to scheduling our conversation.

Sincerely, Victor Bloomberg, LCSW

**WISR Informed Consent Form**

Principal Investigator: Victor Bloomberg

Title: "Transformative Psychotherapy, In-Person and Telehealth"

WISR Research and Ethics Reviewer:

Informed Consent (45 CFR 46.116(a))

Research Description: My dissertation explores the difference between online and in-person psychotherapy, as viewed by practitioners. I use the order-of-change classification (1.) First-order change is focused on adaptation to a status quo. Second-order change seeks to resolve problems that come from patterns formed in the past; and such transformational psychotherapy is the focus of my dissertation. (1) Fraser, J. S., & Solovey, A. D. (2007). Second-order change in psychotherapy: The golden thread that unifies effective treatments. American Psychological Association.

Risks: There are not psychological, social, or economic risks to the participant, a licensed clinician. Integrity and fidelity to the terms of participation are managed through full disclosure. Each respondent can read the dissertation prior to its publication. The methodology protects the clinician, and their agency (if applicable.) The clinician’s clients are not a subject of study; and an inadvertent disclosure by the clinician is a minimal risk, and if made, it will be de-identified in the dissertation.

Benefits: The collaboration with the clinician, which at minimum is a one-on-one interview followed by the opportunity to read the dissertation, and at maximum will include an opportunity to engage in one or more group conversation(s) with peers, presents the possibility of useful insights for professional practice, as well as growth for the clinician’s professional network.

Alternatives: Not Applicable (N/A)

Confidentiality: Comments by a respondent that are used for the dissertation will not be attributed.

Compensation: There is no compensation for any participant, the student, or WISR.

Contact: Victor Bloomberg, LCSW:

Voluntary Participation Signature and Date:

**Recording Consent**

The Purpose of Recording

This is an addendum to the Informed Consent. Privacy and Confidentiality are defined. This is consent for recording of streaming conversation via the WISR Zoom service, which is not HIPAA-compliant. Strict permissions limit access to only authorized persons. Recording is a method to take notes that is used by Victor Bloomberg, LCSW. Any and all confidential information that can be reasonably considered confidential or private will be scrubbed from the recording before it is stored in an offline drive; and then the recording will be permanently deleted from the WISR Zoom service.

The use of any audio/video segment of the recording, apart from its purpose as a form of notes for the written dissertation, shall require a separate agreement.

Consent Options: No recording | Voice Recording | Voice and Video

Participant’s Name:

WISR Representative:

Doctoral Student: Victor Bloomberg, LCSW

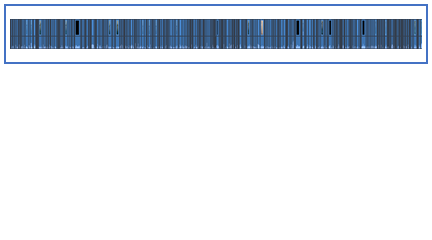
# Appendix B: Interview, Recording to Text

Here are some of the lessons I learned about the creation of audio clips from a streaming conversation. This could be useful to a person or group that imagines using recordings to create educational material, but who do not have money to hire professionals.

Twenty-three interviews were more than I had hoped for, and permission to record was given by twenty-two respondents. There were a lot of interviews to put into writing. The bountiful harvest made it necessary to create a work plan to handle the load.

As I thought about my work plan, I had thoughts about future, possible uses of the recordings for educational purposes. After all, it would be a lot of work for “one and done.” Video clips, I quickly realized, could not be used because people had not prepared themselves for that kind of presentation. But the audio might be usable were there a clear purpose, adequate quality, and a new permission from any respondent whose audio might be used.

I learned-by-doing, using a low-cost video editing app for a Macintosh Operating System (OS) and a free app for editing sound on Windows OS. This is a graphic representation of the first stage of work:

I edited each video recording of an interview, which brought it down from roughly an hour to about 20 minutes. It was a lot of work, for several reasons. A conversation goes back-and-forth, and sometimes loops back to an earlier part to add a thought. The first thing to do, was put thoughts that belong together in the right place in terms of the interview sequence; and to remove almost all of my comments. Next, there are a lot of “um”, “uh”, stutters, ping-pong or pinball-type thoughts, and silences as people thought aloud. Those needed to be removed for each recording.

I could have used the edited video like a tape recording, play a little, type, and repeat. But the sound was hard to follow. Sometimes audio was loud or soft, fast or slow. I needed to even it out, just to type from it. Why not use speech-to-text, so as to reduce the amount of typing involved? Well, the Mac, low-cost, video editor’s audio functions were not very good. I had a better one on my Windows. So I converted the audio track for Windows, processed it to even out the sound, and then created a Mac-friendly file.

I used the Mac to play the audio and Windows to transcribe. A good quality microphone was set next to a sound bar (six feet away from the computers.)

Transcription did not go smoothly. “Smoothing” the sound for my ear was not good enough for the computer which has “dog ears.” It picks up sound waves that are inaudible to me. Sometimes I needed to use the keyboard to mute soundwaves from electronic reverberation or two persons talking at the same time. I learned to put a sound-free, 1-second “space” between sentences. It seemed to help computer “buffering” and do speech-to-text for a segment, and it helped me pause the recording and turn transcription on and off.

Unlike online transcription that can use machine-learning to build a dictionary and even learn context, speech-to-text that is part of a Windows computer does not learn words or context. It was sometimes funny, the transcription results.

I was able to create audio clips and seek permission to use them. I think this is a good way to develop interesting educational material, substituting sweat equity for money.

# Appendix C: The Interviews

The abridged transcripts give a fuller picture of the respondents’ answers. I did not include comments about work with children, families or other situations outside the scope of my inquiry. Each respondent was given an opportunity to say, “Take that out.” That material was removed.

[Interview One. #11-20210315](#_Interview_One._#11-20210315)

[Interview Two. #12-20210319](#_Interview_Two._#12-20210319)

[Interview Three. #13-20210319](#_Interview_Three._#13-20210319)

[Interview Four. #14-20210323](#_Interview_Four._#14-20210323)

[Interview Five. #15-20210323](#_Interview_Five._#15-20210323)

[Interview Six. #16-20210323](#_Interview_Six._#16-20210323)

[Interview Seven. #17-210325](#_Interview_Seven._#17-210325)

[Interview Eight. #18-210329](#_Interview_Eight._#18-210329)

[Interview Nine. #19-210330](#_Interview_Nine._#19-210330)

[Interview Ten. #20-210409](#_Interview_Ten._#20-210409)

[Interview Eleven. #21-210401](#_Interview_Eleven._#21-210401)

[Interview Twelve. #22-210402](#_Interview_Twelve._#22-210402)

[Interview Thirteen. #23-210402](#_Interview_Thirteen._#23-210402)

[Interview Fourteen. #24-210402](#_Interview_Fourteen._#24-210402)

[Interview Fifteen. #25-210406](#_Interview_Fifteen._#25-210406)

[Interview Sixteen. #26-210407](#_Interview_Sixteen._#26-210407)

[Interview Seventeen. #27-210409](#_Interview_Seventeen._#27-210409)

[Interview Eighteen. #28-210409](#_Interview_Eighteen._#28-210409)

[Interview Nineteen. #29-210412](#_Interview_Nineteen._#29-210412)

[Interview Twenty. #30-210413](#_Interview_Twenty._#30-210413)

[Interview Twenty-one. #31-210319](#_Interview_Twenty-one._#31-210319)

[Interview Twenty-two. #32-210420](#_Interview_Twenty-two._#32-210420)

[Interview Twenty-three. #33-210426](#_Interview_Twenty-three._#33-210426)

Interview One. #11-20210315

Question 2. Is the distinction of first-order and second-order change relevant to your practice?

Oh yes, yes. So before the pandemic, the hope of psychotherapy with me was to be transformative with people. Since the pandemic it has massively switched to the first order, people needing direct support, health check-ins, and improved coping strategies. It’s been general emotional support and it’s been personally draining. Because you know it’s a very different kind of exercise. Before the pandemic, I say to the best of my ability and under the right circumstances, I was trying to do inside oriented psychodynamic therapy. And from many it was successful and it was very satisfying.

Question 3(a) What are your methods when the focus is on improving stability in daily life?

Let’s add mindfulness and personal self-awareness to all those daily habits that allow people to stay in the moment, reduce anxiety, teach deep breathing, progressive relaxation. We do deep relaxation and body scans. You pretty much do whatever the clients need to do because people are in crisis. They are suffering and it’s not correct to ignore that. People can’t deal with being insight-oriented when they’re crying, so afraid they can’t leave their house. You have got to be very flexible and listen very carefully to what the person needs at this time and give gentle, regular reminders to live the healthiest life that they can live. For a lot of single people living alone, I was like the only person not work-related that they were talking to. And it became completely just support therapy. At times I thought, “What the heck am I doing here? You know this is not this is not psychotherapy.” But you know what? At this time it was, because without a daily check in with me, you know people went awry. So things changed.

Question 3(b) What methods do you use for transformational change?

When I was in my training, I remember this really good child psychoanalyst and I had a weekly supervision group with him. He said, “Just listen for the first 15 minutes.” It was really hard at first. Then you know what? It was everything, because people would start with the day and they would kind of go on and then if you just let people lead themselves, they would get to a much more pressing issue. Now I have to say I’m not so good at that right now because you know people are just talking about their day, their daily struggles. But that was always a really helpful supervision tip. Yep, just let people come in and get into their stuff and it seemed to work.

I’m a huge proponent of people being trained in development, emotional development across the lifespan. When growth is happening, when and what does it look like – and when it didn't happen. Also social development. I'm not kidding. Every time somebody is talking to me, I am putting it into that understanding. Where is this person now and what is the conflict? Where should they be? What do we need to do to help this person get there emotionally? What coping mechanisms do they have? In my work, I always put that kind of a frame first and it’s very helpful. You can get somebody in who is incredibly upset and you think they’re psychotic, but if you do get a good history and you understand theory and development, you can very quickly get to a person’s main issues.

Question 4. What is your theory about how transformative psychotherapy works?

How does transformative therapy work? Okay, so you know, thank God, after 30 years I have my own thoughts about that. It’s always really amazing to me that people change because they forgive themselves. They can love themselves. It starts with the therapist’s empathy towards the person’s dilemma. And I explain it back, supporting that part of them that was hurt or mistreated, and that they haven’t shut off themselves. Some psychotherapy works and some doesn’t, because the therapist needs to be able to know where the patient is stuck or hurt in their development, and then to gently focus on that. Make it more meaningful, change the meaning of it, and the experience of it for the person. So like lots of abused women will start to feel badly about their inner child, they start to feel sorry for the little girl that used to be, and then slowly they can empower the woman they are now.

Question 5(a) What do you need from the client in order for you to fulfill your role?

A couple of understandings, an agreement. It’s an understanding that you know that I am there for them and all these ways, but that they also need to show up they need to be honest. They need to just try their best. That’s it you know. I do explain the finance to people. Coming to the appointments is very important, because sometimes you know we want to avoid talking or feeling things. Many people that’s when they will miss or cancel or no-show. Or when they are feeling and doing well, those are super good times for sessions. Even if they feel there's nothing to talk about those days, it can sometimes be the most fruitful ever - because there's no crisis. People can actually just settle into what they were thinking about, with or what you’re feeling. So the biggest thing from people is just this honesty. Sometimes that developmentally is very hard for people. They’ve never been honest. They fake it or put on a different face.

Question 5(b) What does the client need from you to move towards second-order change?

What does the client need from me? I really believe that it is the empathy and the understanding of the patient. They’ll be talking about their life and maybe some maltreatment or abuse they suffered, but it’s my empathic reaction to what they experience that they stop and realize, “Oh, that was not normal.”

Question 6. Do you modify methods for a Telehealth session?

Our clients can’t give us what we need to fill this role when they are in crisis and it’s Telehealth. It is not clear that there can be transformative work done with Telehealth. I’m not ruling it out 100%. Many people have trouble with their devices, getting us tuned in. Then there’s a lot of interference, bad connections. It is much better in person, but you can’t beat the convenience... It’s complicated… I’ve seen weird depressive, suicidal ideations, and situations - because of the isolation. Yes, it’s been horrible. The pandemic has been created in all these kids that I see, so many kids in junior high and high school and I have several college kids, their anxiety is so terrible. The way to treat anxiety is not some insight. It’s coaching, behavioral change, sometimes a medication consult, changing your daily patterns in life. The work is very different.

Question 6(a) What are the circumstances in which, or kinds of clients for whom, your use of Telehealth enhances transformative psychotherapy?

Let me think about that. I don’t know if Telehealth is ever like the number one ingredient of change. I found that a lot of my patients were longer term and we then suddenly had to change from face-to-face to Telehealth, it may have encouraged a little bit more independent functioning. It may be independent problem solving. Here’s another thing to do when you’re in a long-term psychotherapy relationship, it’s not a bad idea when people say, “You know, I think I need a break, I want to apply what I learned.” Developmentally, people need to practice and see how they do, based on where they are now. That’s always a good thing, So maybe in some weird way, Telehealth has thrust itself on therapy experience in a very similar way. It’s like that the patient doesn’t have access to me or the process like they used to. It’s still there in a way, but it’s different. And I haven’t had anybody fall apart going from face-to-face to Telehealth. Maybe it’s just timing.

Question 6(b) Under what conditions is your use of Telehealth less effective?

Where it doesn’t work… [the younger people who are] depressed, isolated, lonely and [they] take it to something’s wrong with them, etc. … I ask every single person, “Did you get out of the house today?” No. It’s terrible. It creates an invalid isolated life… they just need the real face-to-face social.

Question 6(c) Can you give an example (with attention to protection of privacy and confidentiality) where you helped a client make transformational change via Telehealth?

This is a young mother with two little ones. Her husband was in tech [and is hyper, self-absorbed]. Theirs is not a gratifying relationship. She came out of terrible poverty, had an alcoholic father and an emotionally disturbed mother. Her parents were immigrants. She got herself out of that situation by going to college and then she met this guy. She really did feel that he was like the American dream and if she married him her life would be perfect. She didn’t look much farther than that. Now, years later, the stress is pretty bad. I saw her in the office for a year and a half before the pandemic hit. She came in and we worked through a lot together. It really freed her up. She made great strides. It was often very painful. She worked really hard to stay aware of her feelings, to try to make some healthy changes. To allow herself to like to take a walk every day. They were important little steps. But, COVID happened. She did not have a laptop even though her husband was successful in tech. She had to barricade herself in her room to keep the boundaries with her preschoolers. They wanted her. She’d let sessions be interrupted. She stopped that to have her session. Man, that became the beginning of a lot of change. She began to recognize that she sacrificed excessively. And I think Telehealth required her to practice the stuff we talked about. Maybe coming into the office became comfortable, going over how bad things are. Then there was a shift, “I need to make my life better.” She is a changed woman. She is not a victim. She asserts herself. She tells her husband what she needs. She asks things of him. She sticks with it. Her relationship with her children is much better, because she’s much calmer. She realized that she was becoming, acting like her own mother to her own little girls. And it killed her when she realized that. Telehealth came at the right moment. She was strong enough on her own to really start practicing and becoming the life she wanted. Yeah, it wasn’t even screen to screen. It was just a cell phone. That’s it. She and I now meet once a month. And that’s all her own doing. First, she went every other week. Then she started to miss. Things came up. To me, it is always a sign of the client not needing it as much. She was resuming her life. And she was stronger. It’s been incredibly rewarding, and her life is better. The best outcome so far with Telehealth.

Interview Two. #12-20210319

Question 2. Is the distinction of first-order and second-order change relevant to your practice?

First order change is change without change. Basically, the client continues with what they are doing, adjusting it, fine tuning it. It’s more in the realm of counseling, coaching and problem solving. Second order change, the depth of that is real change. Substantial change comes from having some kind of epiphany, an interpretation of a point of view that is truly illuminating. It helps people adjust their sense of self.

Question 3(a) What are your methods when the focus is on improved ability in daily life?

Helping a client become self-aware, that is asking them to report on themselves. Sometimes you don’t have to ask questions, because what comes out is what’s urgent for them. Within that, asking focusing questions, highlighting the depth. There’s asking for nuance. The premise is that it was always there to be seen, but it wasn’t necessarily noted and integrated consciously. “Your dad always did that,” and then you look at it and realize that he probably did it because of that. It’s kind of amplifying what they already see. Getting closer to the picture. That’s the first order, a lot of interactions can be about that and be extremely useful.

Question 3(b) What methods do you use for transformational change?

Sometimes the client gets there anyway. As a therapist, that’s a facilitative process to get them to talk more, more deeply. A more directive thing I do is give an interpretation which is a purposeful redefinition, changing perspective. That could be something as simple as you describe a scenario with your parents and I might say, “That sounds abusive.” They might be able to describe something in the here and now that’s problematic. The question might be, “Where did you get that from?” That becomes a second order change rather than, “I do something stupid that doesn’t work for me and I’m screwed up.” It becomes, “I’m actually replicating a family dynamic.” The next level would be, “How aware are you that you are copying, do you realize you married your mother?” They laugh and go, “Oh my gosh!” It’s opening a door and going into a room that was always there. It’s a new way of seeing the same thing. You’ve passively lived your life, now you respond to the challenge. Someone will talk about their behavior and choices and be down on themselves. The feedback might be, “Wow, that’s how you survived and you know you have a right to survive.” You give yourself the right to survive. You were three, four, five, six years old. You did the best you could. So you perpetuated that, but it doesn’t help you survive anymore. It’s a reframe which is incredibly important. I’m not screwed up versus I’m pretty good, I survived. Now I’m good enough to find a new way to survive.

Question 4. What is your theory about how transformative psychotherapy works?

There are many theories. You hit upon or explore the way that works for the client. It has to do with what their needs are. For some people it’s, “Here’s someone who is caring and listening,” validating your worth and who you want to be. Caring and validating who you are is transformative because their experience is they haven’t been heard, they haven’t been cared for, and they don’t feel they matter. It’s attachment theory, proximity, availability, ability to be a nurturing parent. It’s a traditional transference aspect, I’m an older male with paternal energy. There's been times I've had clients with an emotionally unavailable father and the transformative is here’s a male authority figure who is non-sexualized and intimate, who actually cares and pays attention. That’s incredibly transformative for that person, because “Oh, that’s what it feels like.” … For others, it’s transformative awareness … That allows you to do something about it. “When you are anxious, where do you feel it in your body?” It’s based on the fight-flight response, … Related to awareness, but different, is insight. This is where it comes from, this is how it makes sense. … There’s a transformative aspect of narrative therapy, articulating a coherent story that’s an alternative to false stories like, “Everything is scary and out of control.” The alternative is, “I want control because my family is chaotic.” Psychoeducational can be transformative. The transformative part is kind of like Archimedes said. If you give them a lever long enough and a place to stand, you can move the earth. So you have to find the right lever. … I’m a bloodhound therapist. I follow the scent. If the blood leads to trauma, I’m going to do trauma work. If the blood leads to attachment stuff, I’ll do attachment stuff. If it leads to cross-cultural stuff, that’s what I will do. Here you have someone in front of you, the client. You really want to understand and get to know them. That by itself can be incredibly transformative. Even though I am driving from the client, I do have my preferred assessments. I don’t meander all over the place, I have experience. I have perspective. I am knowledgeable. You look at the pattern and you look at the now, I do both. And I am more interested in the depth. The problem is the problem. Bob Newhart said, “Stop it!” They already know what they’re doing, they shouldn’t.

Question 5(a) What do you need from the client in order for you to fulfill your role?

I need them to be invested in the growth and change. A teenager brought in by their family or a court mandated adult often isn’t invested. Second thing is they have to be relatively introspective, in other words be able to go into themselves. Insight comes after. The next one is the ability to be vulnerable, to go into those places to be sad, to be hurt. The fourth is being connected to their feelings. That’s why vulnerability is such a big deal. Then the last part is the ability to articulate. Some people don’t have the words to articulate what they are feeling. That’s why I swear. They talk about all of the stuff that’s going on. The feedback, the insight is, “That’s really fucked up.” And they go, “Yeah.” That’s an emotional articulation. They need to be invested, vulnerable, introspective, and articulate. Self-disclosure works. People have different feelings and thoughts about that. The thing I tell therapists is to be like Aesop. There needs to be a moral to the fable. Every time he ends a story, he says the moral of the story.

Question 5(b) What does the client need from you to move towards second-order change?

I have a humanistic tradition. Be authentic and real. So the realness. So what do they need from me? It’s kind of funny because it’s so damn obvious. They need me to care, want to care, to be interested in them. Which is why it’s a challenge when there’s a client that I don’t like. That speaks to issues that are much deeper. They need me to really care and be really interested, and to be really honest and genuine. You could trust me to give honest feedback with compassion and sensitivity. The feedback will come without implicit or explicit judgment or condemnation. The trepidation that they bring into therapy is that they’ve been judged. They’ve been condemned. And they do it to themselves. They need me not to double down on that and at the same time not paralyze myself for fear of judging. Sometimes I prepare them and say, “This is going to sound naïve or kind of ‘judgy’ or sexist.” So she’s ready for it, prepared for it. It’s not discounting and not being paralyzed. Much of that is metaphoric to parenting. The parent gives you boundaries and guidance that’s difficult to hear sometimes. And as they know that it comes with caring and compassion, they tell you. They need that energy from you. They need me to know that I’m real, that I care, I’m honest. They need to know that I won’t hold back. I’ll do it in a diplomatic fashion. They can’t be dishonest with themselves and in the relationship. It was uncomfortable because I wasn’t going along with their deception. In a healthy therapy when someone is lying to themselves and deceiving themselves, as I confront them in a way that they can own it, it becomes part of the transformative process. I am a supportive therapist, but I’m not from the unconditional positive regard. If you’re being an idiot and causing pain to the people around you, I’m not going to validate that. You need honesty. That doesn’t mean that I shame you. If I don’t tell you something, I’m implying you can’t handle it. If I tell you, I’m implying that you are strong and powerful. That takes skill. I need to therapeutically punch you in the face and for you to say thank you, because I do it so well. Compassion, skill and there is a foundation of knowledge. I would like to be fearless, but I’m human. I need to be comfortable with fear. It’s a clue. If I feel fear, that means I need to go into it. The truism is that a client will make you feel how they feel.

Question 6(a) What are the circumstances in which, or kinds of clients for whom, your use of Telehealth enhances transformative psychotherapy?

Functionally, the simple easy answer for that is for clients who live far away. Telehealth is amazing. There are clients who I wouldn’t even see. It would be 2 ½ hours to see me with the drive plus the session. Now, they just see me. … The practicality of business is good for the continuity of therapy. People who are roughly mid-thirties and younger, they are so used to video conferencing it doesn’t throw them off nearly as somebody in their mid-fifties. That’s how it has actually been beneficial. From attachment theory, proximity, availability, nurturance, so we’re available. [hat] is therapeutically very powerful.

Question 6(b) Under what conditions is your use of Telehealth less effective?

You see less cues, you cannot see the whole body. On the other side, I can see the home. But I don’t see all of the nonverbal cues that I see from the body. I can’t see them shaking their foot or that nervous tension in the lower part of the body. I can’t see the posture as clearly. And, I can’t smell them. Sometimes smell is important. It could be body odors, perfume or whatever else. There’s therapeutic information from walking up to the waiting room and seeing what they’re doing, the magazine they’re reading, how they’re sitting. On the other hand, it is what it is. Clients will withhold information from you anyway. I don’t know what I miss on Telehealth, I can’t tell. There was a young woman, for example, who came into the office with a low-cut top and hot pants. This was many years ago. Those clues, online, who would see those clues? Here she was meeting this new male authority figure, and dressed in a way that was inappropriate. I asked her in the first few minutes if she’d been molested? She had been...

Question 6(c) Can you give an example (with attention to protection of privacy and confidentiality) where you helped a client make transformational change via Telehealth?

There’s a person and I only saw her on video. She went from having issues with her husband, conflict over parenting, unhappy with her job situation, and it worked. She was able to express all the things that weren't working. It worked to ask her about the family dynamic, traumatic experiences she had growing up, the dysfunctional experiences she had from their parenting, and how and why she got into this relationship with this guy. How and why it wasn’t working. How and why she had an affair. She was able to problem-solve it. She felt heard and she felt listened to. She got more depth of understanding. She was able to work through her options. She changed her job. She’s almost done with her divorce. She’s changed her life significantly. Half of the process is having someone, me, listen to her, hear her. There was an issue with emotionally unavailable adult figures, mother and father… She’s moved along quite a bit. That starts with paying attention to her. The feedback is helpful too. In terms of relatedness, there was shared cultural experience. In the beginning I asked her, “You picked me, does that have anything to do with me sharing your culture as well?” That part is about knowledge and experience about cultural stuff. She said, “No not really.” After the first session, I told her, “There’s a hell of a lot of relevance.” She got it.

Interview Three. #13-20210319

Question 2. Is the distinction of first-order and second-order change relevant to your practice? Does the distinction matter?

First off, I approach everything from a complex systems approach. There is nothing that is not interconnected with everything else. … What you describe as strength-based problem solving versus transformative, I describe as the difference between counseling and psychotherapy. I think there is a lack of clarity when people use the terms interchangeably. There is a point at which along the continuum between counseling and psychotherapy at which a crossover - one into the other - occurs depending on whether we are focusing upon personal coaching improvement or on fundamental personal change factors. …

Question 3(a) What are your methods when the focus is on improved ability in daily life?

I work by a fundamental rule in person-centered approaches. I fit the therapy to the person. Never fit the person to the therapy... What the client wants to know is that they can have confidence in you, their psychotherapist. So if your school of thought helps you feel confident, then it matters, but the client only cares that they think you’re competent and they have confidence in you. That’s one of the factors. The other factors are Carl Rogers’ fundamental conditions for therapeutic growth. These are unconditional positive regard, active and authentic presence, listening, seeing a person as they are, creating a safe place and being competent. If you’re doing those in therapy, the client will create change.

Question 3(b) What methods do you use for transformational change?

Rogerian conditions for therapeutic growth. You have to be absolutely aware, there is never nothing going on…

Question 4. What is your theory about how transformative psychotherapy works?

As a therapist you have to be absolutely aware, there is never a time that nothing is going on. If you can get to a point where somebody arrives at this aha moment, this epiphany moment, this insight moment… You focus on that…

Question 5(a) What do you need from the client in order for you to fulfill your role?

You have to have a certain level of commitment to their own growth. I can’t help you do anything if you’re not in the game…

Question 5(b) What does the client need from you to move towards second-order change?

My job is to be your [sensei], somebody who has walked the path and … showing them along the way to notice this or that…

Question 6(a) What are the circumstances in which, or kinds of clients for whom, your use of Telehealth enhances transformative psychotherapy?

I would have had a different answer before the pandemic. Before the pandemic I might have said somebody who’s comfortable with technology, somebody who's comfortable with this detachedness that’s forced upon you by the medium. All of that is true. All of that became irrelevant a year ago. It was either do it or not. The client has to want it enough to get comfortable with the discomfort of the modality. That adds a level of personal commitment to doing the work. The medium can lead them to increase their investment.

Question 6(b) Under what conditions is your use of Telehealth less effective?

If their belief is that this modality won’t work, they’ll not use it. If they don’t want it enough, they will use their discomfort with the modality to stop them...

Interview Four. #14-20210323

Question 2. Is the distinction of first-order and second-order change relevant to your practice?

Absolutely. It starts with the first phone call. I ask, “What is it you are looking for? What is it you want to achieve by coming to therapy?” We go from there. Sometimes they are not feeling very stable, maybe there’s been a death or there’s an acute issue. Sometimes, which is my favorite, they say, “Well, I’m not really happy. I’d like to look at why and explore that.”

Question 3(a) What are your methods when the focus is on improved ability in daily life?

Clarification and identification of what the problem is from the client’s perspective. My perspective comes in a little, but not initially. After that is thoroughly understood by both of us, then we come up with solution-oriented plans. That’s when I say, “Have you thought about this? Do you think this might help?”

Question 3(b) What methods do you use for transformational change?

Looking at times when they were happy and what’s changed. What is getting in the way? Looking at belief systems and bringing in their past, their experiences. What’s making it difficult for them, what’s getting in the way for them to be happy. Identifying what happiness would look like for them.

Question 4. What is your theory about how transformative psychotherapy works?

I think what works is that if the client really feels heard and that’s really modeled for them then they can really hear themselves. They can be okay and not so judgmental in their head. It allows them to not be afraid. It affects change. It’s a relationship, the feel in the room. I always felt it meant you are in the room that there's safety and trust. Actually there was a feeling going on. There's safety and the client can start to relax. Trust in themselves grows. That affects change.

Question 5(a) What do you need from the client in order for you to fulfill your role?

I need the client’s engagement. Ability to trust. Commitment to the process. I need their ability to have insight. They can have cognitive limitations. I work with developmentally disabled clients. They need to have the ability to have insight, whatever that means for them, to grow in that ability.

Question 5(b) What does the client need from you to move towards second-order change?

The client needs to be assured that I’m gonna be there where they’re at, that I’m not going to get ahead of them. Not going to tell them what to do. I’m not going to drag behind. They need to trust that. And they need to feel some sort of relatability. I think as a person I really do. They need to have some sort of relatability, whatever it is.

Question 6(a) What are the circumstances in which, or kinds of clients for whom, your use of Telehealth enhances transformative psychotherapy?

This is a hard question. I want to answer that I can reach out to people who are homebound. I want to answer that it is concrete. It feels like I can’t give you a psychotherapy kind of answer. Really literally right now I just think that Telehealth allows us to reach folks who we otherwise might not be able to. And that’s all kinds of folks. That’s folks who are elderly and can’t drive. How is it really helpful? Maybe I’m having more trouble with Telehealth because all of my belief systems in my work up until now are getting in the way of my insight. How awesome to be able to validate someone who’s had this experience [of isolation] for a long time and now somebody else gets that. Actually being able to speak to that and going to the office wouldn’t have honored that deep feeling of loneliness they’ve always had, because they’ve always been homebound and somehow, they get to an office. Maybe I’m feeling more isolated.

Question 6(b) Under what conditions is your use of Telehealth less effective?

In the last year many have expressed feeling less safe than in the office. Their environment isn’t completely confidential. It’s harder for them to open up. It’s harder for them to do the work. That’s especially important if you work with domestic violence folks. I have a client who uses it because she is so lonely. She answers my call, but she doesn’t take it as seriously, and isn't as committed. Telehealth allows her to have more freedom in that area. Coming to my office is more of a commitment for her.

Question 6(c) Can you give an example (with attention to protection of privacy and confidentiality. where you helped a client make transformational change via Telehealth?

I have a young client and I Telehealth while he is in his car. He always goes to the same parking spot where there’s not a lot of people and he’s not around his roommates. We talk an awful lot about how he was abused as a young boy and emotionally not respected as a young boy. I think there is more freedom to talk. I had seen him a couple for years in my office and then we had a break. Then he requested support therapy on Telehealth. I notice the differences with him. He was not quite as safe in person. I at one time wondered if it was a female to male but I didn’t talk to him about that. I don’t know that, but I wondered. He really quickly gets to an understanding or an insight about why he is anxious when he’s around people. He didn’t have the opportunity to be relaxed and have fun around people when he was younger. He adjusted so negatively with the self-judgment because it is the old tapes of his parents. He gets to that quicker when he’s in his car in the parking lot in this spot where he always goes. He feels safer than when he was in the office while he’s talking on the phone. We are videoing on the phone.

I wonder if it’s like being in the car and feeling freer to scream and holler at people or give people the finger. If we were in a car surrounding us it’s like a free ticket.

Interview Five. #15-20210323

Question 2. Is the distinction of first-order and second-order change relevant to your practice?

It depends upon how long I’ve been working with someone. For example, if I’m doing long term therapy and now the only way that I can meet with this person is online then we can pretty much continue the way we were talking in the way we were exploring thoughts and feelings, and defensive orientation. When I meet a brand-new person, a brand-new patient, I ask them if they can come to the office so I can at least see them and feel them and begin the process of creating a bond with them. Then I give them the choice of coming online or coming to the office. I’d say about 50% of the people come online, and the others want to come in in-person. I’ve been very fortunate to be well throughout the quarantine myself. And I can take all the precautions in my office. So if online is not a fit, in person work doesn’t feel dangerous to me.

Question 3(a) What are your methods when the focus is on improved ability in daily life?

I’ve been trained in mentalization. It was developed by Peter Fonagy. And I always begin with listening to their narrative. I’m wanting to know how they’re coping as well as not coping. And I am wanting to know how aware they are of themselves as an agent. Shall I give you an example of what I mean? My referral came from a physician. A lady patient is having postpartum depression. So first of all, I met her in person. And I listen to her story of the gestation of her baby, and the birth of her baby, 2 to 3 weeks of good health, and then she is socked with a pretty severe postpartum depression. So we have got to problem-solve how is she going to manage the baby enough to care for the other child? We end up working together with her husband who is now out of work and at home trying to help her with the children, but pretty depressed himself because he can’t work and bring home an income. They’re in a lot of distress. We’re doing problem-solving for organizing every kind of resource we can think of. We’re just resourcing. What would be helpful, where can she get it? It’s kind of a little bit more like social work. I’m working very hard to create a bond with her. So during the course of our Telehealth work, daddy comes into the room with the baby. The new baby is crying and he said, “I cannot handle her,” and so she says to me, “Do you mind if I nurse her?” I said, “Heavens no, go ahead.” So we’re doing direct supportive psychotherapy, coping skills and she’s nursing the baby. And I’m enjoying this beautiful, beautiful child and getting reinforcement with her about how beautiful the baby really is. So now listen to this, it’s like a stack of Russian dolls. It’s a visual metaphor for how we are trying to bond with each other. She is nursing her baby and I am providing support to her kind of like grandma. We are admiring the baby and thinking about various resources for her so that she has a little more time for herself to do some very basic things like go walking, go to the grocery store, go to the doctor, this sort of thing. Now that is just problem solving.

Question 3(b) What methods do you use for transformational change?

She has a great deal of insight and so it doesn’t take very long for us once we create a bond to begin to talk about her internal world. And how she’s coping with this much depression, a new baby, and a 3- or 4-year-old, all at the same time. And her husband is so upset about work. And you meld the two together. The problem solving is the scaffolding of the work, for the insight, especially being able to help her with her sense of herself and her depressive orientation. The insight, she has the capability for that, so we can go there.

Question 4. What is your theory about how transformative psychotherapy works?

I’m trained in the psychoanalytic method. I was fortunate, I was at the first two international congresses of infant psychiatry in Portugal and London, and got in on very early work on attachment theory, and infant life development, how the mind evolves. That really struck home with me that the study of personality, the study of defensive orientation, the study of mind has been a personal interest as well as a professional interest. I was at the Anna Freud Center when Miss Freud was still alive, that was in 1979, 80 and 81. I had the honor to experience the presence of Anna Freud and study how the ego defenses evolve. That was quite an experience. She was quite elderly at the time that I was there.

And I do EMDR. I consider that a transformative psychotherapy, because we really get into ego constructs. Very often I am using what I call transformational work when I am doing trauma work. I am very interested in the display of ego in problem solving skills but from the point of view of self and self-integration that is so well revealed. So I have found myself doing a great deal of that during the quarantine. However, I do not do EMDR online. I need to really see what the individual’s body is doing, in order to know how to use the procedure the best. And I think the people who do it do it successfully online, they are diffusing trauma and they are problem-solving. It would be very hard for me to imagine how you do deep explorative work and integrative work with EMDR online. It is perfectly possible to do that with somebody in the chair with you.

Question 5(a) What do you need from the client in order for you to fulfill your role?

Well you know, some people think they’re coming to therapy just to see a therapist as in, “I’m seeing a therapist,” but it doesn’t mean they’re working with one. And for some folks, who really are avoidant attachers, it takes a long time to feel the bond. I’m working with a lady who has a narcissistic personality disorder. I saw her in the office and then we switched as soon as a quarantine went into effect. She has several health issues and it was a good decision. It took probably 6 months this past year for me to feel a bond with her.

Question 5(b) What does the client need from you to move towards second-order change?

I’m using a great deal of empathy. First of all, I have to welcome them into my environment here and listen to their narrative, to hear what they have to say. How they frame their issues, how they frame themselves, how they frame their bewilderment. I need to listen for key kinds of words. Including when they say, “I don’t know, I just don’t know, I don’t know why I do that.” Because what I’m doing is using a great deal of empathy as I am listening to their narrative, I am establishing a bond. The bond is going to be critical to our work, for as long as it lasts. Now, of course, some patients will not let me do that. They are pushing me away; I can feel that and that’s diagnostic. And here’s how it’s diagnostic. An individual who is pushing me away is not going to let me be very explorative. So I have to stay on the surface with empathy for a while. I listen to their explanation as to why they’re here, what their commitment is, what they’re willing to contribute to the work.

Question 6. Do you modify methods for a Telehealth session?

I’m working with mommy and there’s no peace in the house. She goes out to the garage and finds a beach chair. She drags it out to the alley, gets out her iPad, and we proceed to have our session. Well, we’re in the middle of the session and down the alley is a big black dog who comes over and gives her a kiss and gives me one too. That’s a surprise! The dog probably knew her. We just laughed for about 5 minutes and called it therapy. Well, I’ll tell you the one thing I have noticed over this past year is that I’ve become much more personal with my folks. You know, when you’re trained in the psychoanalytic orientation, you are very careful about transference, very careful about personal comments, jokes, and that sort of thing. Well I’ve gotten over that, big time, and it’s made therapy so much more interesting to me, to really become not only a purpose but much more of a pleasure. Of course, I’m an older therapist and I can take more privileges with people. You're either mom or grandma, depending how old you are. There is a little more privilege that goes along with that in terms of being more direct when you need to be, setting boundaries when you need to, and also being kind and careful with people’s feelings. You balance that out more, I think, when you’re a little bit older.

I just wanted to comment that I took a 2-day training in Telehealth which gave me a certification. I spent 2 days learning how HIPAA works on the Internet. It did nothing to enhance my therapeutic skills and I was so glad to have had the background of theory of the mind. I think Telehealth education has got to find a way to teach psychotherapeutic theory, as well as being so protective of privacy.

Question 6(a) What are the circumstances in which, or kinds of clients for whom, your use of Telehealth enhances transformative psychotherapy?

It was out of necessity. A patient was reassigned to the east coast by the military. We would have had to stop transformative work right in the middle of the game. It started out with trauma, PTSD work. And then it transcended to ego development type work. The person had to leave and go to the other end of the country. Were able to keep our alliance, to keep our bond, to keep our work going thanks to Telehealth. It would have been very disruptive to both of us if we have to break up so to speak. So that was really a gift, to be able to continue the work . Another example are mostly women, not men so much, but women at home with their children. Their children are not in school. Somebody has to be in the house with them. And although we can really get interrupted by the kids coming and going, at least we get to do problem-solving things together thanks to Telehealth. They would not get therapy, I’m pretty sure, beyond their friendships, if we didn’t have Telehealth. So that is another example, parents at home. She has to be there with her children and she can at least talk in a supportive way with me.

Question 6(b)Under what conditions is your use of Telehealth less effective?

Where I have had difficulty with is when I am working with personality pathology, like narcissistic and I have a few borderline patients. I can’t see them well enough; I can’t feel them well enough when they begin their shifts, their abandonment worries and so on. So I fumble, fumble around more, and am more awkward in trying to reach what they’re feeling. This is with personality pathology. So anytime I can talk them into coming into the office, I do my best. But we carry on, it’s like a port in the storm.

Question 6(c) Can you give an example (with attention to protection of privacy and confidentiality) where you helped a client make transformational change via Telehealth?

This person has a narcissistic orientation, this person would dominate the sessions with talk, and I could not feel this individual coming into an alliance with me. Highly intellectualized, cogent, certainly not crazy. But, dominating the attachment by, in truth, avoiding me. I’ve been using mentalization approaches, which are really based on a balance of empathy and teaching somebody how to feel. So over time, we’ve been working together for about 8 months now. Over time, I can really feel what this individual is telling me, which is greatly enhancing my ability to focus on her. She is willing to just come closer to the screen. We’ve both come closer to the screen. We both can feel that and she’s begun to send me beautiful poetry that illustrate some of the depth that she has, that’s been awfully coiled up in defensive intellectualization. So what has shifted is a sense of closeness in our bond, and secondly her ability to take her talent which is writing and find some emotional content to make poetry. I consider that a big step.

Interview Six. #16-20210323

I’m 76 and I’ve been practicing psychotherapy for about 50 years. I graduated with a MSW from [University] in 1979. It was in November 1982 when I was working for [County]. I quit working for the County in 1984 when I got married and had a baby. I started a private practice, worked part-time and raised our baby. Over the years the practice grew and I was able to a variety; adoptions, therapy for Federal Pretrial felons, couples counseling, workshops for molested women, supervision, geriatrics, and others. I love it and it’ll be hard for me to stop with both groups of people, the transformers and the problem-solvers.

I’ve always had people who have had occasional telephone sessions. But Telehealth really began for me in March of 2020.

Question 2. Is the distinction of first-order and second-order change relevant to your practice?

I don’t think of it that way. It operationalizes that way, but I’ve never used those terms. I do work with both problem-solving and transformative. I talk about brain theories in a very simple way. I want people to understand that what they’re telling themselves is going to create their reality. It’s going to groove their brain; and I try to get them to understand that they really can’t afford negative thinking because it creates a negative life. I talk about the negativity bias. It is all so interesting.

Question 3(a) What are your methods when the focus is on improved ability in daily life?

There are first-order people, for problem-solving. Those are people who don’t have a large capacity for insight. I was thinking too, there are people I see who are wanting their life to improve, but they really don’t want change. Often, they want to complain about it. Perhaps they like a little bit of problem solving, but mostly they want to be heard by somebody who they believe understands them in a way that other people cannot.

With the people who are problem solvers, I just focus on letting them come up with solutions to the problems. Then I present the solution that they’ve come up with that is most logical, most healthy; and help them implement that…

Question 3(b) What methods do you use for transformational change?

With the transformational work, I probably do more guided imagery. They have capacity for insight; they can grab onto the meaning of the imagery. I was thinking about my goal for people. What I tell people, if they ask, is that my goal is that they can be happy and self-expressive and transparent of their authentic self. Their transparent, authentic self is happy, relatively, which I would say is the overall goal for people for their life.

Question 4. What is your theory about how transformative psychotherapy works?

I don’t think there can be a dividing line, because I consider myself to be eclectic. …

When people come to therapy, there is something that’s motivating them. They are unhappy, uncomfortable; and they are looking for an alternative. If they feel they can trust me, if they basically fall in love with me and I fall in love with them, then we’re fine… That warm supportive environment, that warm supportive person in their lives, can help them feel that they can try something new. As they are doing that and as they are thinking differently, talking differently, they are forming the ability to make those changes. Some people are better at it than others. Some people take longer.

We have to just let something emerge. People come in and say, “I don’t have anything to talk about today.” I will say, “Good, those are usually the best sessions, just ramble around in your mind and see what happens.”

Question 5(a) What do you need from the client in order for you to fulfill your role?

They need to show up and have an open attitude; they need to be willing to be open. The people that you can’t work with are the “yes buts”, especially my court clients on pre-trial; they had not been adjudicated yet, but they were filled with anxiety because of that. … some of those people are wide open and ready to change; and I’m still seeing some of them. Others will close down, be guarded, defensive; and they’re not going to make any change. Basically that’s it. I need them to trust me, be willing to try something new. That’s really all I need, just an open mind.

Question 5(b) What does the client need from you to move towards second-order change?

It’s just that I have to care about them. They need me to care about them. They need me to pay attention; and come up with some ideas that fit their lifestyle, that they can hear and accept. If they’re religious, then I frame things in those terms; if they’re not religious, I frame things with secular overtones. What they need from me is just my wisdom. That’s all. Not much more. Sometimes I think that I can be really mean, but I don’t mean “mean.” I might say, “No, no, no that’s bullshit, I’m not buying that.” But I feel like what I give people is the love that I truly have for them. And I can be pretty patient with them. If they don’t do the homework, fine, I don’t care. It’s up to them.

Question 6(a) What are the circumstances in which, or kinds of clients for whom, your use of Telehealth enhances transformative psychotherapy?

Here’s what Telehealth does, it makes it easier for me to work. I can have my pajamas on and put on a sweater. I can roll out of bed and in ten minutes be in front of the computer. I don’t have to drive to the office and remember to bring a key.

It’s often easier to include a reluctant spouse; someone whom I would like to come to therapy but doesn’t want to do it. He’s right there at the house. I can say, “Would you ask him to see if he would like to come over and be a consultant for a few moments?” You can’t do that if he has to drive to the office. And I think the clients are more relaxed. They don’t have to deal with traffic or parking, or the anxiety of being in someone else’s space. They are in their own space; they don’t have to get a babysitter. Those are the positive aspects of Telehealth.

People always ask me when I’m going to retire. I think of my trainer, his wife at 87 went back to school and got her MSW, and started practicing psychotherapy. She always wanted to. She’s 94 now. She still has one client. It’s Telehealth, of course. I thought that was pretty cool.

Question 6(b) Under what conditions is your use of Telehealth less effective?

I can’t see the subtle changes in someone’s body language, especially if we’re doing it on the phone. I can’t hardly see them at all. It’s amazing to me that I can see as much as I do see. I’m looking for that little shift in someone’s eyes, they’re going to cry but they’re holding back. That’s where I want them to go, I can’t always do that. And then there’s the client who can’t see my body language. I can’t give them a hug at the end of the session, if that’s appropriate. I can’t give them a journal, book, and all those things. That’s different with Telehealth and not as helpful.

Question 6(c) Can you give an example (with attention to protection of privacy and confidentiality) where you helped a client make transformational change via Telehealth?

I’ve been working with this woman. She lives with her boyfriend. She has an issue with him about sexuality. Things came to a head when she told him that she wanted to vibe out, which means she wanted to get out her vibrator, be sexual and have him accompany her. She wasn’t asking him to be sexual per se. That was so threatening to him. I asked her if she would ask him to be with us, because I can’t really work on this issue without his input. He did come, and sat down. He had so much shame that he couldn’t be casually involved with her sexually without feeling all that shame. As a kid, he was shamed so much and harassed so much. I had him do a little bit of visualization, getting really relaxed. And then I had him hear a knock on the door, open the door and a little child came in. I went through the whole inner child thing. Talk with that little child about his shame or whatever he wanted to say. I had him pick up his little inner child and have that child melt into his body. And I could see him relax when he got that; that he was responsible for his own inner child and that he could take care of that child, and other people didn’t need to tease him anymore. It was very moving and he was very different after that. He was more relaxed. And he didn’t even have to vibe out.

Closing Comments

#16 I lived through what happened, with changes made by insurance companies. They would say you have $2000 of benefits in a year, that’s it. … Then they moved from that to managed care; they were trying not to give any care. Managed care was much more restrictive than it is now. Now I don’t find them particularly restrictive. They’re just a big pain in the neck. … You know it’s difficult if you want to make enough, especially in [City] or [State]. You really have to hustle, be working all of the time, and charging really high rates. I’m really not interested in charging high rates; I really want therapy to be something people can afford. You have people who really need it; and they don’t necessarily have the money for it, or good insurance policies. The whole money part of it has been a sad experience. [During] this whole COVID thing, is that the insurance companies were forgiving the copays and they actually raised the rates they paid.

I saw the house of the guy who heads [Insurance Company], in Florida. It was one of those boat tours; they take you to see it. It was disgusting. People should be ashamed of themselves for taking that kind of money. What can you do? You can’t do anything. There’s no point. That’s the problem with negative thinking. You can’t dwell on that, because it’s not healthy for you.

VB Sometimes people ask me, “What can we do?” If there is a connection with their own personal healing, I can ask, “Well, is there any charity you can volunteer for, or is there a career choice you’re making, or is there social activism you can join that passes forward your own healing to other people?” Sometimes that flips the negative thinking into positive action. And the other thing is, voting makes a difference. We’re seeing this in the current administration. I hope people will encourage their senators to pass voter protection and civil rights protections, because everybody who’s paying attention and cares can see it makes a difference.

Interview Seven. #17-210325

Question 2. Is the distinction of first-order and second-order change relevant to your practice?

I had to think about that for a bit. The answer was yes, because what I do is use transactional analysis as my primary method. Transactional analysis is flexible, that is you can help people at both levels. And I adapt how I use transactional analysis to meet the needs of the person and the readiness of the person.

For instance, if they’re going to resist psychotherapy, they’re really not wanting to have any insight. It's early in the treatment and I’m trying to establish trust and credibility, I might just stay in the transactional proper level and just talk about ego states in the most simplistic of terms. I’m not going into the second order, not going into the difference between structure and functions. Just talk about, “You know this feeling crappy about the way your wife talks to you, the tone of voice, the behavior that she shows. You can adjust to that if you are managing your child from your adult.” I can draw circles and an arrow that shows that. If you can practice that, and I can show you some tools and some ways to get there, you’ll have enough awareness and self-management to stay out of feeling bad so often. Now it becomes transformative when we move in the direction toward, “Let’s figure out the life’s script in this area. Where’s that coming from that you have those reactions? Where did you get that?” You copied from your parents. What is going on in terms of reliving old childhood experiences? And what’s here and now, rationally, using reasoning and problem solving, reality testing? Once you have that worked out with the origin, you can mediate that so you’re using the best of those parent recordings and you’re screening out the worst. The same thing with the child, and you’re always filtering those choices so that you’re functioning well. It’s the same thing for moving into transformative, but with more complexity. It gives a person a more detailed map to work the territory. The third level we get into when that’s not enough for the person. We get into the redecision work, where you get into an emotional state.

Question 3(a) What are your methods when the focus is on improved ability in daily life?

It would be twofold. One is that using the TA theory and methods, it’s an educational model and linking that up with their existing coping mechanisms, at least the healthy ones. Helping them to optimize that. Basically, it would commonly be a person presenting a situation that they are facing. I would say, “Well you’ve faced that before, how you dealt with this situation, what worked best for you? And what hasn’t worked?” Once you get some of that material to work with, then feed that back to them in terms of transactional analysis. So then they have a mental map and a visual map to help them have an understanding of what's going on and what they can do differently, using the skills that they have. So that would be first order.

Question 3(b) What methods do you use for transformational change?

The deeper work that I talk about, where people get into script analysis and redecision, that’s all part of transformational work as I see it. Redecision, as it was described by the Gouldings whom I studied under in the 70s, involves the two-chair technique. Get them alternating their child and adult in one chair, dialoguing with the parent in their head, in the empty chair. Get them to, with an emotional charge, address the issue they had when they were a child, to articulate the decision that they made. Then the adult can challenge that decision. Challenge them to filter that through their adult. If it works, then they make a new decision. They can let go of that memory as an emotional force and replace it with something healthier that will allow them to be freer, more autonomous in the grown-up world.

Question 4. What is your theory about how transformative psychotherapy works?

I’m going to pull together two worlds now. At the [Center] … they articulated three elements: assessment, challenges, and support. Assessment is what’s going on, … Challenge is what you have to do to… move toward the goal. Support is what resources you need, from yourself and from the outside world … [With] transactional analysis, the assessment phase is developing self-awareness… that is deeper than the level of experience that people come into treatment with. … Transactional analysis provides them with a different way of thinking about it and visualizes it… so that the individual can assess and understand what’s going on. Then once that’s there, the issue is what do you want to do to change it? … They set the goal. We’re ready to move onto the challenge …

The third area is support. I check out in treatment, “Does the person have a fairly healthy internal controlling parent?” I don’t necessarily demonize the controlling parent. “Look both ways before you cross the street,” we don’t want to throw that out. Choose the good messages. Check to make sure that they have enough good messages to support them, and they understand the assignment, the challenge well enough to do it, and they feel inspired to practice it. … There it is, assessment, challenge and support married with transactional analysis to accomplish transformative change.

Question 5(a) What do you need from the client in order for you to fulfill your role?

Trust. I need the client to trust me. I have a very transparent presence with a client because I like to model that for them. And because it is likely to build trust. TA is contractual in that you have some set of mutual understandings about what’s going on and what isn’t, in the relationship. That helps to build trust.

Question 5(b) What does the client need from you to move towards second-order change?

The client needs safety. Safety has to do with clinicians being aware of the full scope of what they’re dealing with. I never start or end a session without doing my own assessment, my check in, is the person okay to go out in the world. I’m pretty good at being able to confront something, able to confront something with a nurturing parent rather than a critical parent, and a lot of adult mixed in there. And I have enough empathy and demonstrate enough empathy for the child so that I can give feedback in a way that creates a sense of safety. So people will very early in a treatment relationship open up about stuff that they don’t want anybody else to know. As more stuff emerges, more comes pretty quickly, the dirty laundry, that’s because they feel like I’m not going to misuse it or abuse them in some way. In the background, they don’t necessarily know it, they do benefit from it, I do monitor for danger to self and others. For example, I monitor for more serious Axis One kinds of issues. Actually, as I’ve gotten older and less interested in dealing with anything that registers in the DSM, I refer people out for that heavier work… That way they feel safe that I’m going to do what’s in their best interest… a clinician needs to provide protection so that people will feel safe.

Question 6(a) What are the circumstances in which, or kinds of clients for whom, your use of Telehealth enhances transformative psychotherapy?

What are the circumstances that telehealth enhances transformative psychotherapy? I couldn’t think of any.

Question 6(b) Under what conditions is your use of Telehealth less effective?

Two things come to mind. One is two-chair work. The other is what we do with screens all day long.

The two-chair redecision work, the highest level of transformational work, I can’t find a way to do two-chair work or to get a person to really get into deeper levels of what’s going on in terms of the residuals of their child-parent relationship, whoever their parent figure was, to do that in a Telehealth situation. I am able to do the middle level, the script analysis kind of work. For the highest level of transformative work, I like to use the two-chair technique. Imagine trying to do that in this situation. A person would have to set the computer up so you can see two chairs. They’d have to twist the computer as they moved from one chair to the other. It would be cumbersome. That would be disruptive. If I could see them with both chairs on the screen, I couldn’t detect subtle differences in eyebrows, facial expressions. Some gross body language I can see. But I couldn’t detect if their skin was flushing at a certain point. I couldn’t be as in touch with them. Their movements back and forth, awkward at best. I can’t envision it, so I haven’t tried it. I have this conviction that it would fail. I never want to do something if it’s likely to fail, because of the loss of credibility. A counselor needs to be aware of their skill set and the context in which it’s appropriate. A good provider makes that discrimination. That speaks to the issues of protection and safety and trust.

What we do in front of the screen all day long is the second issue. We look at screens to process words, email, spreadsheets, search something on the Internet, and then we watch TV and get entertained. All of that, that we do, it’s all using what’s on the screen as an object. It’s an external object that informs or entertains or takes our input. But it doesn’t relate to us. The screen really doesn’t relate to us. It’s an inanimate entity. By nature it’s impersonal. I can’t imagine that we can get in a conversation online and not be burdened or influenced by all of that history and experience of impersonal relationship with what’s on the screen. I certainly experienced our conversation and the sessions that I have with people these days as more personal than watching [TV]. But it’s not the same as the experience of being in the same room with someone. It still doesn’t have that connection.

Question 6(c) Can you give an example (with attention to protection of privacy and confidentiality) where you helped a client make transformational change via Telehealth?

I helped an individual understand that their messages were coming from the parents and I pulled a diagram up on the screen. We looked at what messages are. We identified the filtering of their adult. The goal was choosing the best of the messages in terms of the situation. I can do that. It’s a bit awkward. It’s much easier to walk up to a flipchart and draw circles than to switch to another screen that has a slideshow on it that I can use to point out what I want to point out. It’s awkward and less efficient, but I can do that well. It’s halfway to transformative.

Closing Comments:

VB I’ve been doing this so long, you know, I do what I do like the back of my hand. It’s been so beneficial to me, personally, to be listening to clinicians like yourself. I have a follow up question. You used the word “energy” and you talked about “an emotional charge.” Are those two things involved in how the transformation works? An emotional charge or energy, does something happen there?

#17 I see them as two different things. Eric Berne talked about different forms of energy bound and unbound, the cathexis of energy in an ego state, the energizing in an ego state. So when somebody’s in their child and they shift to their adult, there is a shift of energy, in my way of thinking, in the shift from child to adult. An emotional charge can be part of that movement back and forth. The emotional reaction that you witness, in the clinical arena, gives me an understanding of the full message of what’s going on with the person and whether or not it’s congruent with the way the person is thinking and saying. So monitoring a person in that regard is important. When you have a person who is totally congruent, and they are in tears, and they say to their mother, in the empty chair, “I can’t get angry at you because you’re so good.” And they sort of stop there. And you say to them, “Can’t?” And they realize, “Yeah, it’s okay to be angry at Mom.” That’s when you have redecision. That’s transformative.

Interview Eight. #18-210329

Question 2. Is the distinction of first-order and second-order change relevant to your practice?

Yes, from my understanding of what I’m hearing. The idea is solution-focused and can be a way of understanding what the person’s first idea is of what their symptoms are that they don’t like and they need to change. The transformative part is working with the person to go a little deeper into why they may be manifesting these symptoms, these characteristics, and having that understanding, working with recreating the meaning behind it.

Question 3(a) What are your methods when the focus is on improved ability in daily life?

I come from a science … nursing background… The research in neuroscience [shows] it’s connection between the therapist and the patient. … [Rick Hansen] defined resiliency as connection. The underlying feeling for some people is fear and that’s why they make the decisions they make. So if a person feels safe in the relationship, then hopefully they can learn to also have that connection with other people besides that in therapy. That’s what helps them have resiliency and that feeling of well-being, and figure out how to navigate their way through challenges of life. The … dopamine and serotonin, all those things can be measured. The connection with people increases those things, as I tell my patients, it’s the pharmacy within.

Question 3(b) What methods do you use for transformational change?

Listening, validating and supporting the person as they go through their painful experiences without judgment, whatever it is you’re feeling is okay to recognize, accept, investigate, and self-nurture. And that would be the acronym RAIN from Tara Brach, which is one of the methods that I use quite a bit.

Question 4. What is your theory about how transformative psychotherapy works?

It’s a receptive person, open to change, they’ve opened themselves up. Therapy is opening up that space for potential and possibilities.

Question 5(a) What do you need from the client in order for you to fulfill your role?

One, the person has to want to make change. That also fits in with being receptive to making changes, and feeling safe enough to know that they can make changes.

Question 5(b) What does the client need from you to move towards second-order change?

I think that fits with safety, connection and then there’s how one defines connection. It requires non-judgment. Connection is different in the ways it can be, like connecting over basketball or liking the same recipes. You know there’s that feeling of safety, building that rapport that Carl Rogers talks about.

Question 6(a) What are the circumstances in which, or kinds of clients for whom, your use of Telehealth enhances transformative psychotherapy?

I think it’s really wonderful that a client can check into Telehealth, and other than, “How’s your day,” we can get right to whatever is happening in their life at that moment. As opposed to, “What’s going on about that $12 price for parking?” or they can’t find a parking place or “Why was the person at the front desk so rude?” I think that they’re not having to worry about traffic, to have therapy in a place that they find comfortable helps in terms of what we were talking about earlier in terms of safety and in building rapport. It can be AOK from the get go, because 50%, now it’s more than 50% of my people that I work with. I have my first connection with them through Telehealth. When I first started doing Telehealth, it was to help people who are in remote areas that would otherwise not have access to therapy and counseling. And again I go back to my public health career where we’re trying to work with the most isolated people in the population so they can have well-being, health wise. Telehealth provides an opportunity for people who wouldn’t otherwise be receiving counseling. And that's the existential value of this profession, well-being.

I have people who are working on really deep, painful, challenging pain. They would say after a session, “I feel really drained.” They worked really hard to go to difficult places, emotionally, and for them to not have to hop in the car and get on the freeway, they are in a comfortable place in their own home and they can do what is being heard in the session, which is self-nurturing, self-care. They can do that when the session is over.

I wanted to add more about the connection thing. I have really liked that with Telehealth I can see it when it’s snowing outside. I can see their brand-new remodel. I can see their cat and their dog and the kids come popping through. A spouse specifically wanted to come in and meet me and say hello. We wouldn’t have that in the office setting. There are certainly pros and cons to both. But I just think that being able to see these things is another way of connecting.

Question 6(b) Under what conditions is your use of Telehealth less effective?

EMDR. I work with veterans, they are high functioning, so it’s not necessary to use EMDR. But they’re going through some sort of trauma and still have triggers. So I think meditation, EMDR, guided imagery is not really going to happen in Telehealth and be as effective as it could be in person.

Question 6(c) Can you give an example (with attention to protection of privacy and confidentiality) where you helped a client make transformational change via Telehealth?

Everyone has made some transformative changes. I think people can still feel connected and that goes back to when a person has that feeling, they find the resiliency within themselves. They find they actually have more confidence than their anxiety, stress and worry.

I’m hesitant to just talk about one person. But if we take the diagnosis of sexual addiction, and I have more than one patient fit under that, and Telehealth helped and was effective in helping them talk through their demons so to speak, their fears and work through how to find healthier choices to fill that void.

People tell their problems to the person right next to him on an airplane. So maybe something that, you know, people feel very shameful for acting out sexual addiction. Maybe it’s easier because there is this space. Maybe where in the room, the same office, maybe they wouldn’t feel as comfortable.

Interview Nine. #19-210330

I worked for inpatient. I’ve been doing a lot of supervision for them… A healthcare clinic approached them, that was before COVID. We were getting a lot of referrals, mostly from the Medi-Cal population. They did not have enough therapists to fill the demand so they contracted... Right now all we’re doing is individual. We’re not doing any family work. … Then COVID happened. That’s when they said, “We’re going to do Telehealth.”

Question 2. Is the distinction of first-order and second-order change relevant to your practice?

It is. My understanding about these terms, I had to look them up, the first order and second order. Definitely, solution-focused is very important. I always start there. I do work with my training and I work with my own instincts. I’ve always trained a new social worker about the use of self that we bring to the relationship that we develop with clients. Why is a client coming in, what is the client wanting? In my first session I always ask that. What is it that you would like to accomplish? Why are you coming in? They have an idea. The clients that I am seeing are not being forced to get treatment. Definitely solution-focused therapy is very important. If we can accomplish some minute goals that they have, sometimes they can give me very big general goals, but you can break it down and start with something. Then with the relationship, the genuineness, the caring, the trust, the developing all those kinds of things, I see that those tools are what I use to help the clients not only accomplish some of those short-term goals, but then looking at the bigger picture which is their interpretation of things. Then we’re helping them change some of those beliefs that they have about themselves. With support, guidance, and the tools that I give them in the form of homework to do.

Question 3(a) What are your methods when the focus is on improved ability in daily life?

I begin with ongoing assessment. It’s my roadmap to the treatment, and to the interventions that I’m going to bring to them. So I believe very much in doing very thorough assessments. And then I’m going to go back to my use of self, being empathetic and being supportive, allowing people to share, in a way that they feel supported. They can go on and give me more information. That’s my method. Once I identify what is the issue in their daily life, then I want to know what they’ve done about it. Then from there, “What worked, what didn’t work?” From there we explore some interventions, some tasks. Let’s see, maybe it’s something that they can do and are going to do.

Question 3(b) What methods do you use for transformational change?

It’s more that it’s an outcome of being able to complete that first phase. And how do you build on that success with some real support? I do praise my clients when they have made some steps.

Question 4. What is your theory about how transformative psychotherapy works?

I would say that some of them kind of morph. It takes a while to meet those daily life issues. I can see that as they themselves become more successful, they start to say things that I had said, in maybe a different way. They bring up things we explored in sessions past. Then all of a sudden, it’s coming out from them. They are then challenging themselves. And taking risks for what they want to accomplish. So I see it as a continuum.

Question 5(a) What do you need from the client in order for you to fulfill your role?

I need them to show up. Thinking back to my private practice, in those days I was getting a lot of referrals from Child Protective Services, and I worked at Children’s Hospital. Not only did I see kids, I saw adults, parents. What do I need from them? I need them to give me a chance. That’s really basically it, because if they give me a chance and they start opening up, then we can go from there. As the relationship goes on, getting a chance to demonstrate my genuine caring for them, then from there we build on that. They keep coming back and we keep working on things.

Question 5(b) What does the client need from you to move towards second-order change?

The clients I am getting are mostly anxiety, panic attacks, depression, social anxiety. I need to be trustworthy. I need to be able to be empathetic. I need to be genuine.

Question 6(a) What are the circumstances in which, or kinds of clients for whom, your use of Telehealth enhances transformative psychotherapy?

I was surprised because I hadn’t done Telehealth before. I’ve had over forty clients over the past year. At first, I wasn’t sure how they were going to react to it. For the most part, I have found that clients like it. They like being at home. If they don’t have privacy, some go to their cars. And I was surprised at how well we can connect, that emotional connection and form the therapeutic relationship, even those clients I’ve never seen. There have been clients who have done tremendous changes in their lives that I discharged. They’ve gone way beyond, they’ve done transformative, I've never seen them. I can think of a client, a woman who is divorced, mother of an adult child, late 50s. She has been struggling, she’s a Hispanic woman. She didn’t speak Spanish with me, but that’s fine. She speaks English perfectly. She had real difficulty with boundaries. with her boss, with her friends. She tended to let herself be manipulated. She was not protective of herself. I had been talking to her for a while. And we do phone. A lot of my clients do phone, not video. It’s their choice. We were working on helping her recognize what she was doing. She had trauma in her past. She started to understand what she was doing, she started to understand how she was allowing people. She had feelings of being less than. She said to me, because she had made some really significant changes in taking risks. Again, I talk about taking risks. She was challenging herself. Setting clear boundaries. She told me about another person that she had set boundaries with. Finally 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, I’ve never seen the woman. I have no idea what she looks like. And yet for her, that allowed her to be able to share with me some of the painful stuff about herself and her life. And I think there was some embarrassment. When I see the growth, I ask them if they see it. I wait to see if they recognize it first. Then I tell them what I see. And that was her response to me.

Question 6(b) Under what conditions is your use of Telehealth less effective?

I had someone with agoraphobia. I found that one harder to work with over Telehealth. We had maybe four sessions. We had made some progress. I was trying to get him to do some exposure. And he did that, in that he was successful. But then he stopped.

Question 6(c) Can you give an example (with attention to protection of privacy and confidentiality) where you helped a client make transformational change via Telehealth?

A young woman said to me that she had had a good week. I said, “What’s going on?” She said, “I’ve decided that I need to respond more maturely.” She was back home from college because of COVID. The family’s from [Country]. So there’s a lot of cultural issues. So she’s back home now and they’re treating her like a child again. There’s a lot of cultural factors which she had stepped away from when she was in college. So she came home and she started acting like a child, of course. She began arguing with your mother, confronting her mother on her cultural issues and all that. We talked about that, in and out of other things. But then she said, “I just realized that I need to do that, to be more mature.” And so she had a conflict with her mother. Well it could’ve been a conflict with her mother. Something her mother did, and the client chose not to react the way she had before. The idea and change came from her. We had discussions about it, her reactions to her family and the cultural issues. Her loss of independence. She said, “When my mother did that, I would’ve in the past yelled at her, gone into my room, and had a tantrum. I chose not to respond. Mom is Mom and that’s the way it’s going to be when I’m back home.” We had been working on that. She had some depression at home, some anxiety. As we were working, she was able to integrate and make it her own. I've had that with several, all Telehealth clients.

Closing Comments

#19 It’s the stories that we do learn from. I’m a hands-on person. I learn from people and so the stories are the most important thing.

VB We somehow send and receive in a way that the connection can form, then the relating happens, it goes from there. My words are a little different, we’re describing the same thing.

#19 I think about that for myself. I think about what I do and how I do things, because I do supervision for the intensive outpatient program. So I’m doing a little teaching. I think about those things, so that I can pass it on to them for their work with their clients. It’s good to get feedback from you, because I haven’t had a lot of contact because of COVID.

VB I also supervise by listening and explaining with everyday language. If I can’t do it with everyday language, how is the person I’m supervising supposed to be able to use it with the person they’re working with?

#19 That’s right.

Interview Ten. #20-210409

Question 2. Is the distinction of first-order and second-order change relevant to your practice?

Yes, it is relevant to the work I do. … The goal of the therapy [is] to improve communication and I used some of John Gottman’s tools to do that, active listening and reflective listening, “I messages.” I also work from a Bowenian perspective where I work to lower the anxiety in the room and use myself as a conduit to accept the messages and reflect back, before instructing the two people to do that with each other in a couple’s session. I use a pretty big strength-based focus. … I do a lot of focus on strengths and values that people have. That has been a kind of solution focused, in-the-moment psychotherapy… common issues are clear communication, respecting each other and being open and transparent about things … Interestingly enough, sometimes those first order things led to deeper pieces.

Question 3(a) What are your methods when the focus is on improved ability in daily life?

My focus when improving ability in everyday life has to do with the “Big 5” for regulating yourself in terms of your eating, your sleeping, your exercise, your spiritual time, and fun social time. Something I use also is motivational interviewing, because sometimes people come in and they’re not exercising enough or they want to do more of something else, but for some reason they feel a little bit stuck. Motivational interviewing fits in very well with my kind of overall approach, no matter whether I’m working on helping people improve things in their daily life or that second-order change. It has to do with partnership in collaboration with people. And based on those principles of unconditional positive regard for feelings, empathy, really reflecting back feelings and affirming people for any little strength that they have or any small step that they are already doing. It is a bit of positive psychology as well, because I really know people’s strengths and I focus on that happening from the outset. I’m asking people and honoring their own autonomy, their personal autonomy to say what it is they want to work on. They define, of course, how deeply they want to go.

Question 3(b) What methods do you use for transformational change?

To do transformative work I’m really looking to be extremely present with the person and let go of any judgment, and I find particularly people with trauma are very sensitive to it, whether it’s a look on my face or the wording of something and the clients let me know. Or rather “the people I serve,” I like to say. The people I serve let me know by their reactions when I’m off the mark. With that, a willingness to hear really challenging things, to let people know that it’s okay to talk about certain things, which I do by not reacting when they tell me things that they have never shared with anybody else or things they are deeply ashamed of. That’s when I feel really honored. It is when people say the space is so safe. It is really interesting to me because oftentimes people with trauma in their childhood don’t identify that initially. And we might start to work on that first-order change and then what comes up is certain patterns keep repeating. I ask if they’re willing to take a look at that or if you’re curious. I'm always thinking at all times of doing transformative work with people. When I’ve asked them what was most helpful, which I usually do at the end of the session, for what was most significant that stood out, especially and typically when we’re working for that deeper change, people say things like. “I was afraid to talk about this. But you didn’t judge me.” You know you really hit the mark when people ride those waves of emotion. Then there is a cathartic release and it’s such an honor to be in that moment with people. I honor their courage, their bravery. We’re really lucky to do this work.

Question 4. What is your theory about how transformative psychotherapy works?

I really believe it goes back to parenting, although I’m not actually thinking of that when I’m doing it. I’m being kind of intuitive in the moment. What I’m looking for is creating safety. I’m saying safety and I think there’s a whole process for safety to be in place. One of the things I notice I do regularly is I check in with the person. I ask permission if I’m curious. Is it okay if we talk about this piece further? You’ve mentioned three different things and which of these would you like to focus on? And then also bringing my concern or something I see, but asking permission if I can share that. I use something called elicit-provide-elicit. It is extremely respectful of people. I ask what they already know about the childhood part, and then I reflect back and ask permission if I can share a thought. “I don’t know if this would be helpful for you, but other people in your situation have kept a journal” of these memories that are coming up or for whatever the thing that is happening. Then I ask, “What are your thoughts about that?” And they let me know whether that would be helpful for them or not. There’s this team of true partnership in collaboration and mutuality. Let me say it this way, they are the experts on themselves and I bring expertise in ways of being with someone. So we each are putting something into that. Now I understand there’s a power differential as a therapist, of course. And a way to create safety is to do some leveling of that. And I think that whole demeanor comes across, even when I misstep and make mistakes, because we all do. Even when I do that, because there’s that relationship established, it’s AOK for me to say, “I missed the mark.” I don’t see the person being resistant. I see it as being something in the interpersonal relationship between me and the person I’m serving. And you notice that you used that word. I started using that word more than “client” even though I know they’re still my clients. I will say, “I’m sorry I missed the mark there. What I meant to say was, “This is a tough time.” Or, “ I didn’t get what you said to me, you need me to understand it and hear you.” Being willing to do that modeling, being a good enough therapist, which is kind of like being that good enough parent. I don’t think that reparenting exactly is running through my mind, but in a way that is what’s happening at that second-level change. It’s an invitation to them to call upon themselves to have that experience of being accepted. They say, “Really?” To be loved in the therapeutic context. I guess I’m waxing philosophical here.

Question 5(a) What do you need from the client in order for you to fulfill your role?

I need from the person I’m serving to show up, keep appointment times, communication, to have openness. I don’t know how I keep getting these people to work with, they seem very willing to do that. I guess that’s part of the health of people. They get tired of things not working, tired of being unhappy. They naturally want growth and to go to a better place. I’m thinking of Maslow’s hierarchy, I believe that’s intrinsic in all of us to want to go to this place. Especially when people seek support. They are hurting in some way and in a way, it is such an opportunity for people. That’s what I need from them. Show up.

Question 5(b) What does the client need from you to move towards second-order change?

If people aren’t keeping appointment times, if they start not coming in, that’s a good opportunity for me to affirm, “Maybe you’re already getting what you need” or “Would you like to see somebody else?” I do it in a non-rejecting way because I want people to know I’m there for them. Sometimes for people I’ll say, “It seems like it’s difficult meeting weekly. Would it be better for you to go every other week?” Rather than blaming them or shaming them, I’m so attuned to that. Because people do that to themselves automatically… I want to model something different… Previously we’ve talked about the repeating patterns and transference. It’s something different than what they experienced growing up or even what they’re doing with themselves as an adult… Here it’s my willingness to look at my own countertransference and for me, I need to be aware of what’s happening internally with me… I believe that’s something my clients need for me, the willingness to consult with other people when I’m feeling stuck, and to be aware of my countertransference, which actually is my friend, … That's okay, as you would say, grist for the mill. And my awareness to work these things through with a colleague really helps open my heart. So when I’m present with someone, it's extraordinarily mindful. You know, nothing else exists at that moment.

Question 6(a) What are the circumstances in which, or kinds of clients for whom, your use of Telehealth enhances transformative psychotherapy?

Well I have done phone sessions. Right now I’m only doing video on their phone, so I can actually see their face, but not as well as I can with video on the computer. In Telehealth, I’m so focused on people’s eyes and their expressions, as much as I can be. I think I’m more reflective with people on Telehealth because I’m watching so closely and so intently, and there’s this smaller range to see on the screen. I have worked with a couple of people who are really doing a deep dive into how childhood trauma formed their unhealthy choices. I’m thinking of one person in particular. It seems to have really worked well doing that deeper, deeper, dive. But it could also be because there’s less opportunity to be out and about, they’re doing more writing. And I’m more reflecting. They come really prepared for the session to share with me.

Question 6(b) Under what conditions is your use of Telehealth less effective?

You can probably tell that I talk with my hands, but you can’t do that with people with just the phone counseling. More importantly, it’s been very difficult for one client I work with. That person had some depression, anxiety, and her voice would drop off in a conversation, almost like they got relaxed, like when you’re meditating and you just nod off. And that was a real challenge until I started doing the video Telehealth… Now interestingly, with a couple of other people they actually like just doing the phones because they walk and talk. It is so interesting. It’s better with the Telehealth video on a computer portal, but it’s still not as good for some people as in person.

Question 6(c) Can you give an example (with attention to protection of privacy and confidentiality) where you helped a client make transformational change via Telehealth?

This person had a lot of childhood trauma. We were discussing some of the childhood trauma and the person was talking about their feelings. I would reflect back, sometimes a complex reflection… There was some recognition that they had been very protective of their parents and not really felt how angry they were. And how much that affected their decisions in their adult life, because of the fear of them going further than the parents. They were stuck between the mom and the dad and it was a very challenging situation. The parents had mental health and substance abuse issues. To help the person getting in touch with their fear about that I said things like, “Wow, in today’s world child welfare would have been called. What’s it like to talk about this? What are you feeling right now, as you’re telling me this and you’re hearing my response?” This has been a journey to this place of forgiveness for themselves for getting this wrong message, and then to forgiveness of the parents, seeing it in a way that doesn’t have the same emotional impact as before. I do think that that was very transformative. This person does better self-care. There are changes for them as they are more loving towards themselves. It’s amazing to work with this person. It is interesting because after I’ll do the session with them, I will sometimes feel very tired. It’s a lot to hear and hold that, but at the same time it’s like this you’re holding both things in your hands. At the same time for me, I realize that I’m witnessing something that’s powerful. And that splitting apart in a way that it’s opening up things. They’re opening up. It’s so beautiful, their courage. Honestly, I look at the people I work with and I think, “Wow, I’m learning something about courage. I’m learning something about sticking through hard times.” It is such an honor. I wonder when I say that to people if they think I’m a little effusive. More often I give affirmations of people’s own values, those are what matter most to them. Because that’s what resonates for them, their values.

Interview Eleven. #21-210401

Question 2. Is the distinction of first-order and second-order change relevant to your practice?

Yes. I know when it happens with my clients. It makes sense, but I was thinking about your questions. It was an interesting formulation of questions, because of how I think about Telehealth. Is it effective or is it not? The distinction makes sense to me. I know when it happens with my clients. I know what you’re referring to because I conceptualize that way too, for my clients.

Remaining Answers Removed: Private and Confidential

Interview Twelve. #22-210402

Question 2. Is the distinction of first-order and second-order change relevant to your practice?

A lot of how I am going to approach the work with a client is to include that client in the dialog. Actually, those discussions have been really meaningful. Some people have heard of characterological change, personality change is sometimes how they refer to it as, and they kind of know the difference between that and behavioral change. I certainly have met enough people who cannot tolerate whatever it is in terms of personal resources to really dig deep. I have met more people who really, I think, do well with supportive work. They are satisfied, I don’t want to say “less,” because I don’t mean it in this quantitative way, but what they’re looking for would be to ease problems.

Question 3(a) What are your methods when the focus is on improved ability in daily life?

I attended a few Judith Wallerstein lectures. It was in the late 80s or early 90s… She told an anecdote about a couple who were in a very high conflict relationship… Well, fast forward, they worked with her and they decided to stay together. Then she did a three-year follow up with the couple. They came in and she asked, “How’s it going?” The wife said, “It’s going so well. Bob here threw the cake down the stairs, but we’re fine.” Well, when I looked at myself, I thought, “I don’t want to be with Bob who throws the cake down the stairs.” I sat with that. I remember talking to my own therapist about it. The change for me was to understand that if I had some notion of a pristine relationship, and I’m really barring abuse in this… I now understand that what people can live with is actually rather extraordinary. That understanding opens up such opportunities.

Question 3(b) What methods do you use for transformational change?

Listening. I start, initially, with a fair amount of questioning, but not in an interrogatory fashion. I want to see my client unfold. So I’m not digging but trying to deepen the thinking and the feeling that goes into the work. I really want to know every pore of a client.

Question 4. What is your theory about how transformative psychotherapy works?

When I was in training at [University], there was a very heavy emphasis on family systems work and I gravitated toward that… Well, all of my placements were with psychodynamic supervisors. So I have to say… that business about how one grew up, I found very intriguing. I really never wanted to ignore that nature-nurture piece… I went to see Murray Bowen about family systems. … I was thinking, “If I don’t go see him, it'll be a missed opportunity.” He had this blend for me, looking at family of origin, thinking systemically, and he had this lens about becoming an observer to be able to stand being with family during holidays. That stuck with me, really, really stuck with me.

I really think that to be able to develop who we are, who we need to be, can happen within the context of loving relationships. Now as I listen to myself, I sound so idealistic. And yet, it really represents what I think I bring to the process with most of my clients who almost always come in with relationship issues.

Question 5(a) What do you need from the client in order for you to fulfill your role?

If it’s an adult, talk. And quite honestly, I don’t do well with people who don’t talk. I need my client to be a good listener, which is often what we assign to our role. I don’t need people to be enthusiastic. They need to have enough courage, which is developed, I believe, to be able to share what hurts.

Question 5(b) What does the client need from you to move towards second-order change?

Some kind of chemistry. Maybe that comes from the client’s understanding that I understood what they were saying. I think one of the biggest compliments I was ever paid was from a client who was terminating and said, “You wanted to know me.” I really do want to know them, and that includes all of the things that aren’t so pleasant.

Question 6. Do you modify methods for a Telehealth session?

One of the placements that I had in training was with the Child Abuse Prevention Agency. Part of the work was the crisis hotline to prevent child abuse. And there were at least mid-1980s thoughts about whether anything could really happen on the telephone. I had clients that I worked with more than once a week for a year. And I was quite stunned at the level of intimacy that we were both able to experience. So I think even though I entered this Telehealth thing kicking and screaming, there was a part of me that knew it was going to be okay. I think this kind of dialogue is the stuff we’re made of.

Question 6(a) What are the circumstances in which, or kinds of clients for whom, your use of Telehealth enhances transformative psychotherapy?

The most obvious is the capacity to see my clients’ environs. I’m looking at what I see in terms of your backdrop. That opportunity has been really helpful. There is a difference here that I want to make as a distinction. I have long term clients. I have seen some for 25 years. I do want to say that the transition from in-person in my office has been absolutely smooth. In a lot of ways it was just like picking up where we left off, except for some initial bumbling and acknowledging the differences.

Question 6(b) Under what conditions is your use of Telehealth less effective?

It’s really interesting because I work with a few clients who need medication. I haven’t explored how that all fits in. I believe that it does. Suddenly we’re in COVID-19. There have been consequences to people’s lives, and now I’m thinking of my clients who rely on medication. It’s to the good that these medicines are working. They’re having the most trouble.

More generally, I think there’s a level of self-consciousness that clients have and aren’t even aware of. For example when I see my longer-term clients in person, they’re not making little Kleenex balls. They don’t have too many anxious mannerisms. Interestingly enough on Telehealth, there was an acknowledged awkwardness on their part. I didn’t feel it at all, but I could see it in them. We’ve talked about it. Once a client said, “This is the most ridiculous thing I’ve ever done. It’s like watching Star Trek.” And I understood. She argued with herself that it shouldn’t be this way. That it really shouldn’t. That the best way is always in person. That lasted about one session. And once she spilled it, she just marched right on.

Now I do have to say I can’t tease out something about a client. I referred her back to her psychiatrist because she started to have more intrusive thoughts. It was clear to me that the problem with her intrusive thoughts was the content actually. A bit of background, we’ve worked for years on this. Does the content mean anything? Are you really going to kill? And she’s adamant, “No.” She’s not going to do that. But the thought is so troubling to her. We tried thought blocking. We tried a few little CBT things. We tried looking at the content. We did not make much headway. That was when I originally referred her to the psychiatrist. As luck would have it, because here’s what happened. I think if you can get a good cocktail, it’s not to be pooh-poohed. And she did get a good cocktail. And the reduction in those thoughts was like a miracle. Okay, so now we’re in Telehealth. And it’s COVID-19. The isolation is problematic for her. It’s necessary isolation. What do you suppose happens? There’s a big uptick in intrusive thoughts. She thinks it’s something she’s done wrong. I referred her back to the psychiatrist. There’s a very reasonable modification made in the meds. It doesn’t take her back to the place where she originally was before Telehealth. But it’s much more manageable. And she feels better. Could all of that happen in person? Yes. I mean something could have happened to put her lifestyle into a tailspin and those intrusive thoughts could have recurred. Here we were in, as she would call it, in the contrived circumstance of Telehealth. With the medication adjustment and our continued work, she is sailing right along. She really is doing well.

Question 6(c) Can you give an example (with attention to protection of privacy and confidentiality) where you helped a client make transformational change via Telehealth?

A new client during the pandemic, I think it has to do with meeting someone for the first time on telehealth with such a devastating story. The detail, I believe, no one should have to own. And all I can tell you is that whatever the chemistry was, I don’t have the sense that I just met them. I can't tell if the presenting problem, we can talk about it in that way, simply overrode this thing called Telehealth. I just know that the pain was so excruciating. Somehow, Telehealth has not been an issue.

Interview Thirteen. #23-210402

Question 2. Is the distinction of first-order and second-order change relevant to your practice?

Yes. If someone is mourning or grieving, I only see them for three sessions. The work is about how to get through the grief. If someone is getting divorced, the work is about finding a lawyer. What steps need to be taken?

I prefer to do transformative work. What I like about that work is I’m able to actually have this intrapsychic connection with someone, really fit together with them. We think about what their desires are in terms of how they want to live and what changes they’re willing to make to live the life they want to live. Within that transformative type of therapy I like to do, we sometimes need to figure out very pragmatic issues. Our focus is really different than when someone needs to get a referral to a couples therapist or a referral to a lawyer or something like that.

Question 3(a) What are your methods when the focus is on improved ability in daily life?

It’s not so black and white, I firmly believe that the most important aspect of how therapy heals is the relationship between me and the person I’m working with. I try very hard not to focus on pathology but to understand how a persons’ responses to various situations in life have served or not served them. What do they want to keep, what do they want to let go of?

If it’s solution focused, for example ,when the hoarder does not want to stop hoarding, we don’t really talk about that, but we talk around it. By talking around it, and by understanding someone for who they are, there is a hope that someday they’ll understand themselves better. It’s more challenging with an avoidant personality who is in pain. So how can you transform if you don’t shine light on what you experience through the shadow part of yourself, that aspect of the self. How do I convince someone that if you shine light on the shadow, it will be less powerful?

Question 3(b) What methods do you use for transformational change?

Are you familiar with the work of Bion? You talked about metabolizing information. During a therapy session, hopefully people learn about themselves. Or I shine light on parts of them that I observe that they haven’t noticed before. Sometimes in the moment, I know this is what I’m like, I don’t think so quickly on my feet. I have to go away and think, not just digest it, but to metabolize it. That’s why I refer to Bion. I don’t think of myself in terms of method. I think of myself in terms of relationships, and how I experience someone else, noticing with warmth and with care and not in a self-righteous pathologizing manner. I work with a real curiosity and hope to understand. And let me point out that each person needs something different.

Question 4. What is your theory about how transformative psychotherapy works?

When you talk to me about this, of course, I think about my individual clients, how I work with each of them, and how each person has different needs. How I am in the session is my methodology. I just keep on coming back, how do I connect? What does this person need, in order for them to see that I’m listening, that I see them, that I understand.

With some people, I don’t talk very much. They just need to talk and be listened to. Some people have a problem to solve, and so we talk together about what’s available to them, and share ideas. Sometimes I have knowledge about what they need to find, and sometimes I don’t have that knowledge. So we talk about how they can get that knowledge. Sometimes people just want to talk about what they notice about their feeling state, and I try very hard to slow it down. And do the age old, “What triggers that? Then what happens? Oh, and then what happens when you have those thoughts? What does that remind you of?” For some people, their history is important, because it helps me understand how they got to where they are. For some people, it doesn’t matter how they got to where they are. They just want relief in the present time. Again, with each person, the strategy to help them find inner peace, comfort with life, self, it depends on who they are and what their history is, and what they need in the current moment. With some people, it’s very hard to really talk about this inner landscape, what they think and how they feel. It’s for a variety of reasons. Fear of being judged, fear of closeness, not having a willing listener. For some people they’re in that role of being the caretaker and they’re not used to having anyone listen to them. Some are petrified of feeling pain, sadness. They stay away from topics like, “This is where I was born, this is where I lived, this is what it was like in high school.” It’s so threatening. So the work is challenging. How do you get to know someone if they don’t want to talk about themselves? Experience says, “There’s something about their shadow self, there’s something she’s avoiding.” I think that if they looked at it, it would actually be freeing. And I don’t talk about it explicitly. But rather it’s subtle. I bear it in mind what I’m thinking of. I hold my idea in mind. I slowly and gently try to talk about who she is and how she behaves.

Question 5(a) What do you need from the client in order for you to fulfill your role?

Maybe for some they just need someone to vent to. Maybe they want to have someone to talk to on a deeper level and they cannot do it in other relationships. Maybe someone else wants permission to talk about death and dying, and they can’t talk to anyone else about it because it upsets people too much. I offer a place to talk about what might be unspeakable in other situations. And what I like to get is a willingness to join me in the exploration. That is easier said than done many times.

Question 5(b) What does the client need from you to move towards second-order change?

What I find is that the client needs compassionate listening. Perhaps knowledge of other people who have had similar experiences and what has led them to find relief, or to normalize their experience, or to point out that maybe it’s not healthy. I think they need me to be honest. Compassionate and honest and caring, tender honesty. They need me to remember what they told me.

Question 6(a) What are the circumstances in which, or kinds of clients for whom, your use of Telehealth enhances transformative psychotherapy?

I have several consultation groups that I am part of as a clinician. One is called “Group’s Name” . We are all therapists 60 and over. We have talked extensively about Telehealth. What works, what doesn’t work, why it’s good, why it isn’t good.

There is lots to say about this. One is the benefit of being in one’s home as the container, no driving, no rushing, no parking. I am a friendly introvert. I consider myself an empath. I pick up other people’s energy very easily. I have a little home office which is a room off of our house, kind of on the edge of our little garden. I can control my environment, for example I can get a snack when I want to. I feel comfortable. This puts me in a place where I am really open and receptive. That’s the role my personality plays in Telehealth.

Then there’s the client. I see someone who lives in [City]. I’m in [Another City]. I couldn’t see them otherwise. I’m able to work with people who otherwise would not be able to meet with me because of the distance, or because they’re too sick to come in.

Question 6(b) Under what conditions is your use of Telehealth less effective?

People can feel free as if they are on the couch, not looking at the clinician, when we are on the telephone. Alternately, other people are hiding and would benefit from working through the anxiety of being exposed which can be limited online as compared to in person.

Many of the people that I work with are high functioning, a couple of them are not very high functioning. For the people who are less healthy, an in-person experience would help them connect to themselves more. That’s what I think about when I think about them hiding. There is this analytic theory that if you raise somebody’s anxiety it’s good for the work. It’s not that I want to raise somebody’s anxiety, but I want to talk about what they don’t want to talk about, which is that shadow stuff. I think that would be revealed in a more fluid way if we were sitting together in person. I would notice their body language in a different way, that you just can’t online. Some of the people I’ve met in person in my office and seen for years, they chose to do telephone therapy. There are people I have never met and we only do phone therapy. They don’t want to do it online. One woman doesn’t want me to see her messy house. People I’ve never met online like it, because it feels more connected to them. There’s no one answer. It’s different for everyone. What is consistent is how I am, because of my experience.

Question 6(c) Can you give an example (with attention to protection of privacy and confidentiality) where you helped a client make transformational change via Telehealth?

This has usually occurred when I saw the client pre-pandemic and we terminated during Telehealth. I don’t think we’re going to have any definitive conclusions about Telehealth until we go back to in person therapy, to have a comparison. Although, from what my discussions have included, everyone is going to have a hybrid practice from now on.

There’s one guy, I saw him pre-pandemic. He just was not changing. It wasn’t happening. He’s someone who really needed a break in order to metabolize the information. Then I saw him on Telehealth. He told me that he used, what he called my interview techniques, at work. This was a way he could be closer to people, in a way that he didn’t know how to be previously.

Another person I saw in-person, had a palsy. During the time that we met during Telehealth, she improved more and more and more. Until she felt like she was good enough. We had gone over some of her history and what she had interpreted as to why she developed an immune response to some of her behavior. I think that if I hadn’t seen her in-person it would not have been the same, because it was a physical manifestation of her psychic injuries.

There is someone whom I’ve seen for 10 years who has grown so much during the pandemic. Would she have grown so much had she been coming in person and having to go into work and all of that? She is someone who gets very impacted by being around other people and their behavior. I wonder if part of the reason that she’s able to have a deeper lens into her own behavior, and has been able to change more rapidly, is that she’s not as exposed to other people. If you run anxious, not having to deal with other people is less anxiety inducing. I’m just wondering about it. She is doing better than ever.

Closing Comments

VB A footnote about Jung – I had lost the concept of shadow self. But I find this discussion and Jung’s work around active imagination important, probably because of my art background. Sometimes the talking doesn’t work. Movement therapy or art therapy sometimes is a way to bring up some creativity and reflection that talking gets in the way of.

#23 Whatever works, essentially. Some people are online all day long because of their jobs. When it comes to their therapy, they don’t want to be online anymore. But I can be on the phone with them. And I can connect with them in a different way. I can, to use your words, creatively imagine them. I know what their voice is like. I imagine what their body is like or where they’re sitting or what they are doing.

Interview Fourteen. #24-210402

Question 2. Is the distinction of first-order and second-order change relevant to your practice?

In my practice as a psychotherapist, I’m currently seeing about 35 clients a week. There’s been a spike since COVID. Part of my self-care is spending time in my office, even when I’m doing mostly Telehealth. It’s nice to leave the house. In my practice when I was younger, I didn’t really know how to capture in words what I do. Now I have the experience to answer your questions. We start in a supportive psychotherapy along with a psychodynamic of why they do what they do; exploring that and problem-solving new ways to respond. They might start with a specific and also know there is a need for deeper work. Not just more into the past, but also more into your inner workings; that’s where the more transformative work happens. I see a garden variety caseload… Some of it is easier when you have accrued enough experience to make new sense of it through the processing. It’s in the processing that you make your meaning. It’s in making your meaning that your perspective will emanate. Perspective is truly essential. I am truly eclectic; I have a lot of tools in my toolbox. At the end of the day, we get perspective about self and on self, and therefore of others.

Question 3(a) What are your methods when the focus is on improved ability in daily life?

I’m very casual in my language and my approach, even as the work is serious. I like this chance to ask myself, “What do I do with people?” I meet with someone; we always start a conversation. Hopefully we feel the connection evolve. I listen as completely as possible, nonjudgmentally, the sense of self, the sense of presence that you bring to these kinds of conversations. Just listening to someone is therapeutic. Few people have that in their lives, to take as long as needed to get to where they need. We start with the connection, the therapeutic rapport. We get to reframing, to get to a use of accurate language to share with others. At some level, words are king and queen. To get to hold and capture another person’s experience is one of the most effective ways to help people reframe the language away from the extreme black-white language. I help people with anxiety, for example, not to catastrophize. I help people find more nuanced words, positivity for people entrenched in hopelessness. When I’m talking with parents or individual adult clients, I think about where you are in the stage of human development… It’s a grounding in psychoeducation. Where are you developmentally? I know empathy is a huge, huge, huge part of connecting with anyone. I also know that empathy only takes you so far. You have to have a way to challenge people about what they do, when you do it, and why you do it… I’m becoming a parental substitute for a while. I embody something you’ve never had, that unconditional love and regard, and with love say, “What about this instead.”

Question 3(b) What methods do you use for transformational change?

When I’m talking to clients and other non-professional folks, they don’t need theory or jargon. They need plain talk. I don’t think, “Oh we’re doing intrapsychic psychotherapy.” It’s much more interpersonal. I do think the transformative work can happen at all levels. In the transformative work we are not shifting in the environmental pieces. We’re more rooted in who you are no matter who is around you, and no matter where you’re living, no matter what you’re doing. When we go into intrapsychic role, I feel less overt, more subtle, so as not introduce or lead with as much input as I would otherwise. It best occurs, that transformative change, when it may not be initiated by the client, but it is led by and pushed more by the client. In the supportive role I am often telling people what to do. “If you don’t like what’s happening at work, try doing this.” The transformative mode, in that more intrapsychic level, I am there but my presence is subtler. I’m in a quieter space. I’m shifting in a place a being there. The client is like a child who initiates what they need to do if you let them. The kid often knows more about what they need than the parents do. It’s a quieter sense of therapy for me. It’s a more client led conversation. It is less about suggestion and intervention; and it is more about feeling, joining their sense of self in the cleanest of therapeutic ways. I’m highly aware of my boundaries. In that intrapsychic state where that transformative work is happening, I’m profoundly boundaried and never more expansive, because the other person is leading. It’s much more feeling based. It’s much more an identity-based phase of change. It’s about the action of joining them in a phase of processing through far more of their emotional experience.

Question 4. What is your theory about how transformative psychotherapy works?

I think in the supportive psychotherapy mode there is a lot of action, suggestion, intervention, and directive base. In the transformative space my sense of myself and my role is very quiet, pure if you will, distilled to where I am in that place where that cosmic essential other, with that ever-present availability. I’m tracked in with the client process which is rooted in how you feel about yourself regardless of what’s going on.

Why that orientation, that way of being, and connecting, why does that help people make the transformative change? I’m looking at the trees and birds and letting my thoughts come together. Something coalesces. People are cool, Victor. People ultimately want to look good, feel good, be good, whatever that means to them. I think when you join them in that space where they inventory themselves and what that means, what it looks like and what they need to do, it’s the best thing, the only thing, one of the limited ways to help someone make that change by tapping into themselves from a place of profound connection. They know what we’re sharing, that odd therapeutic distortion, it is really all about you. It’s not about what I need from you. It’s not what we’re doing, it’s not where we’re at. It is truly a conversation of self and with self and in the presence of that beautifully available, supremely helpful, other. I mean there is divinity in that moment.

Question 5(a) What do you need from the client in order for you to fulfill your role?

Their honesty, bravery, trust, vulnerability, presence, their time. It doesn’t happen quickly, easily. Patience. There is a sense of love that comes into the room when we’re in that space. We both need tolerance for the process, that’s embedded in patience.

Question 5(b) What does the client need from you to move towards second-order change?

The list is kind of the same. Part of what they need is my experience, I’m not in my thirties and forties. It’s life experience… Even if I haven’t dealt with your situation exactly, I have dealt with so many undesirable situations that have informed my perspective… [Tolerance] for the process. ... My graciousness, my patience, my tolerance, my steadfastness. I know it can look different when I’m in the office. I have my own life with its own complexities, what it’s like to be me. That impacts me no matter what hat I have on that day. I feel like there’s not a whole lot of difference between the personal and professional hat. I bring a lot of love to that space. I remember thinking, all the way back to graduate school, “Oh look, different people doing the same job differently.” Even back then, I knew I was going to be someone who had different boundaries than many of my peers in terms of feeling comfortable with self-disclosure, and just the way I bring myself into this space. In particular, where the work is more intrapsychic bonding to create that kind of transformative change.

Question 6. Do you modify methods for a Telehealth session?

The irony of ironies, in January of 2020, I thought to myself, “I need to get on board with Telehealth.” Just as a means of having another venue. It’s true that I had heard of COVID. My best friend, a school district nurse, was telling me, “Yeah, something’s out there.” She was making me aware that something’s coming. I had no idea, like many of us, what the hell was coming. So, I decided to explore Telehealth. And then everything happened. In March a different friend asked, “Are you ready?” I think I said “Yeah, but I think I’ll wait it out, I’m sure it’ll be fine.” I thought, “I don’t think it’s gonna be a big deal.” After that first week, “Whoa, what is going on?” Some people went into telephone mode, audio only. Some used videophones. Then I got on the computer Telehealth and now I’m fairly Telehealth conversant.

Question 6(a) What are the circumstances in which, or kinds of clients for whom, your use of Telehealth enhances transformative psychotherapy?

In my fairly diverse practice, I found that even though it’s different, and I don’t easily embrace change, even that I advocate others doing. Even so I was aware pretty quickly, “Oh, this is okay.” Probably dependent on the individual and our relationship... Most of my adults were seemingly fine with Telehealth. I think they made the transition over better… Even early on, some people had pandemic wariness and remote learning wariness and work from home wariness. Just the trepidation about getting what we used to get, but now through a screen. There are people who prefer it, because their COVID container is very different from mine. They will not come into an office because of COVID for a very long time, if ever again. It saves you 45 minutes to just hop on the phone. You don’t have to leave the house, come over, park, go through all that. I think some people have presentations in their life that make it easier to be on the phone. Do I think I’m doing as much transformative work in Telehealth mode as compared to when I’m in my office? No. I don’t. I think it’s easier to stay in that supportive space. It’s harder to bring yourself into that distillation of essence that transformative work requires… Some of this work only happens when you’ve known me for so long.

Question 6(b) Under what conditions is your use of Telehealth less effective?

I did notice that there are some groups of folks who don’t do as well... There are high need people with chronic and difficult to resolve presentations, they don’t do well in Telehealth mode, because we lack energetically whatever we’ve got when we share space physically.

Question 6(c) Can you give an example (with attention to protection of privacy and confidentiality) where you helped a client make transformational change via Telehealth?

I’ll keep it condensed, even though it could expand. It started with a call reaching out in 2020 through the EAP. In EAP we stay in that supportive mode for 3-8 sessions. I reference that because an EAP benefit is designed to be a short-term solution. This was a Mom, her grown kids back at home. They are in various stages of college. Her marriage was super long, they met in high school. She was calling about her husband’s increased alcohol use during COVID. I never met this couple in person. I never even saw them via a visual connection. We remained in audio only until we wrapped up a year later. We made a plan to check in to make sure things are on track with the goals. These people are therapy savvy and have been in individual and couples before. The issues of ongoing substance use and occasional abuse, and the dynamic of the non-drinking partner brings to the other’s ability to remain in that space. Partly because of the pandemic space and then they had known each other since their adolescence, they had done enough work in prior places, they were really ready to feel different. Not because there was anything on the surface that needed to get shifted around. It was all more deeply held beliefs about who they are to themselves and each other and in the world. What defined real intimacy after a lifetime of having lived with an image. Looking back and looking ahead, as they prepare to wrap up professional lives, children prepare to launch and pull in their own family of origin work. They did it all. There was some shifting around of things, around the substance use and communication, but the working out both within themselves and together was definitely in the transformative space. We never saw each other, audio only. To go as long as we did in time and the transformative work all on audio only was unique to me.

Interview Fifteen. #25-210406

Question 2. Is the distinction of first-order and second-order change relevant to your practice?

Yeah. It was weird to read the way it was written, first-order and second-order. I think of short-term goals and long-term goals. At the start, it’s more solution focused. And then when you work on it, you want it to be more transformative.

Question 3(a) What are your methods when the focus is on improved ability in daily life?

It’s more solution-focused to try to help them suffer less, less anxiety, and getting sad less. It’s more coping skills, like self-soothing.

Question 3(b) What methods do you use for transformational change?

Really it is not so much of a matter of methods, but it’s more that it’s relationship-based. Creating a space for a person to be able to reflect. It’s not the skill, it’s more of the space that they make so you can think more deeply about what they want, and what is good for them.

Question 4. What is your theory about how transformative psychotherapy works?

It’s the connection. When you can feel that you connect to someone you feel that that someone is listening to you, really, really listening. When you can have that, someone who truly listens to you, then you can just keep going. Then when you talk about things, you can process more. That’s how it happens. When you feel heard, you can change from when you felt hurt. I can see for one thing that the posture is different. They lean forward and there is less space between you and the client. Also, the facial expression is different. I can see in the face that they are lighter and they are more expressive. They say, “I feel better now, I can understand myself more.” So I see it by expression and also by body language. There are some similarities for all clients, because we are human. But there’s also some differences. I’m Asian. Asian clients seem to talk less about their somatic problems like, “Oh my head doesn’t hurt as much. Or my body feels better.” Compared to my other clients, Asian clients can be more verbally expressive, like “I feel better so I can express myself more, everything is clearer. I can see clearly.”

Question 5(a) What do you need from the client in order for you to fulfill your role?

What do I need from the client? To me it’s more like what does the client need? The client might say, “I just want to get something, a technique to help me with my anxiety and that’s all that I want.” Some clients came with something like, “I want to figure it out, about why. Why am I this way? Why am I having things that have bothered me since a long time ago?” They want to figure it out. I think it’s from what my client told me, and then I go from there.

I think it’s more about their willingness to see and to process what’s coming up. Sometimes there’s difficulty when you dig deeper, because that’s when you work on it. Sometimes it’s more painful than when you ignore it. The client needs to be able to understand that. Going through the process, I’ll probably need them to be more tolerable to the pain that might come up before being transformed, to be seen in our life. Usually we just go on and on and on with life, and try to survive things. In the time you are in this room, it’s your own time to be able to slow things down. Going through your life story so you can maybe use that time to slowly think about things, choosing what you want to think about and feel about, that’s what I mean by process. Process is a word that I use in English and I want to try to say it in my language. I couldn’t find a word to say it. So I understand it, but I can’t explain it to others in English.

Question 5(b) What does the client need from you to move towards second-order change?

What does the client need from me? A lot of clients tell me that I’m calm. When I work with them, they feel peaceful. They need my ability to listen well. And they need a sense of safety and trust.

Question 6(a) What are the circumstances in which, or kinds of clients for whom, your use of Telehealth enhances transformative psychotherapy?

Yes, it’s good for a client who doesn’t have transportation or who doesn’t like to go out. You can be in your own house and get therapy, that’s awesome. To my surprise, some clients are very comfortable, more comfortable even. Because they don’t have to get dressed, they can wear whatever they wear in their own house. And they can sit in their chair where they feel so comfortable.

Question 6(b) Under what conditions is your use of Telehealth less effective?

To my surprise, I don’t think so. But the one concern that I think about Telehealth is the client who is at risk of self-harm, or suicidal. I think that those are the clients who may not be good for Telehealth.

Question 6(c) Can you give an example (with attention to protection of privacy and confidentiality) where you helped a client make transformational change via Telehealth?

Just a small one of someone who shows more understanding of the nature of her relationship with her family and how it affects her. It felt even better than in the same room. In some way, it helped speed the process.

I have a few things to share a little bit more. It’s because it is in their own home, “You know I’m just sitting in my home and I’m just talking to someone that cares about me, that listens to me. So I can just spill my guts out.” I was surprised to see that in some of my clients, actually. Because I’m new to Telehealth, too.

Interview Sixteen. #26-210407

I connected with the platform that I use for Telehealth in March of 2015, but not with the intention of doing it on a regular basis. It came in handy for many of my clients at various points during our time working together. If someone were too ill to come to the office but still wanted to meet, if someone had transportation issues or child illness and needed to stay home for that, and I had clients who were out of town on business but still wanted to have our session. So I’ve been using Telehealth actually on and off since March of 2015. However, it didn’t become my regular practice until March of 2021.

Question 2. Is the distinction of first-order and second-order change relevant to your practice?

Of course, I think you can’t have a rich psychotherapy practice without engaging in both at one point or another. It may be that one follows the other, if things go as a therapist would like them to go. In this profession, most relationships with a client start out a little bit more solution focused. When I started out, there were generic “good things to do” in therapy. There are now many different “brands” of therapy, so “short term solution focused therapy” is now some sort of official category. In any case, I’m now using it just as a descriptor. We often start out by dealing with the problem at this point in their lives that led them to actually seek therapy. In my experience, there has usually been some precipitating event. It’s not that suddenly some light went on, and they realized that they needed to be some sort of self-actualized person. Something happened that drove them to seek extra help. You aren’t going to get to that transformative process unless you establish a good therapeutic relationship by helping them through those initial problems. So I believe both of those come into play, and there are some people who don’t get to that other level. Some say, “I gotta get through this, help me get through this.” Then 6, 8, 10 sessions later, “OK, I can handle that now, goodbye.” In my practice most people stay longer. I do believe it’s further down the line that you get to that transformative process; more needs to be established between the two of you and within their own being to get to that transformative level.

Question 3(a) What are your methods when the focus is on improved ability in daily life?

I think number one is just being fully present with the person and where they’re at in their lives right at this moment. Sit back and take a breath, and really take in all that they’re saying, not just the words but the affect, the mannerisms, the posture, all of that. I get a real feel from the person in terms of where they’re at emotionally, mentally, and physically too. And be able to empathize and reflect back my understanding of what they’re expressing. Not be too quick to jump to that solution… They need time to be heard, understood, and affirmed. I think that establishing a therapeutic relationship in the early sessions is the goal, regardless of what the issue is… It always begins with establishing a sense of trust, a sense of positive regard. It requires that I set aside any biases that I have that come up as I listen to the stories that they’re telling me. I need to get a feel for what it’s like to be in their skin.

Question 3(b) What methods do you use for transformational change?

It’s more about who I am than what I do. As the person expresses their inner process, there’s reflection and description, “This happened and my gut reaction was to do ‘A’ but I took a moment.” I’ve had clients say to me, “I heard your voice in my ear.” Or, “I remembered what we talked about that time.” They are able to shift their perception of the situation and they don’t do their usual steps in how they would have responded. It’s the idea of them having little “Aha moments” throughout the day. And then there are also those times where I will notice and they haven’t. They will describe a situation that they had been in, and I will point out some similar situation that they had been in 6 months or a year ago, 2 years ago in some cases. I’ll point out that they responded to it very differently. They didn’t even realize that they had responded differently, they hadn’t made that connection. But when I pointed it out, they go, “Huh, wow, I was really a different person then.” Or, “I had forgotten all about that, I can’t believe that I responded that way.” So that’s where I can see there’s transformation happening, and I have to say that as a therapist, it’s so affirming. Sadly, that doesn’t happen with everyone. Some people need to keep grinding those wheels over and over, until who knows if their “Aha moment” will ever come. It’s definitely the underlying goal that people will arrive at those places themselves. I might ask, “How does it feel to recognize that?” Or, “Do you have any ideas on why that might be the case?” I give them an opportunity for reflection on their own journey. I also regularly ask people to sit with that realization and see how it settles in their body. I want them to have a little more body awareness of how they process things. Our lives, emotional and psychological, are not all in our head, it’s in our bodies as well. That is also a clue about where we’re at during various points in our lives, how our body is reacting. It’s all connected, mind, body, and I use the term spirit as that other awareness that isn’t as tangible. That is part of what being human is. All of these different levels of awareness, connection, responsiveness, if we ignore any one of them, we are off balance. For those who are more biologically minded, I may go into discussions about neurochemical transmitters, or the vagus nerve, or how our gut responds when cortisol levels peak, and the effects on the amygdala, which can become overactive. I have some clients who are more scientifically oriented and want to know about the physiological processes. So I can give some good solid examples. They come to me because they want to be more comfortable in their human skin. This is part of what it takes to be there.

Question 4. What is your theory about how transformative psychotherapy works?

That one hour in my office is the only time in these people’s lives that they are fully present with another individual, or another individual is fully present with them, without any distractions. Especially in this day and age of checking our devices, many times per minute, even. And just being fully focused on them. It’s such a rare occasion for most people. I try to be as non-judgmental as possible, which is not something one comes across much in everyday life. Also, I keep on top of current research as far as having some scientific basis for whatever interventions I might be using. It’s knowledge that I will share with a client when they say, “Why should I do this?”… I feel there is an energy exchange going on too, where I genuinely have positive regard for my clients. I’m very engaged with them to be their best. I don’t write anybody off… so many people have surprised me. I thought it was going to be a couple of sessions, to just get past this one issue, and then they ended up being long term clients who really made major changes in their lives. And conversely, I thought this was going to be a really engaging, energetic therapy, and they say they took care of what they needed to do and that’s that.

Question 5(a) What do you need from the client in order for you to fulfill your role?

I need them to show up when they say they’re going to show up. And be honest with me. Be sober, not be under the influence of other substances during our sessions. I don’t want to say that I need their trust, but I seek their trust over a period of time. Because if they don’t trust me, then there’s no reason they should think I can help them. To want a better situation… [One] person had no motivation to change their life in any way, they just wanted somebody to complain to once a week. Nothing we went through seemed to make any difference in their behavior or mood. We were at square one for a year. It was clear that they had no real goals for therapy. And that’s not therapy. I used my internal processes as a guide for that, too. I had gotten to a place where I was judging, or I was not able to be empathetic, because there was not an exchange of energy and effort. Effort is one thing I need from a client, as well. A little bit of effort, a few ideas or goals.

Question 5(b) What does the client need from you to move towards second-order change?

Nonjudgmental acceptance, professionalism, being able to hold their issues without imposing my own issues on them. My knowledge and expertise on personality styles, and knowing realistic expectations for this person given the way they are wired. Knowing what is the reasonable goal for someone who’s wired the way they are. A consistent presence so they know what they’re going to walk into from one week to another. They probably have enough of not knowing what to expect in their lives with other people.

Question 6(a) What are the circumstances in which, or kinds of clients for whom, your use of Telehealth enhances transformative psychotherapy?

For some with Telehealth, the convenience of it. I did have some clients who had a really hard time showing up on time, always being 10 to 15 minutes late, because they didn’t predict traffic or parking or whatever. But for Telehealth they were just staying in their room, and they were able to be there on time more regularly. Well, one thing that I found interesting was that I was able to see where they live, in some cases. I see their living room or their study. Sometimes they would show me certain things…

Question 6(b) Under what conditions is your use of Telehealth less effective?

For some people privacy was an issue... I had a client who was on the spectrum and also transgender; and had difficulty with the video seeing themselves. They had difficulty with the little box with their image because they weren’t looking the way they wanted to look. Also with neurodiversity, difficulty with talking into the screen.

Question 6(c) Can you give an example (with attention to protection of privacy and confidentiality) where you helped a client make transformational change via Telehealth?

This particular client is a very wealthy white woman. She doesn’t recognize her privilege. She came to me with significant family difficulties. That is what I was mostly working on with her. However, along the way it became clear she was someone who was supportive of our previous president. This was not an easy client for me to work with and stay open with. There were times when she said things that made me cringe, especially on some social justice issues. For example, blatant racism, blatant homophobia, blatant transphobia. At this point in my life, I do not let it slide. You have to be very careful how you choose to address that in a therapeutic setting. I’m not there to champion social justice issues, but I am there to affirm the humanity of all people. I give a few little hints here and there, statements to help her to change her perspective a little. I think they started to take seed a little bit. It was hard to see. I had to take a lot of deep breaths when I was in session with this person. At one point, and it was in the Teletherapy time, there were many occasions where I just sort of pointed out perspectives of other individuals with whom she came across them in her life; and where that person might have been coming from to behave this way. She asked, “Why is this young Black man walking past my house? I’ve never seen him before. Do you think he’s casing the joint?” I said, “You know, schools are closed. Recreational places are closed. People are going out for walks now that didn’t used to go for walks. Maybe the young person was just out for a walk.” Anyway, she was relating a story to me that was about being at a store. As she was berating the sales clerk, she suddenly had a realization. She said that, in the middle of her rant against this person about why things should be done her way, it came to her that she was being unfair to this person. She stopped and tried to look at herself from the sales clerk’s eyes. She realized how horrible she was being. She stopped what she was doing and apologized. She basically just had a change of heart in the middle of it. She realized that this poor person wasn’t the evil one trying to harm her. She had a shift of perspective. There was a little bit of softening about her as she told me the story. We had a few other exchanges after that where I saw glimmers of a more open perspective. Perhaps a little more empathy for those who are not of her ilk. I totally didn’t expect her to have compassion for people outside her immediate circle.

Interview Seventeen. #27-210409

Question 2. Is the distinction of first-order and second-order change relevant to your practice?

Yes, it does. I don’t use first-order and second-order change on my website description, but I do describe that distinction. I say, “Some people come in for communication skills and problem-solving.” … Then I say, “Some people continue, they like to go on with their therapy, and get to the root of the problem.” I use that in my description of services. When I meet in-person, I do use the terms “first-order change, second-order change.” I describe them as, “First-order change is fixing the problem and second-order change is fixing the underlying things that caused the problem.” Most clients come in for first order-change, that’s where their focus is. That’s certainly where we start. Then as we go along, we can talk about the possibility of going a little bit deeper and addressing those issues that really cause the problem in the first place...

Question 3(a) What are your methods when the focus is on improved ability in daily life?

I primarily work with couples and individuals… Some individuals are in couples’ therapy and seek to begin individual work, some are individuals wanting a satisfying relationship… The first thing is, I really try to listen. I try to get a clear understanding of what I think of as the problem situation. I am very nondirective, very, very, nondirective. Many clients will just start telling me, just start talking. They will tell me where they want to start. With clients who don’t know where they want to start, I’ll ask questions like, “... What’s happening right now that’s brought you in?” … When I assume that I know something about the client, then I provide a reflection and really do my best to listen again. … Once I understand the problem situation, I listen for strengths. I’m looking for where the client already feels they have some efficacy or where they show some ability to change. I try to join them there, do reflective listening around their strengths and highlight those strengths… to apply those strengths to what I perceive to be the problem situation… It’s pulling together my understanding of the problem situation and the client’s strengths, to uniquely come up with a strategy that’s going to be most effective.

Question 3(b) What methods do you use for transformational change?

My framework is called “relational neuroscience” which was developed by Bonnie Badenoch. She looks a lot at how early life experiences impact later, current relationship dynamics. Bonnie’s framework isn’t anything new unto itself. It’s a synthesis of other frameworks. Taking attachment theory and polyvagal theory and interpersonal neurobiology and putting them together to come up with an understanding about how we form relationships. The question that I’m asking myself when I’m listening to clients is, “How is the history of my client’s family living through them now?” I always have an ear for that and as early as I can, I start asking clients about their early life relationships. I ask them to paint a picture for me of what their early life was like….Pretty early in counseling I help them reframe their experience based on how it makes sense due to their early life experiences. Even when I’m working with them on first-order change, and that’s where their focus is…That starts to help that part of them, the deeper part of them, the implicit part of them, make a more accurate narrative. Instead of a narrative that’s focused on all these cultural norms that are not based on science and are not accurate, there begins to be some wiggle room for conceiving of themselves differently... And later when we begin to move intentionally into second-order change as a team...

Question 4. What is your theory about how transformative psychotherapy works?

First of all, there’s a big caveat. I’m going to be painting with a broad brush. A lot of what is transformative is happening outside of the therapy room… So I want to talk about this through the lens of what I value the most, and be open to the possibility that is not what’s working but it’s what I value… I think my model’s way of understanding is you are really addressing what would be considered right hemisphere processing, which would be the implicit side of things as opposed to the explicit. Most people process implicit memory from the right hemisphere, and they tend to value or acknowledge left hemisphere processing over the right hemisphere processing. They will acknowledge the details, the facts, the analysis and value that is greater than the felt experience. That is painting with a broad brush… I can acknowledge the client’s felt experience as valid, rational and over time bring it into the room more. And start to create a sense of cohesion and attunement between the client’s felt experience and their thoughts. I think really listening for the client’s felt experience, consistently attempting to accurately reflect the client’s felt experience, helping the client come up with a narrative on their life, that is less based in cultural shame and expectations; cultural, familial, larger shame and expectations, and is more based on adaptive strategies, and understanding from a neurobiological perspective, how there is a biological imperative for survival…

Question 5(a) What do you need from the client in order for you to fulfill your role?

I need my client to pay for services. With that in place, it allows me to do my part. Clients don’t have to show up on time…They don’t have to stop being defensive. I view defenses as a natural adaptation that protects our most vulnerable parts. There is almost nothing that a client has to do other than consistently pay for sessions. For me there can be a lot of understanding around all of those behaviors if the basic agreement is, “This is your time. I’m here to support you in your process. What I need is the payment to come through.”

Question 5(b) What does the client need from you to move towards second-order change?

The client needs me to really listen. They need me to be aware enough of my own implicit history and my own internal state that I can accurately hear them… One of the things that I tell clients is that we all carry our history with us. I know that my history is showing up to the room with my clients. For example, I’m same sex oriented and I grew up in a non-affirming family. So when one of my clients talks about being gay and growing up in a non-affirming family, I can feel my heart tighten a little bit. I can feel my stomach drop a little bit. So I will be with those sensations and think, “How much of this is my history and how much is caring and accurate resonance with the client?” I’m just going to be with that. It’s this process that is always unfolding where I’m always practicing moment-to-moment mindful awareness, “What’s happening inside of me?” [Without] that way, I can’t be effective… in tune with the client’s moment-to-moment needs.

Question 6(a) What are the circumstances in which, or kinds of clients for whom, your use of Telehealth enhances transformative psychotherapy?

I really liked this question when I read it in the package that you sent me. My mind immediately went to a client who was born with a physical difference. I met with this client two or three times early last year. Then in March, I gave the client the option of video or phone, and the client chose the phone. And it was really remarkable how the quality really shifted by being able to be like a voice in his life, without me looking at the client. We were able to talk about that over time. But that physical difference that they were born with, which everyone sees, the first time they see this person they’re probably going to notice that physical difference. That creates such a state of anxiety for the client that they find themselves reacting in different ways. It’s a constant. First, I noticed the quality changing when they were able to be in their home, to be in a place without anyone looking at them, to be in a place that felt really safe. We did some really good work over the next few weeks after that change. Then I brought it in consciously and asked, “What is it like for you to experience our time together in this way without me seeing you?” And I have offered the client several times to go back to two-way video. We’ve explored that and he says, “No, the phone works for me better.” I think that’s an example of when there’s maybe something in the client’s physiology or perceived physiology, that creates a sense of anxiety or distress, that creates an additional barrier to connection and attunement. That’s only one example, I think that there’s probably many.

Question 6(b) Under what conditions is your use of Telehealth less effective?

There are a lot of concerns that I have. Not all the concerns are an absolute barrier. But what is a challenge can be used therapeutically over time. Some things are just challenges. First and foremost I’ve had more than one session where a client starts crying and I don’t realize that they’re crying because of the quality of the lights in the room where they’re at and the video connection. So I’m talking with a client and we’re going back and forth. At some point I do a reflection, 30 seconds or a minute. I’m just sharing like I’m sharing with you now, not realizing that the client has begun crying. If they were in the room and I saw them crying, probably my tone of voice may change, or something in me may shift to be with the client in a different sort of way. Not even recognizing someone’s crying doesn’t allow that to happen. So I’m really curious about what impact that has. I don’t think that’s as effective as being able to accurately gauge a client’s emotional state. Crying is one example. But going into sympathetic arousal where in the room I may notice when the client starts tapping their foot, or when they really tense up or when their whole-body freezes, I may notice changes in breath a bit more acutely. Changes in breath I do notice pretty well over video. But it’s even more noticeable through the in-person. So again, part of the way I practice is based on Porges’ polyvagal theory… I think a lot of that is easier to gauge in-person. Some of it can simply be lost through the computer. The other aspects are things that I don’t have to think about in person…

A client may share something really sensitive. They may share a trauma history. I had a client sharing for 8 minutes, and they’re weeping about a trauma event in their life. And then the first words I say causes feedback from their speaker. If we’re talking back and forth, their computer does a really good job of seeing who’s talking and regulating the volume. But sometimes if I haven’t talked for a long period of time, there’s this moment of really loud volume and sharp feedback. So if there’s a client who’s been processing trauma history for several minutes and I’m using my nonverbals, and the very first time I speak, there is a very jarring screech and blast of sound. But I don’t know if that’s very effective. It’s not that these challenges can’t be addressed, in the long term, and be folded into therapy, it’s just that I don’t know that they’re always helpful and perhaps sometimes they may be detrimental.

Question 6(c) Can you give an example (with attention to protection of privacy and confidentiality) where you helped a client make transformational change via Telehealth?

This was a client who I saw briefly in person before we transitioned to Telehealth. After switching to Telehealth and continuing to build our rapport, this person was able to talk about a childhood experience of being sexually abused and also later sexually abusing someone else. The client was able to talk about both of those experiences, but especially the second one, as well as a period of suicidality that occurred afterwards. And we stayed with that experience for probably two or three sessions going slowly in whatever way that client wanted to, we’d circle back to certain areas, skip over other areas, and then come back to them again. Then the client felt ready to move on. And really things started changing in their life. This is an experience that they had earlier in life and then again in adolescence, and over 20 years later, the client had never talked about it to anyone. Never talked about in therapy or with family members or anyone else. It was part of their life that in some ways was important to their sense of self. So being able to discuss it really allowed them to start forgiving themselves. We didn’t talk about it after the two or three sessions focused on it. After that we focused on self-love, self-compassion, self-forgiveness. So we weren’t directly talking about the experiences, but continuing to build on that theme. The client has experienced so much transformation in the relationships in their life and their career, their sense of self and their sense of self-care. Other compulsive behaviors have sharply declined. So what I feel is and what the client reports is transformative work occurred. I don’t know if the client would have been able to share it if we had been in the same room just feet apart from each other. This is a client that chooses to use the phone. It may be that extra space of not having to see my face provided some level of spaciousness. The client didn’t say that themselves. But one thing I noticed about Telehealth is that some people find it much easier to open up when they don’t have to look at anyone. Some people find it much easier when they have that two-way eye-contact. I don’t think I’ll ever know if that client would have been able to open up and share in that way in person. But I do wonder if that spaciousness, that they could be in that safe place, in a place very familiar to them where they have a lot of control, that they could end it at any time, without permission, without leaving, without doing anything. I do wonder what factors allowed them to share in that way. Otherwise would it have been possible or would it have been delayed?

Interview Eighteen. #28-210409

Question 2. Is the distinction of first-order and second-order change relevant to your practice?

I would say that the first-order change or solution-oriented conversation does come up. In my work, I am predominantly focused on transformative change. I practice from an attachment perspective and so I go all the way back to childhood, how we were treated, how important we feel, where our needs are, how valuable we feel. I very much believe that the story that we make, the meaning that we attached to things, and how our core beliefs and story that we’ve created, and we are continuing to create about ourselves, really impacts our behavior, the relationships that we choose to have, how we treat ourselves, how we treat others, our worldview, so on and so forth. I specialize in trauma and substance use. At times I’ve tried to do something that would maybe be potentially less heavy, and I continue to gravitate back towards that transformation and change and a lot less on the solution-oriented, unless it’s a crisis. If we need a specific solution right now to stay safe and move through something, then it’s later when we’re going to go deeper. I'm okay with that.

Question 3(a) What are your methods when the focus is on improved ability in daily life?

I think my answer will be very similar for both, but it is the relationship that I cultivate. I don’t use specific interventions often. I more subscribe to the philosophy or the perspective that the relationship is the healing agent... So I try to be a trusting, transparent person even if it is delivering deep breathing, journaling or meditation. I really think it’s the foundation. That’s what I focus on, the foundation of the relationship. Just being present, transparent, honest, reliable. Sometimes I think it’s either what people truly believe that needs solving or it is the safer place to start so that they can get to transformative work. So I’m happy to begin there. … [Then] you’ve established enough trust, enough depth that the client then comes aboard and is willing to do the transformative work.

Question 3(b) What methods do you use for transformational change?

So just to reiterate the idea that the relationship would be the most powerful entity in that style of work. Something I describe to my clients regularly and more than once throughout the course of our relationship is I see my job as several things. One is to reflect back a lot of how I see them. To reflect back their strength, their resiliency, what they have overcome so as not to become a problem-saturated or trauma-saturated story… And then we begin to look at how things from the past are informing the present, although they may seem like… they’re just miscellaneous pieces… I also very much focus on emotion. “Okay, let’s just sit with what’s happening from an emotional standpoint. … what are the feelings that come up?” We tie that into the story that they’ve created. If we are unaware of the story that’s running us, we can’t create change. So awareness and insight are, really, what I’m digging at for clients. The behavior follows suit. Once I think and feel differently about myself, how I act changes. We don’t need to do skills anymore. It just happens. We just flow differently. It’s like the gates of the dam open and now you’re just flowing this way.

Question 4. What is your theory about how transformative psychotherapy works?

The healing happens over time, it doesn’t happen quickly in the way that I work. But it happens because we develop, ideally, a safe attachment. We develop a connection between client and therapist, myself and the client. That challenges a lot of what they believe about themselves. So there I am somebody who sees something other than what they see in themselves, ideally something more positive, strength-based, resilient. This relationship is trustworthy, it’s consistent and it's transparent. And I, client, feel valuable in it, I feel valued, I feel seen, I feel important. And when I have one of those experiences in my life, duplicating something is easier than creating from scratch. Now that I know what that feels like, and I shift just a little bit in my belief about myself, “Oh my God, maybe I am interesting or maybe I am stronger than I thought.” It puts cracks in the wall that we had around us. It is holding space for being genuinely and authentically in relationship with my clients which allows them to be genuine and authentic. Which in turn, begins to shift the way they see themselves. And then they begin interacting in the world differently. And sometimes it’s literally just about showing up for them. People haven’t had that in the past, “Oh yes, I am here.” … I challenge and offer perspective. I’m really transparent in that way. I come from a place of curiosity and not direction like, “You need to do this.” Because if it works or doesn’t work, they give me the credit, it doesn’t matter because I prescribed it. I want to make sure there is a choice in their next step, because that’s a place of empowerment. Then if it works or doesn’t work, they get to own that. And then continue in their world.

Question 5(a) What do you need from the client in order for you to fulfill your role?

My first answer is just to show up. What I might want to say is to be willing, but willingness is in coming, being there, to come is probably the thing. Because of a lack of willingness, resistance which I hate that term but it’s used all the time, difficulty being stagnant or stuck in the story, having to go through it multiple times, all of that is part of their process. I really think it’s just showing up. I mean participation of course, if you don’t talk, we don’t have a relationship. We share space, but it’s going to be pretty basic. Something that I ask for is honesty, and I respect and recognize that sometimes you offer layers of a story, not all at once and I don’t perceive that as lying. Sometimes specific details are too hard to disclose based on the depth of the relationship, but honesty, for sure. The more information that I have, the better equipped I am to help you because if you give me just a tiny piece of the story that’s all I have. It’s like one piece of an entire puzzle, then I’m ill-equipped and in that respect.

Question 5(b) What does the client need from you to move towards second-order change?

In order to move forward, I need to be a predictable person because predictability creates safety. I need to respond, not in uniform ways, but not be erratic in the way that I show up. I need to be a stable force for them. I think the other thing, too, is honesty. I was taught in grad school to make sure there’s not a lot to be read on your face. But if the client does something outlandish or makes an outlandish comment or says something that is horrific and is not reacting themselves, sometimes I think one of the most powerful things that I can do for them is have a big reaction, because it’s human and it’s authentic and it shows them that I care and am invested. But too, that their baseline may have been reset. So sometimes I think that’s really helpful, authenticity, for sure. There’s a quote from Gabor Maté that talks about how, especially with people struggling with addiction, the way that they have survived thus far is essentially through a bullshit meter, excuse my French. In order to have a chance at succeeding in developing relationships you have to show up authentically. The other thing I would add to what I’ve said about what I would need to offer them is a really good modeling of boundaries. Being very clear on what my healthy boundaries are, specifically for people with trauma, they more often than not struggle to set their own boundaries and they also struggle to recognize others’, because boundaries don’t exist in the trauma world. So it is important being really clear about what that is, and being able to work through it when clients become uncomfortable, either with my boundaries or theirs.

Question 6(a) What are the circumstances in which, or kinds of clients for whom, your use of Telehealth enhances transformative psychotherapy?

The more logistical side of things, circumstantially a client who thinks that going into the office, the extra time that it would take either from perspective isn’t reasonable for them or literally can’t be accommodated. It frees that up. Second piece is I’ve done my best to create a safe and inviting and warm office space, but it is different from doing it from their living room or their own space that creates safety. The comfort of their home or their space whatever that may be has allowed for additional disclosures.

Question 6(b) Under what conditions is your use of Telehealth less effective?

I do a lot of couples work. Couples work I think can be tricky because something that has been explained to me by clients is how you brought the energy of the therapeutic experience into our home or our living room, something to that effect. So how do we clear that energy, convert that energy, transition from therapy back to home? Because therapy happened in our home. I think that can be tricky and I actually thought about this a lot when I first started Telehealth, because I wouldn’t want that energy in my space. I don’t do Telehealth in my bedroom; I actually do my therapeutic work from my office. I make a lot of suggestions, “Did you change your clothes? You can take a shower.” Some people are into “sage-ing” or using a diffuser, or opening the blinds, opening windows, having physical movement by going out for a walk, even if it’s around the block. Shifting things around from an environmental standpoint and from a personal standpoint. That shifts energy. Obviously, safety, I can see certain things better in-person than I can view on Telehealth, especially when there’s more than one person. Safety when there is high acuity or potential destructive communication and escalation from there, that worries me. Telehealth can just turn off and I don’t know what has happened. I think circumstantially that can be really hard.

Question 6(c) Can you give an example (with attention to protection of privacy and confidentiality) where you helped a client make transformational change via Telehealth?

Sharing space with the exchange of emotional energy and having to hold eye contact, that literally stunted progress. I had years of working with her prior to Telehealth and her growth was exponential during Telehealth as compared. Okay, so as I’ve been talking it through, I’m realizing it was first-order change to second-order change. The entire first three years of our relationship was skill-building. Do you want to go to a resource group? How about this women’s group of survivors? That was the depth that I could get her to. She was referred to me, I have a specialty in relationship abuse. She is a woman who left an abusive marriage. She came to me probably four years ago. Initially it was like, “I’ll come in once a month.” But even that was a little spotty. She was always on time. She didn’t schedule anything regularly and consistently had things come up, you know work would run late or kids at daycare or whatnot. So attendance was just not regular although she continued to come in some fashion. Body-language, when I saw her, she was just very closed off, she would sit in the farthest corner of the couch. She had a protective stance, pulled the pillow up to her chest. Sometimes she wouldn’t even take off her purse. Again my style, one the biggest part is the relationship. But two, I want to work with somebody to ask, “Have you thought about it this way?” In an effort to normalize her experience, her consistent response was, “I don’t think you get it, mine’s worse.” That was always her reaction back. She’s coming to the session, but I really didn’t think that we had this authentic connection. She was one of the clients where you would think, “I can’t believe they keep coming. This is so wild that she keeps showing up. I don’t feel like much is happening or even feel like she likes working with me.” And then we shifted to Telehealth. She comes every other week religiously. She texts when something comes up at work or daycare, and she says, “I have to see you, what can we make happen?” She’s willing to make adjustments in her work schedule. We try to schedule when her kid’s at home, he’s a little older now. He’ll wear headphones and watch a show. We’ll do 30 minutes instead of 50. It has become important to her. You can tell that there’s value in what she’s receiving. The depth that she has now disclosed, she has gone back to personal traumas that dated back to childhood. And now she talks about how she realizes that she believes that to be married meant that you were loveable and to be divorced meant you were unlovable. In her trauma work, she realizes that the only reason she was bullied was that she was the only African-American woman in the school. She has gone to these depths. And she repeats some of the things, she says, “I know you told me this two years ago.” There’s recognition and a willingness to be vulnerable. There’s no longer this wall, that space. Now there’s a willingness to lean in from her. She is super curious. She reads things and says, “Here are things I now know about myself.” Not just, “Here’s the cool content that I read. I have had personal reflections.” So the depth of her work has transformed completely. Before, she felt power in being separated by being the Other, because that protected her. She could stay where she was, because her experience wasn’t like anybody else’s, therefore she couldn’t change. Now it’s, “Oh my gosh, I’m a human with a very difficult path.” That makes me a human and makes strong and makes me equally loveable as these other human beings. She finds safety now in being part of versus separate. That’s reflected in our work and how she’s partaking in her community. You can tell by the way she looks at you, the tone of her voice. She’s forward, not closed off and back. Everything about the way she communicates, her body language. The type of content that she brings up since we’ve been working on Telehealth. She has grown more in those 8-9 months of Telehealth than she did in the first three years of our relationship.

Interview Nineteen. #29-210412

Question 2. Is the distinction of first-order and second-order change relevant to your practice?

Yes, it is. Most of my clients, and I refer to them as my clients, have been long-term. I was trained in the Psychoanalytic Institute, but I also was getting supervision in Self Psychology which was a precursor to some of the attachment psychologies of today. And there was quite a split at the time I was being trained in the 80s and 90s, with looking at people with deficits or defenses versus looking at people trying to move towards more healthy ways of behaving and integrating their relationships, their ideals in their life. And for the social worker in me, it fit more for me to do the second one than the first. So for most of my clients, I’ve seen them over periods of time. Some I started seeing as children or adolescents, and then as young adults and now maybe young parents of their own children. Now they have had development in their life, psychological development, but also, they’ve had life stressors. Now we are able to look at their more ingrained adaptive responses to problems in their life.

Question 3(a) What are your methods when the focus is on improved ability in daily life?

It’s always so hard to put this in concrete terms. But I think it’s helping to reduce symptoms, to help people manage better in order to improve their daily living. I feel like I’m more direct in pointing out problems or ways they’re repeating themselves. So I might give them goals, ask them to look at things. I don’t typically do homework, but I sometimes finish the session with, “Let’s work on this all through the week and review it the following week.” And then I measure that with, “How do you think things are going? Are you experiencing less of this symptom? Are you managing better?” But it’s more active and more focused on the behavior in these circumstances.

Question 3(b) What methods do you use for transformational change?

The second often develops out of the first. Of course with both kinds of treatment you’re trying to maintain a good relationship. As you develop the relationship, it goes from being what would typically be thought of as a real relationship to an interpsychic relationship. And over time I comment more on that, and I comment more on how they may see me which sometimes is not at all how I imagine myself. But all that information is very useful. I look other important relationships in their lives. Older dynamic theory would talk about that as a transference. I think of it as this relationship that we’re building and we’re trusting in. Also I am more likely to talk about this in terms of how it is a way of experiencing themselves in important relationships, not only the other person, but the way they experience themselves which has some similar patterns. It’s coming up over and over again in their life. So we make a shift in that way, that is with the people who are able to do it.

Question 4. What is your theory about how transformative psychotherapy works?

That’s such a great question, because I’ve thought about that so many times for myself personally, in my own personal therapy, and in supervision. I thought about people that when I first started working with them, I might not have expected them to work so hard. What allows people to trust in this process and make these kinds of changes? I don’t think it’s me. I think it’s them. I hope to believe this, that there’s an innate wish, for most people, to have a more satisfying life, to have a deeper life. And I think, even despite many changes in our social context over the last many years, not just the last couple of years, where people became less psychologically minded, when they are exposed to it, they become interested in that. That probably helps them grow.

Question 5(a) What do you need from the client in order for you to fulfill your role?

These were the two best questions for me in the sheet that you sent out, because I thought about several cases I was frustrated with. So I appreciate those questions. For one, symptoms have to be settled down. When people are hurting in some way, that’s really where I feel I have to stay and work with them. Stable enough and they have to be interested, curious. You know this word “motivation” is used a lot, but I think it’s engaged enough in the process to want to do this. Secondly, there has to be enough of an ability to observe yourself and be willing to continue to work on that when it is harder, for clients to make use of this. And again, people have surprised me, mostly for the positive.

Question 5(b) What does the client need from you to move towards second-order change?

And then I think a harder one was, “What do they need from me?” One of the biggest mistakes I’ve made in my career that I try to tell people is that in my wish to see people to be healthy and my growing to really liking them, I might have underdiagnosed them or under-emphasized how much they are struggling. I think I have to be more honest with them. That can be painful, so I obviously try to do that in a way that doesn’t injure them. There’s a vagueness that I’ve gotten into at times in therapy because I think I haven’t taken that risk to step forward and be a little bit more honest about what I see and where they’re needing to address something that keeps coming up in their life. So I think being more honest with myself and with them, risking that relationship changing into that deeper level. I’ll just add to that I’ve had really good supervision, beyond getting my license. And then, especially since Telehealth, I reached out to small groups of clinicians early on and we talked about cases. When we could meet, we met outside in groups of three. We talked about the process a little bit. It’s been important for me to hear somebody else’s point of view about something, even though it’s not always comfortable to do so. That’s the other thing clients need from me, to be able to look at myself.

Question 6(a) What are the circumstances in which, or kinds of clients for whom, your use of Telehealth enhances transformative psychotherapy?

All of my clients had a previous relationship with me. And I think that that relationship probably helped at the start with Telehealth. On another level, I think that people have felt so grateful to have the screen instead of just a telephone call. I’ve had one new client in this whole Telehealth time. The person had a terminal diagnosis. Sometimes a crisis helps you immediately connect to someone. But I think the other thing is with people who are able to make change successfully, people who are able to talk about how it was stressful at first or things that they like and don’t like about it. It helped us work better. And people that can make use of new information, there’s been new information in Telehealth about each other. Here we are in a different setting. It’s a little more intimate on one level and it is less intimate on another. They can see me at my home, that is my home office. I’m in their home or wherever they’re calling from.

Question 6(b) Under what conditions is your use of Telehealth less effective?

I can speak to this especially since this week I just had a client emergency. When there is a person who is withdrawing into depression or is hiding, unable to be honest about the severity of their mood or their risk factors or their use of substances or their suicidal ideations, it’s risky to be on Telehealth. At that point, I need to be able to see them. Going into Telehealth, I was a skeptic. I thought it was kind of a lesser-than version of therapy. I worried about confidentiality and privacy. You meet online with people in their home and they’re with their families. The first few weeks, like everybody, I got quickly on a HIPAA-compliant screen. It had to be confidential. But I think there’s been more concerns about it because of family members on both sides. For example, my dog just opened the door. I feel it’s been a little less secure on one level. And I’ve tried to talk with people about that. I think it takes more work on my end, and their end too.

Question 6(c) Can you give an example (with attention to protection of privacy and confidentiality) where you helped a client make transformational change via Telehealth?

I’m thinking of two people. One I worked with years ago. She was at a college teaching business law and in a relationship. 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, and many of her colleagues had passed on or she was isolated from some that moved away. What looked like a therapy focused on grief became a life review. Life with her mother and father, she was [from Country] living in [State]. Father went to an internment camp at one point. She had come to the US, with her sister to go to college, leaving her mother behind. There were all these hot points that we never talked about, ever. They were about life, letting go of what felt familiar, stable, and moving on from that part of her life which was more committed. Previously she had all of these ways of coping that were so, so strong. What was so remarkable about it, she was losing so much in this past year. How Telehealth helped, I think, is that she sometimes would take her device to walk me through parts of her home and show me pictures of herself as a child, her mother, or show me things that she collected as she traveled or things that mattered to her, and just talk about that in a very deep way. Honestly, I don’t think that we could have done that in the office. The distance Telehealth provided actually helped that, if that makes sense. I think when we were sitting in my office, that might not have happened. It was somehow safer to do that with Telehealth. So that’s one. Another example is a young man who is in his mid-20s, who the pandemic was ideal for because he’s very, very, bright but terrible social anxiety with maybe some mood disorder, and a very stable family. During the pandemic he could be on his computer screen all day. That’s what he ideally prefers. And he could avoid some of the life decisions he had to make after he got his AA degree. He was encouraged by his parents to go on to get a Bachelor’s. The pandemic allowed him to take a break. Telehealth, because it was his means, he was very comfortable. He knew tech and was helping people get established. He would help me. He would tell me what I needed to do to make my microphone sound better or what I should do to get a better system. I think it helped him to see what was safe for him. He even said that if he hadn’t seen me before in my room, which is what he called my office, he wouldn’t have been as comfortable with me seeing him in his room with his computer things all around him which he showed to me proudly. There was an intimacy in, “Now you’re in my space, my domain.” It was very helpful and now he is getting ready to recognize the world is changing for him. It’s changing again. Some of it may be his maturity. He’s had a year that has allowed him to consolidate. I do think that this was a different venue that was so well suited for him.

Closing Comments:

#29:Actually, this has been very helpful for me. Thank you so much. I try, when I can, to mirror back some of the words they use that are important to them. I also try to understand that in the context of what their life interests are and how that mirror back can be useful. And I try to draw from their history, such as pilots or patients that are struggling with disease and so on. I try to think of the ways we can look at their specific situation and how that mirror back fits in with their mental picture of themselves. I think I learned that a little later in my practice. Nobody had taught me that. I don’t know if this was true for you too, but when I was a younger therapist, I thought I needed to use special words to feel like I had something to offer them. But I think I feel differently now.

Interview Twenty. #30-210413

Question 2. Is the distinction of first-order and second-order change relevant to your practice?

Yes. I always start off with solution-focused with clients who are in crisis. There are definitely times in which I need to utilize that, usually in the beginning when I first start seeing people. They come in really struggling, I do a lot of that. In my first session with everyone, I actually make the distinction you are talking about.

I explain psychotherapy and say that there are these coping skills and the concrete skills that we can work on, but ultimately the transformative piece is through the relationship. It’s the therapeutic relationship that is going to create the most change and they can have this corrective emotional experience. I talk about that with the clients, so they’re aware of it. So once we’ve gotten them stabilized, my hope is that our sessions become much more about the relationship, the belief changes, and all of those things.

Question 3(a) What are your methods when the focus is on improved ability in daily life?

I do a lot of concrete psycho-ed skills like grounding techniques, working on things like, “What is anxiety? Where do you feel it? How do you respond to it? … ” And then the transformational piece, that we talked about, is through the therapeutic relationship. I had a client last week get really angry with me and it was perfect. That was exactly what I was looking for. So then we were able to process, why they were angry and do they do this with other people? So it’s that relationship which is transformational, it is really what I use for the transformational piece. And the coping skills are just sort of scattered in the middle of that, but those are for their daily living. I think what we do is art. You have to know when to bring in the coping skills and you have to know when to touch upon the relationship. And it’s never consistent. It’s like you said, it weaves in and out.

Question 3(b) What methods do you use for transformational change?

I’m in the present moment. It’s important to be authentically yourself in the moment, and not to do too much thinking and analyzing. I usually try to do that after a session. To do that transformative work, I have to feel that I like my client. I have to feel connected. I have to feel like I care for them. So it’s being connected to them in the moment. That’s the biggest piece for me. If I feel myself veering off so that I don’t feel connected with them, then I don’t think it’s as transformative. One of the things I always, always do is bring our relationship into the room. But I give pretty specific feedback. I describe my process as, “I’m nice, nice, nice, nice, and then boom I got you. Then, I’m nice, nice, nice, nice, and then boom I got you.” Some of my clients will be kind of shocked by that. But most clients appreciate that I’m clear in my feedback. I don’t mince words and I don’t sugar-coat, and I don’t think it’s very helpful for people to have that. That’s how I am, that’s how I present in my work.

Question 4. What is your theory about how transformative psychotherapy works?

It’s super complicated, so it’s complicated to actually try to put this into words. I use the term “corrective emotional experience.” I think that’s true. I think that I will repent to people all day. And love them. My favorite quote from Freud is that psychotherapy is in essence a cure through love. And that’s how I feel. I feel like I’m loving people and I’m providing them authentic feedback. And helping them explore themselves and that, I think, is healing. It gives you a nonjudgmental place to be curious about yourself and to ask questions. That is really what makes change, having a trusting relationship so that my clients can trust that when I say, “Hey, you’re actually doing better or you’re doing worse.” To me that is the basis of change. I think if there’s none of that, I just don’t think any of it really matters. Change won’t occur. To me change is a very slow process. I work with people who are not necessarily motivated to change. That’s my niche. I think that all the little changes we make, to get to the big change, are all just so important. So I celebrate every little change that occurs. It’s rare that someone goes, “I want to change this about me,” and then in a week or two or a month or two it’s done. It’s usually a much longer process.

Question 5(a) What do you need from the client in order for you to fulfill your role?

I wrote these answers down, because when I read this question I thought, “That’s a really good question.” My answer to that, for what I need from the client is, I just need them to be curious about themselves. And be willing to engage in conversation with me. That’s it, that’s all I need. If I have those two things, then change can happen, work can happen. I don’t need someone who wants to change. I don’t need someone to really think that there’s anything wrong with them that they need to work on. I don’t need any of that. I just need them to be willing to engage with me and be curious about themselves.

Question 5(b) What does the client need from you to move towards second-order change?

I actually am just going to say this, when we talk about non-judgmental, I think that we’re non-judgmental in the sense that someone can tell me the most horrific scene or thing that they’ve experienced and I will be there and listen and be able to hold that for them. And I won’t judge them for that. At the same time, they want us to be judgmental. They want us to respond when they say, “Is that normal? What do you think I should do? Was my parent abusive?” They need to hear, “Yes, they were abusive.” They need us to have judgment too. So non-judgmental of them, but create feedback and judgment around their life. I think that helps them. They need something to center them. And they need me to be a human with them in the room. They need laughter. They need to feel loved and cared for. And it needs to be interesting for them. That’s what I think they need.

Question 6. Do you modify methods for a Telehealth session?

When you were talking about whether or when we choose to meet or not to meet, it’s more about what works for the client. So if the client doesn’t want to drive and prefers Telehealth, that’s okay. That’s how I did it prior to the pandemic. I had the option for people.

Question 6(a) What are the circumstances in which, or kinds of clients for whom, your use of Telehealth enhances transformative psychotherapy?

I thought about this for a while too. I don’t actually see Telehealth as enhancing change for my clients. I see it as being as effective for many. Like you mentioned, we will go into why it’s not as effective for others. But I don’t see it as enhancing. Now a caveat with that. One is that I have loved to see their homes and cats and dogs and all of that. So for some of my clients they’ve shown me their artwork on the wall that they’ve done. Things like that. So I’ve gotten to know them better in that way. But I don’t see that as necessarily enhancing their change or their ability to change. The other caveat is that I do see it as good for people who have transportation or access issues. They have difficulty getting there because of work or kids or whatever. Accessing, you just have to have a computer and Wi-Fi and you see someone. So in that way, I think Telehealth allows people who were not able to, to get this help now.

Question 6(b) Under what conditions is your use of Telehealth less effective?

I have a lot of these actually. I work in substance use and I work with harm reduction, so I see a lot of people who are still using. And what I have found is that Telehealth, especially from home, was really problematic for my people who were not quite ready to stop yet. I had clients taking shots while on the session. I’ve had people who think that they are in their house so they just do whatever they want. Whereas when they would come into my office, they would have to get there, so they would often not drink before coming to session. Or they were coming to session, so they weren’t intoxicated for an hour, because they wouldn’t do that in the office with me. Now I was having a harder time, I had this client who was getting progressively more and more drunk. Then I had to figure out a way to keep him safe. I had to find someone because they’re alone in their house. So for me with a certain segment of the substance use population, people who are actively using and working on harm reduction, I think it was really unhelpful. It was definitely less effective. Also as a clinician, when my clients walk in the office, I smell them. I’m able to look at their pupils. On Telehealth, I had a client who was like, “No I haven’t been drinking.” But had it been in person I would have said, “I can smell it on you.” And they would have said, “Oh yeah, you’re right.” It just felt more accusatory through this computer screen when I couldn’t say, “I see it on you,” because I couldn’t really see it. I think there are pieces of my ability to be able to be a good clinician that was also lessened with Telehealth for substance abuse. I definitely think that population, Telehealth is much harder, much less effective. So the other one, I have a client who has domestic violence in her home. For her, she could not do Telehealth because her husband would continually listen or it would get worse. So I actually saw her in-person with a mask for the pandemic, because I knew that she needed the help. She could not do it with Telehealth. Then also, there is silence. So I use silence in sessions a lot as an intervention. … I think both the client and myself feel less comfortable using silence online. It doesn’t feel, it doesn’t come across the same way. And when you’re in the office, you can kind of divert your eyes. But you’re just sort of looking at the screen with the face of someone. It doesn’t translate, in my mind. I feel that intervention has been less effective. Not ineffective, just less effective. The other thing is, obviously you lose body language. So someone is tapping their foot a lot, anxious or being angry. The other day, as I had said, I had a client that got angry with me. They started crying, they had slid in their chair, and because of the computer I couldn’t see the crying until later. So you just miss visual cues that you would see in person. And then the other thing, and this is an obvious one, is the clients with bad connections. That is just really difficult. Some people consistently don’t have stable Wi-Fi or they’re trying to use their phone and their battery dies. All of that makes the work less effective for sure.

Question 6(c) Can you give an example (with attention to protection of privacy and confidentiality) where you helped a client make transformational change via Telehealth?

There are three clients that are bouncing around in my head. Most of the clients that I’ve worked with I’ve worked with for many years. I have this client, I diagnosed him with Borderline Personality Disorder. That gives you some information about how he relates to humans. And he has erotic transference. And we have been talking about that for years. There are times where he says, “You know, you’re not bringing it up enough. We need to talk about it. It’s still an issue.” And ever since we’ve had Telehealth, he has said that there’s no erotic transference, “It’s completely gone.” Which I think is fascinating, because that goes to show you that there’s energy in the room and all of that. But because of that, we have actually been able to move through a lot of things that he didn’t feel comfortable dealing with in person because of the erotic transference. So we’ve had more progress in Telehealth. I think he’ll probably request to do a little bit of both, in the office and Telehealth. I’ve had a client who lives in [City]. And she never met with me in person. And she preferred a phone. She never wanted to do a video. And that was fine and it worked for us. We worked and were able to build that relationship. It was fine. It’s really about what works for the client. In terms of transformational change, there’s this client that I’ve had for a while who is depressed and says, “If things don’t get better, at some point I’m going to kill myself.” The client is very successful, very high up in their career, makes a lot of money. All of those things, but incredibly lonely and unhappy. In sessions he was often telling me about their life, but kind of apathetic. He’s giving me details and I just felt like we were stalling. We were going in circles. We did a lot of interpretations about their life and about why they’re in this place and all of those things. There was awareness, but there was no behavioral change. There was no heart awareness. There was mind awareness, but no heart awareness. And so we used Telehealth, or I used Telehealth to push and push and push and push and push. Basically to say, “We’re circling. This is what’s happening.” And this is the person that got angry with me recently. When I pushed and pushed and pushed, they were screaming at me via Telehealth. Screaming saying, “Why isn’t anything changing? I’m paying you. Why isn’t this changing? Why, why, why, why?” Just like crying and screaming. And I let them go and, of course, was trying to soothe them. But we were able to process what was happening in our sessions and what is happening in their relationships is that they’re not connecting. I never felt connected to this person and I can connect with a lot of people via Telehealth, but can’t feel connected to this person. And they’re circling, not connecting, and all of a sudden, I felt all of their emotions and they were connecting with me. We talked, “Why is it that you can’t connect in your relationships? What is it? What does it look like to connect with people?” And that was after working for this person for two years. In person I didn’t get that, and maybe it would have happened in person. I honestly feel like, for this person ,they’re so guarded, I’m not sure they would have let that much out in person. I think it was really a safe way of doing it via Telehealth. And from there they are making a lot of changes in their life and how they connect with people and what they do. That was pretty transformational. I’ve had clients get angry with me, but I don’t think I ever had anyone that rageful, when they are typically a composed professional. For me, that was a transformational change. I’m looking forward to seeing where it’s going to go.

Interview Twenty-one. #31-210319

Question 2. Is the distinction of first-order and second-order change relevant to your practice?

It’s the only way I know to practice. I don’t know any other way.

Question 3(a) What are your methods when the focus is on improved ability in daily life?

When a patient comes in and says this presenting problem, how do I go from there? Well I think behaviorally I look at, “What is your day like? But before I even get there, I do a history, an intake… I want to be where you are, because you are really the one that’s going to solve your issue. You are the one that’s going to solve it. I will help you on your journey. Or even as we build the relationship, I might offer a few options. Patients tell you very, very, quickly what’s going on. They will say, “You know I got written up. I got another PRN.” I will say, “Why was that?” They say, “I was late.” I say, “Oh, okay, so that’s the problem. Too much lateness, you are going to lose your job.” I try to be where they are and get their ideas first, about where they’re at. I think a lot of people really know.

Question 3(b) What methods do you use for transformational change?

I was trained psychoanalytically. After Graduate School I went to an institute. That was my training. Basically that’s the core of the work that I do. I do a lot of early childhood issues, abandonment issues. That’s kind of where I go. I do dream work which is much deeper. And that’s really the kind of work I like to do. I don’t use that word “transformation.” Because transformation is a hard concept for me to wrap my head around. A lot of people are such fantastic survivors. Either they run away from home or leave home. They are on a survival mission, but when it comes to relationships they get into real difficulty. Because they are running away from home. They don’t have trust, intimacy issues. So exactly that’s a good question, “What do I call it?” I don’t know. I don’t have a name for it, but the work is on how do we begin to trust again in a relationship, how do you deal with intimacy? What is that need to run away as soon as someone possibly is close or a trust issue comes in the way? I don’t really have a name for it. I say they are on the wheel. Going around the wheel. I say that sometimes.

Question 4. What is your theory about how transformative psychotherapy works?

I can only tell you what clients have told me. They find that I am not judgmental. And there seems to be something about my voice. They seem to early on have a trust with my voice. When I was in my office, they felt my office was very, very, nurturing. It wasn’t sterile but it wasn’t cluttered. I can’t tell you how many people have said that it’s more Zen-like. They’ve told me that I seem to know things, but also, I have to say, from a younger therapist to an older therapist, boy what a difference. They listen. They call it wisdom. I don’t think I have wisdom. I don’t. I really, really, don’t. But I’ve lived long enough to learn a few things, hopefully. Actually, I have older patients. For the most part my patients are in their 30s, 40s, and a few in their early 50s. So how does my work - work? You know I’m very, very, supportive also of people to go to school and learn something. If you want to be a plumber, go to a school so you can get a license to be a plumber. Go and learn something. I really encourage that with many, many, of my clients. Or if they want advanced degrees, some people need advanced degrees. I work with a lot of people from the [City]. They’ve had a good job there for a long time, but they don’t have a Master’s degree. They aren’t going to do much better with the City without it. Go get it… I try to approach them very holistically. Exercise if you’re depressed before we go for a Med consult. Let’s see what we can do with exercise, food and sleep, a little bit of lifestyle alternative here. I don’t discourage medication, but that is not my first line… I don’t know how it works. I love mystery. This work, a lot of it, can be very magical. One word, one thought, one idea, yes, it is very magical.

Question 5(a) What do you need from the client in order for you to fulfill your role?

I need them to show up and be present. Sometimes I have to wait for that presence. There’s actually a lot of fear and anxiety and stress, seeing some unknown person. I really need them to be on time too. I’m kind of a stickler for time. The first thing I would hope that a client comes in and would be open so that we could start communication. Communication, because the presenting problem often is not the real problem. Or, silence is okay. We can sit in silence, and meditate with breathing, yeah. As long as they show up, that’s what I need first. To show up.

Question 5(b) What does the client need from you to move towards second-order change?

To be present, to listen, also most clients like feedback. One begins to share the issue. You know I want to respect why they came in. “But I would like to take a little bit of a detour into something that I do want to ask you about, when you share XYZ. Can we talk about that a little bit? Then we’ll get back to ‘I don’t have good relationships with women.’ Let’s go around the Mulberry Bush a little bit.” And sometimes one of the problems I do have in session, I might talk too much. I’m, from the past to now, I’m really very different. I’m very flexible. I say what I feel to the client. Before I was a little bit more, not rigid, but I used to hold back more. I don’t anymore. If you don’t like it, tell me. There are some things that I can apologize for. And some things, I won’t. That statement alone puts just another great layer on treatment. A great layer, that’s when I say, “How did that tap into something else?” Or how did that manifest? I kind of like it when that happens, because it just puts another layer on the treatment.

Question 6(a) What are the circumstances in which, or kinds of clients for whom, your use of Telehealth enhances transformative psychotherapy?

Okay, you know what? I guess I have not heard that from a client. It is very superficial. If I could go on and expound on Telehealth. People who I’ve seen for a long time, might say, “You know I love going to your office. It was so nice seeing you in the office. This is really different.” Now, I’ve been remiss to ask, “How is this different?” because they add quite quickly, “Boy is this convenient. I just came in from exercising.” Or, “I’m in my car, it’s quiet, it’s just me. And it feels really good.” … I get to see their hobbies. I have one guy, oh my gosh, he can be quite difficult. [We] talked about hobbies, I’ve seen him for years, when I first did Telehealth with him, he was living in this very austere looking apartment, bare. I said, “Hey, I thought you said you were decorating your apartment.” He said, “I am. Look at my new table.” So he would take the screen and show me his table. I said, “Oh my goodness this looks great.” And then he said, “You know, I’m gonna bring in some plants in here.” I said, “That is perfect for you. Something that you can nurture.” Well, over the month this man has more plants than I would ever dream of having, They’re everywhere. I love that. I’ve talked to him for a number of years about getting a companion, an animal. Well, he did. He absolutely loves this animal. It’s his companion, he’s pretty much alone. He’s had bad relationships that were his fault, I would say, primarily. Now he has these plants and this dog to nurture. In my office, I would never have seen his new furniture. I would never have seen his plants. I could see it in photographs they would take to my office and show me… But seeing it on film, I have to say, Telehealth in many ways has been just such a benefit in seeing the whole person.

Question 6(b) Under what conditions is your use of Telehealth less effective?

I’ll tell you it’s been a great benefit to my practice. However, what I feel about Telehealth now, especially now, it may be because I’ve been working too much, looking at a screen is absolutely getting to be exhausting to me. Exhausting. I take a break every 10 minutes. I’ve come to terms with looking at the screen is rather exhausting. Work is much easier face-to-face. This is after a year doing Telehealth, but only realizing that now in the past few months.

Question 6(c) Can you give an example (with attention to protection of privacy and confidentiality) where you helped a client make transformational change via Telehealth?

Let’s see, it’s a woman. Number one, she is doing the work in solving her problem. She is doing the work. I worked with her in Telehealth, I would say about 8 months. Angry, bitter, she’s single. Angry about a 19-year relationship that she has been in, with an emotionally abusive guy that actually did very little for her. I would say nothing to her, as she told me her story. She was living with him, and his mother in the same complex. They lived down the hall, she got her own apartment in the same complex. Now, this 19-year relationship he left. But he’s down the hall. She’s in her apartment and they don’t see each other that often because there’s different exits although sometimes in the parking lot. This feeling that I got from her was there was always that hope that he would come back. Always. So we discussed it. We discussed his character. We discussed why she continued for 19 years in this relationship, not married, no children. We discussed her childhood. She was a child really who was unloved in the way that she needed to be loved. Her parents loved her. But not the way she needed to be loved. There was something about this relationship that answered the needs for that. At least initially. So she’d hang around year after year after year, kind of like an addiction. Hoping that first high would happen again. Well it never did but she kept hanging on. Two months ago, it was like an absolute breakthrough. She saw him on Valentine’s Day. That visit by him, and her getting a little more insight into who this character is, and her needs, and why she needed him for so long, all of a sudden, her shoulders went down. Her face brightened. She looked great. It was amazing, seeing her on screen from the early times that I saw her. She’s a very attractive woman. I said, “You’re going to meet someone that treats you in a more respectful, caring way. But you have to be available for that too. This relationship continues to cloud that. You’re not available.” Well, something happened. She hasn’t met anyone, yet. But all of a sudden, a lot of the anger just dropped away. She said, “I feel so much better, talking to you has helped me a great deal.” She’s doing so much better. Her work is better. She’s a real estate person, and she’s moving. Oh yes. Staying there was stirring all of those memories. Take flight. She’s not one who has ever taken flight, not even as a kid. She needs to find herself a home that is hers. She got some insight into her own behavior, thoughts, the way that she’s done things in the past, that are not working now. Oh, and what else she got, she’s gotta spend a whole lot more money on a condo!

Interview Twenty-two. #32-210420

Question 2. Is the distinction of first-order and second-order change relevant to your practice?

Yes, it does because I do a lot of short-term counseling with employee assistance programs and other insurance; and I do some longer treatment which is sometimes counseling and sometimes psychotherapy. It’s a mixture. I do art therapy which, as you know, by definition is psychotherapy using art. That is definitely the most transformative work, because it reaches the unconscious. That’s a smaller percentage of the work I do.

Question 3(a) What are your methods when the focus is on improved ability in daily life?

The first thing I do when someone comes into my office is welcome them, explain what I do, and go over policies, just a little bit, verbally, Then we start identifying, Why are you here and what can I help you with? We set goals. Counselors always set goals. That’s part of our training. And then I will listen to people talk about what it is that’s bothering them. Where are they in their life? Why are they here in my office? Then we make a plan.

Part of that plan involves using CBT. I have a lot of training in CBT. Insurance companies like that. One of the things that I found is that a lot of people don’t want to do the homework. CBT works better if you practice between sessions, whether it’s digital, whether it’s audio, whether it’s writing on paper. A lot of people aren’t into that. So I work the principles into the conversation. I talk about how it can help them think differently about what’s bothering them and how they can cope with it. So that’s how that part works.

We also make a stress management plan. Almost everyone who comes in for short-term counseling or even longer term has stressors in their life? What can you do about them? What are you doing currently for stress management? A lot of people are doing nothing at all, “What, I have to have a stress management plan,” they often say. So we do that… A lot of this stuff is really, really, basic.

Let’s talk about the support systems in your life. I have a support circle graphic that I use. I put the client in the middle. Who is in the inner circle? Who’s in the outer circle? People are really surprised when they do that. Those are a few of the very basic techniques that I use with people who need shorter term counseling.

Question 3(b) What methods do you use for transformational change?

That’s not as linear, it’s more circuitous. It begins with a commitment to look inward, to take an inward journey. Are you ready for this? Is something you want? Have you done this before? Usually the most transformational work is done with art therapy because the process does draw from within and bring up unconscious material. To begin that journey, we do warm up exercises. We work with paints. I give them directives. I do a little bit of assessment. We’re always doing assessment in art therapy. Sometimes I’ll give them specific directives.

As it progresses, people create their own path. They know what they need to paint and draw. And in between, we always talk about their work. Occasionally some people don’t want to talk about it and that’s fine. The work speaks for itself. Sometimes we go back to it later. Sometimes people come in and they’re all over the place and I’ll say, “Okay, I’m going to give you markers and colored pencils to give you a sense of structure and to regroup yourself; focus and tighten up.” Occasionally that’s needed. We also work in collage to give people a lot of control, when they’re feeling really out of control. We look at the work, we go back to it. I put it up on the wall, we dialogue with it. It’s a Gestalt technique. A lot of material comes out from that. Along that process, I’m like a guide. Because people are on the path and I am there with them. Whatever comes up, nothing is too small or too large.

A client that I have been working with for a few years, has developed this amazing process. I’ll just share with you. She draws with Cray-Pas and then paints over it. She draws certain things and then blocks them out. And then she goes back in with the Cray-Pas. And not only is it rich and beautiful and textured, but there are layers and layers of information. She has been doing this, and little by little her images have changed. Over the past few years she had always been drawing and painting these eyes. With her history it made sense to be vigilant. The eyes turned into fish swimming in the water with a beam of light shining down. Talk about a transformation! In this kind of process, the images often appear in the work before people acknowledge what it is. It’s an amazing thing. It’s what keeps me going. It keeps me so excited about my work. That’s the most transformative work I do.

Question 4. What is your theory about how transformative psychotherapy works?

Good question. I think sometimes I’m not even sure how it works. I see it and I know it’s working. A person might say something that involves a new insight. Or like what I just described about the image transforming. The eyes were turned into fish, and I saw it happening. How does that work? I think how it works is that there’s a space that’s created. I’m sitting here and the person is sitting there; they’re talking and I’m listening. I say something. It’s the same thing with art therapy. There’s a space that’s created. We’re sitting in proximity, and I’m holding this space with people, and somehow in that space people are free to express themselves in such a way that transformation takes place. That’s the best that I can explain, because I don’t really know exactly how it happens. I just know that if the situation and the setting is right, it will happen.

Question 5(a) What do you need from the client in order for you to fulfill your role?

The first thing I need from the client is commitment to the process. Commitment and then understanding and also an openness to it. Especially if it’s going to be art therapy. Even if it’s verbal, an openness to look within, to think carefully, and then to talk or to create images, and also to be able to reflect on them, acknowledge them and work with them. So that’s what I need.

Question 5(b) What does the client need from you to move towards second-order change?

The client needs a commitment from me to be there, to understand, to accept, and to witness everything that happens without judgment.

Question 6(a) What are the circumstances in which, or kinds of clients for whom, your use of Telehealth enhances transformative psychotherapy?

What I have noticed about Telehealth in terms of, “is this is better than the office,” there are a couple of things. For some people there is a comfort level with being at home, not having to travel, to come into an office, to just be home in their familiar surroundings. I think that does provide a certain amount of safety for a lot of people. Some of the comfort may include the fact that they might have their cat sitting on their lap, the dog is wagging its tail. Their environment gives me a lot of information. A lot more information than if they’re sitting in a chair across from me or at a table to do art. That environment might make up for whatever I miss in body language. We gain a lot by seeing people in their environment. Even if it’s their car. People who don’t have privacy at home talk to me from their car. There they are on the street. We can learn a lot from their environment, if we pay attention to it. It’s very useful.

Question 6(b) Under what conditions is your use of Telehealth less effective?

Sometimes it might take a little bit longer, two or three sessions, depending on the person, to really connect with them. It’s not the same connecting with someone on video as it is in person. There’s an immediacy that is missing. The real person is the real person. It’s like we’re online and we’re “on.” There’s a certain amount of performance, and I think that gets in the way.

Question 6(c) Can you give an example (with attention to protection of privacy and confidentiality) where you helped a client make transformational change via Telehealth?

There is a client who I have engaged in art therapy since Telehealth. He doesn’t do it every single week. He comes every week, but a lot of times he wants to talk. Recently, he did a drawing, mixed media with paint; it was sort of like a landscape. When he finished, he put himself on a bicycle in the middle. When he talked about it, he said, “I’ve been wanting to get out and ride my bike all summer, and it hasn’t happened.” I said, “It looks like you’re riding your bike, now.” He said, “Yeah but,” and he’s talking about his husband, his kid, and his job which he hates, and all of these other things. Meanwhile, he’s looking at the bicycle.

Next week he comes in and he says, “I took my car, I went by myself, I put the bike in the car and rode over on the bridge. I looked over the bay and I felt like a whole new person.” You know, here it is. We draw it and then it happens. People do this. And that was a really transformative experience for him, because he was able to do something for himself which he hadn’t been doing for ages. Then he continued, “We’re going to go riding this Sunday, all of us.” It was simple. There weren’t deep insights, but it was important and made a difference. It led to other good things with his family.

Closing Comments

VB I’ve never been much impressed with this word “depth” or “deep.” Because sometimes what works is that there is little change in digestion and metabolism.

#32 Oh.

VB Digestion is after you take something in. Metabolism is it becomes part of your vibrant self.

#32 Okay.

VB And then there’s the adage, “Don’t bite off more than you can chew.” So little, “little” is in quotes. So these digestible bites that we metabolize into our self, and the big stuff you could just gag on it. Throw it up.

#32 Totally true.

VB Or it can sit there, like a rock in your stomach. So I’ve never been impressed with going deep.

#32 Yeah

VB There’s also the Hippocratic Oath. What if going deep causes re-injury? I really like this story that you just told, because it’s about a small change that’s transformative. The story captures something, I can see it.

#32 It’s visual. I think you can picture those things. Yeah.

Interview Twenty-three. #33-210426

Question 2. Is the distinction of first-order and second-order change relevant to your practice?

Well I think that probably not. Particularly because my emphasis will be more transformative, but of course in the process of transformation we also do problem solving. If I had to pick one of the two, I would say probably more transformation.

Question 3(a) What are your methods when the focus is on improving stability in daily life?

More Socratic asking questions for clients to come up with their own answers. I’m not big on giving advice. I use some cognitive processes. Evidence-based cognitive tools. For example, if you think that your barrier to growth is that you are not worthy, what evidence do you have that that is factual? There’s also a psychoeducational component. Also, I tell people all the time, “You know that freedom comes from options.” What are the choices that you have? What else could you be doing?

Question 3(b) What methods do you use for transformational change?

It’s much more reflective, but one of the things I do is point out patterns. And when I first meet people for the very first time I say, “I work a lot with patterns.” So I think the transformation stuff is when people really begin to see that this is not an isolated incident. For example, we are spending time talking about how to talk to Aunt Jean. I might say, “This reminds me of the time last week when you talked about [that].” And really establish those are patterns, defensive strategies, survival-based, strength-based for BS survival. When you learn those, they are adaptive for where you were. But are they still adaptive for you? Is that still what you would want to be doing? So it’s reflective.

Question 4. What is your theory about how transformative psychotherapy works?

A common thing that happens quite a bit, we’re working on assertiveness for instance. I do this with women who don’t assert themselves. They may come in down the road and say, “I’m so proud of myself. I talked to Aunt Jean. Before I even knew what I was doing, I talked with her.” They start to report their own progress. There’s an insight-based reflection. First subjectivity and then objectivity. And then behavioral change. And they’re able to say, “It felt good.” They’re driven by it and feel empowering. That makes them want to do it again because it felt very empowering to them. And some of that, probably, I don’t know, might be about pleasing me. Reporting good progress. But where I see that transformational piece is where they have that satisfaction based on their own insights and then actions. They have a sense that they’re doing something different. The change is probably reinforced by satisfaction and empowerment.

Question 5(a) What do you need from the client in order for you to fulfill your role?

Well some level of engagement I would say. Do they show up for their appointments? Are they in time? Is there continuity from session to session? Could they say, “Oh I thought about what you said last time.” I might say, “I thought about what you said last time.” So there’s a dialogue. I need the client to be able to dialogue with me about their experience in the therapy and their growth. I think the engagement is demonstrated by a lot of different things. Do they pay attention, show up for their appointments and on time, not cancel? There is something about the continuity from session to session that is helpful too. I would say more helpful than essential. It is important. I also like to work very much in the here-and-now. If somebody doesn’t remember at all what we did last week, but they have something they’re working on now and they are present, that’s good, that’s fine. There is often a thread that people bring and they remember. Also I hold onto the thread and I’ll say, “This looks like what you said three weeks ago when we were talking.” I work a lot with the story, so I tend to remember the stories very well. And so I usually have the thread.

Question 5(b) What does the client need from you to move towards second-order change?

I think they need the continuity for me too. They need me to be attentive. They love it when I remember the names of their children. Frequently I hear, “Oh my god, you have such a good memory.” People come in after a break, they come back to therapy, and they’re surprised I remember who they are, which is shocking to me. Because I don’t think I’ve ever had that happen. I think they need, I guess like any human being needs, they need attentiveness. They need attunement. They need me to be interested in what they have to say and remember what they said. It might be their story or it might just be the name of their child or the name of the dog. Absolutely I think it’s essential about being attuned in the moment. Asking questions. Listening. It just comes naturally when somebody is present and is attending to what somebody is saying and doing.

Question 6(a) What are the circumstances in which, or kinds of clients for whom, your use of Telehealth enhances transformative psychotherapy?

I haven’t had a huge amount of experience in Telehealth, it’s been about a year. I think you and I right now are closer, visually closer, than I would be if I were sitting in a room with a client. Your features are more prominent. You're filling the screen. So I think that patients that need a lot of a kind of reinforcement and attunement, I think Telehealth works really well for them. Particularly if it’s somebody I already know. Some of it might have to do with the level of distress they bring in. So if somebody is more in crisis, I think Telehealth can work better. Because they don’t have as many defenses. They’re not looking at their pictures. They’re more in the moment. They’re more raw, more exposed. Somebody comes to mind that recently had been widowed and I’ve been working with this new person. I have a very strong connection with her and I think vice versa. At this point I kind of forget that I haven’t actually physically met her. It can be a bit more intimate in some ways, because you can see maybe more facial expressions. I think it’s the same as in real life, if you are sitting closer to someone rather than further away. There is more of a sense of more intimacy, “We’re in this conversation.” I do have another case, a brand new one. He’s a very young man. He’s very knowledgeable. He has all of the lingo. It’s interesting, they’ll use the nouns as verbs, “I was Tic-Tocking.” Many of these relationships that they have are formed online. They do have really an aptitude for technology, more than maybe an older person. I find that with older people who have aged into their therapy, they have Medicare, they love that they don’t have to drive. And I think it goes back to your first question. Certainly if it's problem-solving or solution-based, there’s probably not much difference at all.

Question 6(b) Under what conditions is your use of Telehealth less effective?

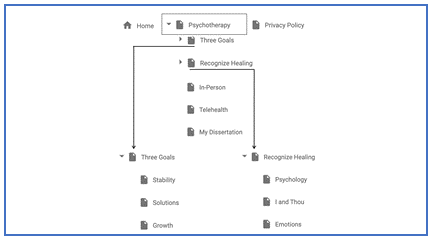
There is the perennial technology stuff. People will freeze up and you will miss some of what they are saying. That’s a real annoyance about Telehealth. Sometimes technology really gets in the way of it. I think that could be problematic. So one of the challenges with Telehealth is starting new clients who I haven’t met before. But I’m finding if I’m working longer term with them that starts to even out. One of the things that is a little challenging is distractions. They are now kind of looking at my house, “Oh I see you have those paintings.” I think sometimes that can be a little more distancing. And if my cat is walking across the room, some like it and some don’t. Some people don’t want that, so I have to be careful about that. If I lock them outside, then they start crying. I have to be a little bit more careful with boundaries. Patients might be more likely to ask me personal questions when they see my house. Sometimes it’s a distraction because I’m looking at their environment, especially if they are sitting back in the context of their room. So it does matter where their camera is. I’m looking at your eyes right now, I don’t know how it feels on your end. Sometimes I can feel that somebody is looking away or up. There definitely is a qualitative difference. When I first started Telehealth, I almost felt like I was watching television. It was like watching a TV show. It was sort of out of body or something. It’s not that way anymore, but at first it was so foreign. So when it’s really about doing reformative work, there is something about being in the room with someone. There is something about the whole-body language. So what you gain by being this visually close, you lose the rest of the body language. I think Telehealth enhances intimacy and closeness. But you do miss the whole-body thing.

Question 6(c) Can you give an example (with attention to protection of privacy and confidentiality) where you helped a client make transformational change via Telehealth?

I’ve only known her on Telehealth. So much of the process of grief is the permission and the support for somebody to express their feelings, their affect. She was very blocked. It was very hard for her. She was very stoic and has kids. She was afraid that she would become nonfunctional. It was a pretty traumatic death. She’s young and her husband was young. His was a cancerous death that took over two years. She was pretty much in shock, still, when she started. A lot of discussion at first was about setting boundaries for in-laws or people that wanted to encroach upon her. And then it moved into how she could help her children grieve. She had a very good sense on how to help them. She is a very good mom and she’s very intuitive. And then we were able to move from that to what if she were able to use some of those tools. It would be like, “If your daughter was telling you that, what would you tell her to do?” The transformation is that she has a lot more affect now, spontaneously.

# Appendix D: Website Concept

Figure 11. Site Map Concept

*Note*. <https://www.vblcsw.com/drvicstories/>

I have two goals for the site. First is to present ideas and stories with common language, photographs and art. Second is to encourage dialogue so that visitors become co-creators, sharing their ideas and stories.

# Vita

I have been a social worker for 35 years and psychotherapy complimented my other jobs. I’ve guided organizations through a comprehensive analysis of mission, people and technology. My role, each time: quickly connect with front line staff and management alike. My duty: bring extensive knowledge of best practices and highly skilled guidance whenever strategic change is needed. All of my clients value professionalism, communication and personal warmth. Sincerity, decency and integrity permeate everything I do. My major organizational accomplishments:

\* 3 World Bank/ USAID business development awards and a bi-national housing development award to a Non-Governmental Organization with a limited track record,

\* >$2.4M program revenue over 10 years preserved by successful turn-around of a multilingual (7 languages) department that was in critical failure mode. This social service agency is contracted by the County and would likely have been closed by a failure, because the department was the company flagship. The flagship department saw 65% increase in Medi-Cal revenues in the first 4 months of redesign; and 80% improvement in contracted services.

\* >$3,465,500 generated for 181 clients in six years through redesigned workflows and compliance with new regulations for Electronic Health Records. Failure would have posed a critical threat to the business, instead they are more efficient and handle more patients (increasing recurring revenue).

\* 100% increase in new contracts: Team excellence turned around a psychiatric hospital in federal receivership and bankruptcy converted to competitive awards from the State of California and County of San Diego.

**Books**

<https://www.vblcsw.com/author-consultant>

Bloomberg, V. (2014). *A Wormhole Named Desire – Blog 2014: Journey from Survival of Trauma to Freedom of Love*. Independently published. ISBN 9-781505-626230

Bloomberg, V. (2015). *Kaboom or Kaching: E=MC2 or EM->2C.* Independently published. ISBN 9-781515-919960

Bloomberg, V. (2015). *Kaboom or Kaching: Or Inspired Leaders & Exceptional Teams Achieve Rewards Through Greatness. Independently published. ISBN 9-781517-724559*

Bloomberg, V. D. and O’Kane, Steve (2018). *Kaboom or Kaching: Strategic Leadership During Disruption.* Independently published. ISBN 9-781724-880796

**Posts**

“Guided relaxation for intrusive thoughts, emotions, or sensations”. (September 2020) <https://www.linkedin.com/posts/victorbloomberglcsw_mentalhealth-wellness-activity-6713515849019486208-Ed7R>

“California Workforce Connection 2019 Independence”. (September 2019) <https://www.linkedin.com/posts/victorbloomberglcsw_california-workforce-connection-2019-independence-activity-6530916165882118144-y7_P>

“How to Cope with Loss and Grief” (2019)

<https://www.vblcsw.com/grief-therapy>

**Presentations**

“Richard Lawrence Reflections on Battles with Racism: A Western Institute for Social Research Seminar” (March 2020). Co-authored an innovative seminar to combine live discussion, video segments, and data collection for qualitative research.

“Richard A Lawrence: Social Justice is Personal” (January 2020). Video conversation with Richard Lawrence [https://youtu.be/8soD-6Xmaks](https://youtu.be/8soD-6Xmaks%20)

“Wormhole Named Desire: Journey from Survival of Trauma to Freedom of Love” An art video. (October 2014). <https://youtu.be/D6i6hY8Nkds>

“Paraguay Report”. (January 2008). Hand-delivered to the U.S. Ambassador Encarnación during his visit with Peace Corp Volunteers in Encarnacion, Paraguay. [https://youtu.be/GMspK9pUROU](https://youtu.be/GMspK9pUROU%20)

**Education**

Doctor of Higher Education and Social Change, Western Institute for Social Research, 2021

Masters of Social Work, San Diego State University, 1984

B.A.-Visual Arts, University of California-San Diego, 1980

1. Qualitative research is used to understand people's beliefs, experiences, attitudes, behavior, and interactions. (Pathak, et al., 2013). [↑](#footnote-ref-1)
2. Telehealth is the use of electronic information and telecommunication technologies to provide care when the client and the provider aren’t in the same place at the same time (Telehealth.HHS.gov, n.d.). [↑](#footnote-ref-2)
3. Snowball sampling is a recruitment technique in which research participants are asked to assist researchers in identifying other potential subjects (Oregon State University, 2010). [↑](#footnote-ref-3)
4. 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, 2015). [↑](#footnote-ref-4)
5. I-It/I-Thou is a philosophical construct about the perception by one person of another as either an object or a human being (Buber, 1970). I often use the book’s synonymous term, “I-You.” [↑](#footnote-ref-5)
6. Intersubjectivity is a shared meaning that emerges from, enacted within the social fabric of interaction. (Garte, 2016, para. 1) [↑](#footnote-ref-6)
7. *Emotion response cycle* is a concept based on a model of the sexual response cycle (Bloomberg, 2015). [↑](#footnote-ref-7)
8. Telehealth is the use of electronic information and telecommunication technologies to provide care when the client and the provider aren’t in the same place at the same time (Telehealth.HHS.gov, n.d.) [↑](#footnote-ref-8)
9. Qualitative research is used to understand people's beliefs, experiences, attitudes, behavior, and interactions. (Pathak et al., 2013). [↑](#footnote-ref-9)
10. WISR (Western Institute for Social Research) is a California Credentialled College established in 1975 and is dedicated to social justice through higher education that is part of and committed to marginalized communities (WISR, n.d.) [↑](#footnote-ref-10)
11. Psychodynamic theory attempts to explain human behavior in terms of intrapsychic processes and the repetition of interpersonal patterns that are often outside of an individual’s conscious awareness and have their origins in childhood experiences (Deal, 2007, p. 1). [↑](#footnote-ref-11)
12. Family systems theory “is concerned with family dynamics, involving structures, roles, communication patterns, boundaries, and power relations” (Rothbaum, et al., 2002, p. 329). [↑](#footnote-ref-12)
13. Schemas (core beliefs) [are different from] “ underlying assumptions (conditional beliefs) and automatic thoughts [that are temporary]” (Padesky, 1994, p. 267). [↑](#footnote-ref-13)
14. *I-You* is a philosophical construct about the perception by one person of another as either an object (*I-It*) or a spiritual being (Buber, 1970). [↑](#footnote-ref-14)
15. *The Force* is a metaphysical and ubiquitous power in the Star Wars fictional universe (https://en.wikipedia.org/wiki/The\_Force). [↑](#footnote-ref-15)
16. Health information technology (HIT) involves the processing, storage, and exchange of health information in an electronic environment (U.S. Department of Health & Human Services, n.d.-a) [↑](#footnote-ref-16)
17. Web 2.0 is used to refer to a new generation of websites that are supposed to let people collaborate and share information online in ways that were not possible before (University of South Florida, n.d.) [↑](#footnote-ref-17)
18. ICT provides asynchronous messages and streaming connection over the internet (NAGB, 2014). [↑](#footnote-ref-18)
19. Health coaching is a client-centric process to increase motivation and self-efficacy that supports sustainable lifestyle behavior changes and active management of health conditions (Lawson et al., 2013). [↑](#footnote-ref-19)
20. Telepsychotherapy, telemedicine, telemental health and telehealth are used interchangeably in the context of my study. [↑](#footnote-ref-20)
21. Expert-level proficiency uses feel and familiarity, does not require calculation, and can improvise in an unfamiliar moment to achieve success (Dreyfus & Dreyfus, 1989, p. 50). [↑](#footnote-ref-21)
22. Schemas (core beliefs) [are different from] “ underlying assumptions (conditional beliefs) and automatic thoughts [that are temporary]” (Padesky, 1994, p. 267). [↑](#footnote-ref-22)
23. Flight-Freeze is part of the Fight-Flight-Freeze response associated with the amygdala (University of Toledo, n.d.) [↑](#footnote-ref-23)
24. *Emotion response cycle* is my term, based upon a model of the sexual response cycle (Cleveland Clinic, 2017). [↑](#footnote-ref-24)
25. Snowball sampling is a recruitment technique in which research participants are asked to assist researchers in identifying other potential subjects. (Oregon State University, 2010). [↑](#footnote-ref-25)
26. Nominal variables are characteristics, qualitative factors used to sort research findings and explain something or form, refine questions for study. [↑](#footnote-ref-26)
27. *Internalized oppression* "[obscures] the relationship between personal estrangement and social oppression" (Martín-Baró, 1994, p. 27). [↑](#footnote-ref-27)
28. Inductive reasoning draws conclusions based on recurring patterns or repeated observations (Inductive Reasoning, 2021). [↑](#footnote-ref-28)
29. Discussion threads were: Seeing Teletherapy Clients (May 1st), A Year Doing Telehealth – General Inquiry (April 28th), Meeting Practice Standards on Telemental Health Platforms (April 27th), Starting Your Own Telehealth Practice (April 27th), Telehealth Laws (April 26th), End of Medicare approving Telehealth? (April 2nd), best platforms for Telehealth (March 27th), starting your own Telehealth practice (March 26th), payer approval for teletherapy from home office (March 5th), Zoom for family therapy (March 5th), Telehealth counseling company closed (February 12th), Telehealth – state reciprocity (January 30th), insurance no longer paying for Telehealth platforms (January 30th), Telehealth advocacy (May 23, 2020). [↑](#footnote-ref-29)
30. Telebehavioral health is another term for telemental health which uses videoconferencing technology to provide counseling and psychotherapy (U.S. Department of Health & Human Services, n.d.-c) [↑](#footnote-ref-30)
31. Millbank Memorial Fund, Telebehavioral Health, Telebehavioral Health Institute; TeleBehavioral Wellness [↑](#footnote-ref-31)
32. Evidence-Based Practice (EBP) Evidence based medicine is the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients.” (Dotson, n.d.) [↑](#footnote-ref-32)
33. “[Telepresence] is a phenomenon whereby technology creates an experience that allows the user to ‘feel as if they were present, to give the appearance of being present, or to have an effect at a place other than their true location’” (Hilty, et al., 2019). [↑](#footnote-ref-33)
34. 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, 2015). [↑](#footnote-ref-34)
35. Polyvagal theory proposes that a state of safety is mediated by neuroception, a neural process that may occur without awareness, which constantly evaluates risk and triggers adaptive physiological responses that respond to features of safety, danger, or life threat (Geller & Porges, 2014). [↑](#footnote-ref-35)
36. Randomized-controlled studies are a subset of scholarship that structures knowledge, categorizes, quantifies and evaluates. (Yale University, 2020) [↑](#footnote-ref-36)
37. CBT, Psychodynamic and Relational [↑](#footnote-ref-37)
38. “Triple Bottom Line” is a framework to evaluate business activities in terms of the impact on people, the planet, and profitability (University of Wisconsin-Sustainable Management, n.d.) [↑](#footnote-ref-38)
39. Paradigm is a philosophical and theoretical framework of a scientific school or discipline within which theories, laws, and generalizations and the experiments performed in support of them are formulated (*Paradigm*, n.d.) [↑](#footnote-ref-39)
40. Tacit knowledge begins as personal intuition before it becomes easily communicated (Polanyi, 2015). [↑](#footnote-ref-40)
41. Paradigm is a philosophical and theoretical framework of a scientific school or discipline within which theories, laws, and generalizations and the experiments performed in support of them are formulated (*Paradigm*, n.d.) [↑](#footnote-ref-41)
42. Participatory action research (PAR) differs from most other approaches to public health research because it is based on reflection, data collection, and action that aims to improve health and reduce health inequities through involving the people who, in turn, take actions to improve their own health. (Baum, et al., 2006, p. 854) [↑](#footnote-ref-42)
43. See “Psychotherapy and Telehealth” in Chapter Two. [↑](#footnote-ref-43)
44. See “A Few Theories About Individual Psychology” in Chapter Two. [↑](#footnote-ref-44)
45. Cisgender refers to a person whose "sense of personal identity and gender corresponds with the sex put on their birth certificate" (The LGBTQ Experiment. 2018, para. 1). [↑](#footnote-ref-45)
46. 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, 2015). [↑](#footnote-ref-46)
47. *I-Thou* is a philosophical construct about the perception by one person of another as a human being or an object [*I-It*]. (Buber, 1970) [↑](#footnote-ref-47)
48. Intersubjective refers to “shared meaning that emerges from, enacted within the social fabric of interaction.” (Garte, 2016, para. 1) [↑](#footnote-ref-48)
49. Emotion response cycle is a concept based on a model of the sexual response cycle (Bloomberg, 2015). [↑](#footnote-ref-49)
50. Sometimes I relied on my knowledge which was formed during the interview to code the main approach. [↑](#footnote-ref-50)
51. Rational-Emotive Behavior Therapy (REBT) “served as a sort of precursor to the widely known and applied Cognitive-behavioral therapy (CBT), and [REBT] is still commonly used as a treatment in CBT interventions” (“Albert Ellis' ABC model…”, 2021, para. 2). [↑](#footnote-ref-51)
52. Heinz Kohut is acknowledged as the founder of Self Psychology, it “[relies] on the empathetic-introspective stance” (Kohut, 1977, p. xiii). [↑](#footnote-ref-52)
53. Adler Graduate School. (n.d.) [↑](#footnote-ref-53)
54. Eclectic Therapy. (2017, April 19) [↑](#footnote-ref-54)
55. Tacit knowledge begins as personal intuition before it becomes easily communicated (Polanyi, 2015). [↑](#footnote-ref-55)
56. Venn Diagram is a visual aid that uses overlapping circles to represent relationships. Some things are separate, but there's a space that is shared. [↑](#footnote-ref-56)
57. “In order to be consistent, and so be predictable for our children, we must be *ourselves*. If we are ourselves our children can get to know us. Certainly if we are acting a part we shall be found out.” (Winnicott, 1993, p. 123) [Italics in the original]. [↑](#footnote-ref-57)
58. See "Theoretical Framework" in the "Introduction" of Chapter One. [↑](#footnote-ref-58)
59. Iterative is something that occurs in cycles wherein the last phase affects the next, it can be visualized as a spiral. [↑](#footnote-ref-59)
60. White matter is “a vast, intertwining system of neural connections that join all four lobes of the brain (frontal, temporal, parietal, and occipital), and the brain’s emotion center in the limbic system, into the complex brain maps being worked out by neuroscientists” (Filley, 2005, para. 5). [↑](#footnote-ref-60)
61. Gestalt psychology provides a “[field theory] perception [that posits] neural… processes with which the perceptual facts are associated are located in a continuous medium [and] events in one part… influence events in other regions in a way that depends directly on the properties of both in relation to the other.” It provides a “field theory” of cognition (Köhler, 1973, p. 55). [↑](#footnote-ref-61)
62. Me/Not-me consciousness is deduced from the observations of newborns and their subsequent development (Winnicott, 1993). [↑](#footnote-ref-62)
63. The Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191, was enacted on August 21, 1996. Sections 261 through 264 of HIPAA require the Secretary of HHS to publicize standards for the electronic exchange, privacy and security of health information (U. S. Department of Health & Human Services, 2013). [↑](#footnote-ref-63)
64. The Privacy Rule protects all "individually identifiable health information" held or transmitted by a covered entity or its business associate, in any form or media, whether electronic, paper, or oral. There are no restrictions on the use or disclosure of de-identified health information. De-identified health information neither identifies nor provides a reasonable basis to identify an individual (U. S. Department of Health & Human Services, 2013). [↑](#footnote-ref-64)
65. Informed consent is a process that involves three key features: (1) disclosing to a potential research subject information needed to make an informed decision; (2) facilitating the understanding of what has been disclosed; and (3) promoting the voluntariness of the decision about whether or not to participate in the research (U. S. Department of Health & Human Services, n.d.-b). [↑](#footnote-ref-65)
66. Confidentiality is the question of how personal data collected for approved social purposes shall be held and used by the organization that originally collected it, what other secondary or further uses may be made of it, and when consent by the individual will be required for such uses. It is to further the patient's willing disclosure of confidential information to doctors that the law of privileged communications developed (Office of Assistant Secretary for Planning and Evaluation, 2016). [↑](#footnote-ref-66)
67. Fraser, J. S., & Solovey, A. D. (2007). Second-order change in psychotherapy: The golden thread that unifies effective treatments. American Psychological Association. [↑](#footnote-ref-67)