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Undoing Aloneness in the COVID-19 Pandemic: How AEDP Clinicians Have Experienced the Shift to Telehealth and the Impact on the Therapeutic Relationship

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Abstract

COVID-19 has not only killed and infected millions of people worldwide but has also resulted in unprecedented psychosocial stressors that continue to have profound mental health consequences for many people, exacerbating pre-existing psychological suffering and contributing to the onset of new stress related conditions. It has also resulted in a major revolution in the delivery of mental health treatment abruptly shifting psychotherapeutic practice to online technology. Psychotherapists need to be prepared for how their clinical work may change.

This qualitative research study has been phenomenological in nature, attempting to capture and contribute to the literature on the lived experience of psychotherapists in navigating the transition through a global pandemic and exploring how the accompanying shift to telehealth has impacted clinical practice and the therapeutic relationship, if at all. A single-session, semi-structured interview lasting approximately one hour was conducted over Zoom with 15 mental health clinicians certified in an integrative psychotherapeutic attachment-based treatment model Accelerated Experiential Dynamic Psychotherapy (AEDP). Research findings and data were analyzed using a thematic coding process and principles of grounded theory.

Significant findings of this study included the identification of factors that might negatively impact the online therapeutic relationship and the recognition of ways to strengthen and enhance telehealth effectiveness with an attachment-based and relational lens. Advantages and disadvantages of telehealth practice were identified and explored in addition to the effects of shared trauma on the therapeutic relationship and the post-traumatic growth and resilience of the therapist. Implications for theory, practice and social work education are discussed. Limitations included the small size and homogeneity of the study sample.

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Dedication

This dissertation is dedicated to all fifteen of my research subjects who participated in this study

and gave their valuable time to be interviewed. I am grateful to these talented and skilled AEDP

clinicians for their remarkable reflections during these changing and unprecedented times.

I am also grateful to the members of my AEDP Study Group in Atlanta, Georgia and Greenville, South Carolina including Kathy Chamlee, LPC, Mary Gay, PhD, Sybil McWilliams, LCSW, and Kathryn Vaughn, LCSW for our learning together and always holding hope for me that I could complete this undertaking.

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Chapter I: Introduction

The Covid-19 Pandemic and Mental Health

COVID-19 (also known as SARS-CoV-2) is a respiratory disease that has dramatically impacted both physical and mental health worldwide. The first case was documented in December 2019 in Wuhan, a city in Hubei Province in China, and ushered in both a rapid spread of the coronavirus infection and an abrupt acceleration of human-to-human transmission via respiratory droplets (Burjaq & Hammoudeh, 2022). Those who have become infected with the SARS-CoV-2 have experienced a range of symptoms that have included more mild symptoms such as fatigue, dry cough, a loss of taste and smell to fever, respiratory distress and in its most severe cases, septic shock, and organ failure (Wang et al, 2020). The World Health Organization (WHO) first identified COVID-19 as a *Public Health Emergency of International Concern* on January 30, 2020, and within a brief number of weeks, officially declared COVID-19 as a global pandemic on March 11, 2020. Health care systems throughout the world soon became overwhelmed, resulting in significant and widespread disruption of daily life which included school systems shutting down, countries closing their borders, employees working from home, and individuals not leaving their homes.

COVID-19 has infected more than 500 million people worldwide and has taken the lives of over 6 million (according to the Johns Hopkins University of Medicine Corona Virus Resource Center as of early April 2022). The United States has been one of the countries that has been hit the hardest by the pandemic. Although representing only 4% of the global population, it has had approximately 25% of the world's COVID-19 cases and 20% of the world's deaths (Johns Hopkins Coronavirus Resource Center, July 2021). Much focus in the global health care community has been centered around finding biomedical solutions to control the viral transmission of this

complex, acute and in some cases, severe and deadly respiratory illness. Developing effective treatment protocols and protective vaccines in addition to the enactment and enforcement of mandatory quarantine and social distancing restrictions to mitigate contagion have all been a primary focus. The nature of COVID-19, how it impacts the human body in both the short and long-term, and how long it will take for people to develop greater immunity are all not fully known (Sudre at al., 2020).

In addition to significant global physical health care concerns, the pandemic continues to have profound mental health consequences for many people, exacerbating pre-existing mental health disorders and contributing to the onset of new stress related conditions (World Health Organization, 2020). When the demands placed on a person exceed their coping abilities and resources, mental health can be impacted (Centers for Disease Control, 2020). At their most extreme, these consequences could manifest as increased suicide rates and self-harm without the availability of effective treatment options and services (Johns Hopkins University, 2021; Kumar & Nyar, 2021; Lancet, April 13, 2021; United Nations Policy Brief, 2020; World Health Organization, 2020d).

Mental health is the foundation of general well-being and remains one of the most neglected areas of public health with countries globally spending only about 2% of their health care budgets on mental health needs (United Nations Policy Brief, 2020). More than 75% of people with mental health and substance abuse disorders in lower to middle income countries receive no treatment for their condition at all, yet are faced with stigma, discrimination, and human rights abuse (World Health Organization press release, November 28, 2020). In developed countries even prior to the COVID-19 pandemic, a significant treatment gap existed

with evidence suggesting that between 44% to 70% of those needing mental health treatment being unable to access it (World Health Organization, 2019).

Before COVID-19 emerged, statistics on global mental health already documented major mental health issues and alarming concerns. According to the WHO (World Health Organization, 2020), depression is the leading cause of mental health disability worldwide, affecting 264 million people in the world, with the global economy losing more than US $1 trillion per year due to both depression and anxiety. People with severe mental health issues die approximately 10-20 years earlier than the general population. Suicide is the second leading cause of death in young people aged 15-29, and it has been estimated that one in five college students experience one or more diagnosable mental health disorders worldwide (Zhai, 2020). COVID-19 has clustered with pre-existing mental health issues and has interacted with them, impacting more vulnerable individuals already at risk for mental health issues (Khan et al., 2020). Others who have had few experiences of anxiety and distress have developed mental health issues due to the stressors of the pandemic (Burjaq & Hammoudeh, 2022).

The Adverse Childhood Experiences (ACEs) study found that nearly 40% of adult participants had been exposed to at least two or more traumatic relational events during their childhood years with early life adversity potentially affecting adult functioning (Center for Disease and Prevention, 2003). New traumatic events and extremely stressful situations can stimulate past painful experiences of psychological distress or uncertainties and fears that might not have emerged earlier (McBride & Cohen, 2020; Ronen-Setter & Cohen, 2020). Living through a global pandemic can reactivate past trauma for those who might have a history of insecure attachment and abuse, neglect, loss or separation from loved ones, and many people who had previously been coping well may experience increased stressors due to the pandemic (McBride & Cohen, 2020).

Mental health problems exist along a continuum from mild or time-limited distress to more severe mental health conditions, and the pandemic has influenced where people are situated on this continuum.

Good mental health is critical to well-being and needs to be at the center of every country's response to an ongoing recovery from the COVID-19 pandemic (Centers for Disease Control, 2018; United Nations Policy Brief, 2020). Ongoing studies in attachment and affective neuroscience along with research on the neuroplasticity of the human brain continue to suggest the benefits that mental health care can have on a person's brain and subsequent well-being (Cozolino, 2014; Goss, 2016; Siegel, 2017). Psychotherapy continues to be regarded as a beneficial and legitimate practice of healing and addressing mental health care needs (Wampold, 2019). Further study is needed to address the psychological impact of the pandemic and force nations worldwide to deal with the mental health gap and to make mental health interventions available and part of routine care (Taylor et al, 2020; United Nations Policy Brief, 2020).

The biopsychosocial impact of the COVID-19 pandemic on all of humanity will continue to unfold for decades to come (Banjeree & Rai, 2020). Many individuals who have recovered from COVID-19 have since reported ongoing and lingering symptoms that have now come to be known as long COVID. According to Burjaq & Hammoudeh (2022), the consequential fear and anxiety associated with the coronavirus, including increased concern about the possibility of death, has led to the development of what is now referred to as "coronophobia" or the state of a more prolonged anxiety that can lead to the increased risk of major psychiatric illnesses. In addition, the prolonged periods of social isolation due to physical distancing measures has led to an increase in an individual's likelihood of developing mental health issues that include anxiety, depression, post-traumatic stress disorder (PTSD), and insomnia with economic stressors and

financial losses exacerbating these issues (Burjaq & Hammoudeh, 2022). Overall, infectious disease outbreaks are associated with higher rates of mental health symptoms in survivors, their family members, healthcare workers and members of affected communities, and mental health consequences have continued to emerge progressively during the COVID-19 pandemic (Brooks et al., (2020); Kumar & Nayar, (2020); Serafini et al., (2020).

Psychosocial Factors of the COVID-19 Pandemic

The COVID-19 crisis has erupted onto the world scene not just as a virus, but also as a complex psychological and social phenomenon with profound implications in the lives of humans (Downing, 2021). Identifying and bringing awareness to the ongoing psychosocial factors of the pandemic has continued to be critical. Although approximately 65.9% of the American population have been fully vaccinated and new rates of infection have markedly decreased (Mayo Clinic, March 2022), the social and mental health issues of the pandemic continue to abound and warrant further understanding to heal and to better prepare for future outbreaks (Burjaq & Hammoudeh, 2022)

Compared to what was observed by the World Health Organization in 2017 on common mental health disorders in the general population, COVID-19 pandemic-affected populations have rates of depression that have been documented to be three times higher (15.97%) than in the general population, four times higher for anxiety (15.15%), and five times higher for post-traumatic stress symptoms (21.94%) along with a higher prevalence of insomnia (Cenat et al., 2021). According to a COVID-19 mental health practitioner follow-up survey conducted by the American Psychological Association during the spring of 2021, psychologists have reported an increased demand in all areas of treatment during the pandemic including anxiety, depressive disorders, trauma, and stress-related disorders. Although mental health challenges have been a

silent epidemic for decades, levels of distress, fear, anxiety, loneliness, and depression have continued to increase globally (World Health Organization 2020c, Holmes et al, 2020).

<center>*Fear*</center>

Due to the wide-scale threat of illness and death due to COVID-19, fear is understandable and can be one of the most common and frequent psychological reactions and neurobiologically appropriate responses to pandemics (Serafini et al., 2020; Shutlz et al., 2016). Existing studies that have researched mental health concerns during the SARS viral outbreak (2003), H1N1 influenza (2009), and Ebola virus outbreaks (2014- 2016) have all demonstrated that those who have been exposed to the risk of infection may develop pervasive fears about their health along with increased worries about infecting family members and others (Cenat et al., 2021; Khan et al., 2020; Serafini et al., 2020; Shigemura et al., 2019). The wide-scale and collective threat of illness, one's own mortality and death, and potential separation from loved ones can result in fear responses (Bowlby, 1989). Individuals who might not be able to regulate their fears or who have difficulty processing their emotional experiences may be at increased risk for the development of anxiety, depression, or maladaptive defensive behaviors (Fosha, 2009; McBride et al., 2020). Fear of the unknown and unpredictable has been shown to raise anxiety levels in healthy individuals as well as those with preexisting mental health conditions (Khan et al., 2020). Those who have a history of insecure attachment may experience even higher levels of fear and health anxiety (Rajkumar, 2020; Shigemura, 2019).

In addition, COVID-19 related fear has been associated with health risk behaviors that include increased rates of insomnia and post-traumatic stress symptoms as well as increased rates of alcohol and substance abuse (Buckner et al., 2021; Rajkumar, 2020; Rogers et al., 2020; United Nations, 2020). Compared to those who abstain, pre-COVID-19 substance users and

COVID-19 substance initiators demonstrated the highest levels of worry and fear about their

well-being, with those that began using increased amounts of substances after the pandemic

having the highest rates of fear and worry (Rogers et al., 2020).

<center>Anxiety</center>

Countries throughout the world have used social and physical distancing, definable as

"public health interventions designed to diminish physical human interaction within communities

in which individuals who may be infected with an easily transmittable disease and have not yet

been identified" (Luiggi-Hernandez & Amador, 2020, p.1). These measures have restrained and

blocked social interaction with "lockdown" regulations, mandatory quarantining and "stay at

home" recommendations. Aiming to halt and contain the spread of the virus, more than half of

the world's population has faced social confinement (Cenat et al., 2020). Quarantine, a forced

separation from loved ones entailing loss of freedom and uncertainty over disease status, can be

an unpleasant experience for those who undergo it and can lead to negative psychological effects

including increased anxiety symptoms and generalized feelings of uncertainty about the future,

substantial anger, increased incidents of suicide and post-traumatic stress symptoms (Brooks et

al., 2020; Serafini et al., 2020). Longer durations of quarantine have been associated with the

increased prevalence of post-traumatic stress symptoms as also evidenced in earlier studies

conducted after the containment around the SARS outbreak in 2003 (Shah et al., 2020).

Winnicott (1958) has suggested that "the belief in a reality about which we can have

illusions, the belief that somehow we can control our destiny" protects us from disabling anxiety.

The COVID-19 pandemic has impacted us all, oftentimes bringing with it a sense of

helplessness, challenging the illusion that we can control what happens next, and bringing with it

accompanying anxiety (Boulanger, 2103). Those who already have an anxious attachment style

can be even more debilitated by the isolation brought about by the pandemic (Johnson, 2019; Rajkumar, 2020). In addition, some studies have reported an onset or increase in obsessive-compulsive disorder (OCD) symptoms during the COVID-19 pandemic, associated with an intolerance for uncertainty and distress as well as an increase in and a higher level of perceived threat, resulting in both panic buying and hoarding behaviors (Rajkumar, 2021).

Loneliness and Depression

Although social distancing has served as an ethical response to the pandemic in working to prevent future transmission of the virus (Luiggi-Hernandez & Rivera-Amador, 2020), it has also exacerbated the longstanding loneliness epidemic, making mental health care particularly imperative (Brooks et al, 2020). The negative effects of social isolation and loneliness have been correlated with higher rates of depression, worsened physical health, and poor cognitive functioning (Smith & Victor, 2018; Leigh-Hunt et al, 2017). Experiences of social disconnectedness characterized by fewer and more infrequent social interactions has led to increased rates of perceived social isolation, which is also closely associated with significantly higher rates of anxiety and depression (Vrach et al., 2020).

Prior to the COVID-19 pandemic, the U.S. Health Resources & Services Administration (2019) described a "loneliness epidemic" with two out of every five Americans reporting that they always or sometimes feel their social relationships are not meaningful, and one in five reporting that they are lonely or socially isolated. Nearly 40% of Americans identified as lonely, up from just 1 in 10 in the 1970's (Johnson, 2019). COVID-19 has contributed to factors towards feelings of loneliness, sadness, or social pain across different social strata, amplified by the social distancing restrictions and mandates of the pandemic (Ahorsu et al., 2020). In some

instances, increased suicidal thoughts and attempts have been documented (Griffiths et al., 2020).

Various studies have shown that the experience of social pain caused by physical or psychological distance from others shares a significant overlap in the same biological and neural circuitry as physical pain (Zhang et al., 2020). Social disconnection and loneliness can have enormous health consequences with some studies demonstrating that social isolation can be as harmful to a person's health as smoking 15 cigarettes a day (U.S. Health Resources & Services Administration, 2019). In addition, isolation and loneliness can also be an independent risk factor for sensory loss, connective tissue and auto-immune disorders, cardio-vascular disorders including higher systolic blood pressure, higher body mass index, lipoprotein cholesterol and obesity; furthermore, it can increase the likelihood of early death by 26% (Holt-Lunstad et al, 2015; King, 2018).

Approximately 8 out of 10 reported deaths in the United States from COVID-19 have occurred in people aged 65 years or older (United Nations; 2020). In addition to increased fears and anxiety about contracting the disease, the risk of social isolation and loneliness has been shown to be higher in the elderly population, associated with both biological and social health risks that include increased risk of mortality, implications for cognitive decline and dementia, and increased depression rates and suicide (Banjeree et al., 2020; U.S. Health Resources & Services Administration, 2019; Vrach et al., 2020).

For some, increased social isolation at home and changes in daily work schedules marked by a multitude of video-chat meetings has also increased social pain and taken a toll on mental well-being with increased fatigue and feelings of disconnection, anger and protest behaviors, and depression (Blashki, 2021). Psychotherapists can support clients in addressing feelings of social

isolation by bringing awareness to psychological defenses and helping clients to connect more fully with their fears and experiences of loneliness (Yalom, 1980).

Convergence of Racism and Inequity

The COVID-19 pandemic heightened and amplified other existing inequalities, placing unprecedented stress on every facet of society (Horesh & Brown, 2020; UN Policy Brief, April 2020). "People from ethnic minorities are disproportionately more likely to be infected and to die from Covid- 19; black-ethnic groups had 486 women and 649 men diagnosed for an average of 100,000 population across the country, whilst white-ethnic groups had 220 diagnoses for women and 224 for men for the same population" (Iacobucci, 2020, p. 386). "Coupled with the brutal and hate-filled murder of George Floyd by a police officer", the COVID-19 pandemic has "ignited awareness of the racism hiding in plain sight in the United States" (Tosone, 2021, p. 8).

COVID-19 continues to expose deep and underlying social and racial inequalities, health disparities, and a governmental response that can be likened to Hurricane Katrina in New Orleans in 2005, an unexpected disaster which prioritized profit-making over the welfare of its devastated and overwhelmed citizens (Boulanger et al, 2013). Vastly different outcomes among countries (in terms of deaths) and secondary effects are beginning to suggest that social, political, economic, and cultural factors have determined the impact of the pandemic on well-being, not just the pathogen itself (Horton, 2020). Inequality at the intersection of race, class and gender has continued to unfold (Yavorsky et al, 2021). The ability to work remotely has revealed stark contrasts between those who can work from home and those whose jobs cannot be completed remotely; the highest pandemic mortality rates have been working-class people of black and ethnic minority backgrounds, most likely exposed to the virus due to the nature of their occupations, dependency on public transportation and the higher likelihood of underlying health

conditions (Madianou, 2020). These disproportionate levels of infection and death in black and

brown individuals have highlighted an additional pandemic: racism and the disparities in health

care for African Americans, Latinx as well as LGBTQ communities and economically

challenged groups including indigenous Native American tribes (Richardson et al., 2020;

Tosone, 2021). All these groups have experienced increased mental health issues and have been

hit harder by economic challenges brought about by COVID-19 (Khan et al., 2020; McBride et

al., 2020; Salari et al, 2020; Vrach et al., 2020). In addition, xenophobia and discrimination have

been an unfortunate response during the ongoing pandemic with stigmatizing narratives that have

also developed about the Chinese and Asian cultures (Blashki, 2021).

Ecological/Systems Impact of COVID-19

The COVID-19 pandemic has directly resulted in rapid and dramatic lifestyle changes

that have rippled through and touched every level of the ecological system and human life

experience (Horesh & Brown, 2020; McBride et al., 2020). Ecological systems theory was

developed by Urie Bronfenbrenner (1979) and can offer a framework of how COVID-19 has

impacted individuals in their communities and in the wider society. At the macrosystem level,

global distress has influenced societal and cultural attitudes towards illness, public spaces, and

resources. The 24/7 news media coverage of the pandemic has impacted the public's mental

health with its sensationalist headlines and constant running tab of death tolls, new infections,

images of dead bodies and coffins, and at times, misinformation (Khan et al., 2020). Mandated

social restrictions in hospitals, healthcare facilities and public ceremonial gatherings have

contributed to increased societal fears of death and not having the opportunity to say goodbye to

dying loved ones (Khan et al., 2020). Mourning loved ones and not being able to be physically

close to them as they take their last breaths can significantly impact the grieving process and the

ability to work through feelings of loss and grief (McBride et al., 2020). As per Dr. Debra

Kaysen (2021) President of the International Society for Traumatic Stress Studies (ISTSS),

> "One of the biggest mental health challenges of COVID-19 has been collective grief. For those who have lost friends, coworkers, and loved ones, COVID has interrupted our grieving rituals and processes. When someone is ill, we want to be with them. When someone dies, we often grieve by gathering together as a community, by comforting each other with touch and with our physical presence. All of these things are problematic during this pandemic, which can make grief harder to bear and can also make it more difficult to feel a sense of finality about the loss…For those of us who are grieving the old lives we had, who are grieving the milestones that have been interrupted, or the anticipated events that aren't happening the way we expected, these are also losses."

At the exosystem level, there have been major changes in economic stability. Millions of

people have faced financial turmoil after losing or facing impending loss of their income with

business shutdowns. Social distancing policies have placed severe economic strain on the

hospitality, entertainment, and sporting industries. The mental burden of government and

business restrictions on social gatherings and the accompanying changes in the usual routines

and livelihoods of people has not yet been fully realized (Khan et al., 2020; Kumar & Nyar,

2021).

At a mesosystem level, people have faced losses related to not being able to access places

of worship, to the closure of schools and universities, to the dangers of infection and subsequent

closure of the workplace, experiencing fears of contagion among family members and social

supports. With unprecedented directives for student relocation from college campuses and

dormitory living spaces to virtual online learning, COVID-19 has profoundly impacted the

already developmentally vulnerable population of college students worldwide with reported

increases in experienced levels of stress, anxiety, depressive thoughts and an altered sense of

well-being and concern about their health, the health of their loved ones, difficulty in

concentrating, and concern about their future (Liu et al., 2020; Son et al., 2020).

At a microsystem level, families have faced burdens of working from their households while educating their children. Pregnant and new mothers are especially likely to be anxious given the difficulties accessing services and fear of infection (Ahoru et al, 2020). Although COVID mortality rates have been documented to be higher for men than women, it is women who are suffering a higher amount of psychological strain during the pandemic and are more likely to bear the burden of the social and economic consequences of the pandemic (Ahoru et al, 2020; Burki, 2020). Across the globe, women earn less, hold less secure jobs, have less access to social protections and make up most single-parent households (UN Policy Brief, April 2021). The pandemic is deepening this pre-existing gender inequality, with women lagging behind men in the recovery of jobs and telecommuting posing gender-related productivity and work challenges, particularly for mothers in the lack or absence of institutional childcare support (Reid, 2013; Yavorsky et al, 2021). The consequences of COVID-19 on future gender inequalities in the labor market could be far-reaching (Power, 2020).

Gender-based violence, child abuse, and neglect have increased due to social containment measures that have included community and school shut-downs and stay-at-home orders leading to all family members being at home and isolated together with increased emotional and physical demands within the family system due to such additional duties of homeschooling and taking care of older relatives (Chandan et al., 2020; Lee et al., 2020; United Nations, 2020). Although some couples and families have experienced social containment measures as an invitation for increased intimacy and attachment, others have experienced increased household stress, overcrowding, and loss of income due to job loss and a host of financial stressors that have put families at increased risk for domestic violence (Chandan et al., 2020; Lee et al., 2020; McBride et al., 2020). A significant rise in calls to domestic violence services has been documented during

the pandemic: the National Domestic Violence Hotline reported over 2,000 COVID-19 related calls with both women and children experiencing increased episodes of domestic household violence between mid-March and early April 2020 (Barker & Barker, 2020; Blashki, 2021; United Nations, 2020). In addition, the social consequences of the pandemic may affect brain health development in young children (United Nations, 2020).

Collective Trauma in the Age of COVID-19

Trauma can be caused by a stressful occurrence that is outside the range of usual human experience, and would be markedly distressing to almost anyone, encompassing serious threat or harm to one's life and physical integrity or serious threat or harm to one's spouse or other close relatives or friends (Levine, 1997). Traumatic events can produce unexpected, overwhelming, and lasting changes in physiological arousal and emotion marked by features of disconnection and disempowerment (Herman, 1992; Van der Kolk, 2014). "Traumatic events are extraordinary, not because they occur rarely, but rather because they overwhelm the ordinary human adaptations to life" (Herman,1992, p. 33). Resmaa Menakem (2017), an African American psychotherapist specializing in the effects of trauma on black families and black society, concurs that trauma involves anything that happens too much, too fast, and too soon, without the opportunity for repair or soothing. The COVID-19 crisis can and should be viewed from the perspective of trauma (Horesh & Brown, 2020). The pandemic encompasses many features of a traumatic event, and it has subjectively been experienced and felt both individually and collectively to be traumatic (Cherry, 2020).

Collective trauma refers to the psychological upheaval that is experienced and shared by groups of people of any size, up to and including entire nations or societies in response to a mass traumatizing event (Tosone, 2021). Examples of collective trauma events include natural

disasters, world wars, the Holocaust, slavery in America and the September 11, 2001 terrorist attacks (Cherry, 2020; Horesh & Brown, 2020). The COVID-19 pandemic is a new type of mass and global collective traumatic event that has affected the entire world and has infiltrated into every part of society (Tosone, 2021). Experienced globally, people around the world have faced significant distress through similar experiences of loss, uncertainty, helplessness, and grief. In addition, the pandemic has exacerbated today's real-life struggles of racism and the complexity of a global society entrenched in white supremacy and deep social and economic divisions (Tosone, 2021). Van der Kolk (2020) shared his view that the traumatic impact of the COVID-19 pandemic was further exacerbated by the failure of leadership to provide predictability and trust, contributing to feelings of helplessness and vulnerability.

Although collective trauma can be a "cataclysmic event that shatters the basic fabric of society" and may be passed down to future generations, it can also inspire a "crisis of meaning" (Hirschberger, 2018, p. 1). The pandemic may also support individual growth, resilience and the drive for collective societal change and transformation in its aftermath with many recognizing strengths and coping skills that they did not realize they had, along with the drive for collective societal change and transformation (Silver, 2020). Implementing community-based strategies to support shared resiliency and build intimacy in the age of the virtual world and social restrictions has been fundamental in navigating the COVID-19 crisis (Serafini et al., 2020).

In addition to increasing the mental health issues of such vulnerable groups as racial and ethnic minorities, women, the elderly, college students and young adults, the COVID-19 pandemic has also had a negative impact on the mental health of medical and healthcare providers (Restauri & Sheridan, 2020). Ongoing and emerging research has documented the adverse effects that healthcare professionals have experienced working frontline with people

during epidemics including fears of exposure, becoming the source of infection to loved ones, heightened levels of stress and anxiety (related to emotional fatigue and reduced performance), depression and poor sleep quality, and a sense of loss of control (Aughterson et al., 2020; Cenat et al., 2021; Salari et al., 2020; Serafini et al., 2021). Research from the SARS and H1N1 epidemics has underlined the psychological strain on healthcare professionals who are at the frontline of efforts to address the virus with reported feelings of "extreme vulnerability, uncertainty, and threat to life alongside somatic and cognitive symptoms of anxiety, increased depressive symptoms and poor sleep quality" (Konstantinos et al., p. 3451, 2020). In addition, mental health care professionals are also vulnerable due to their role of being at the frontline of addressing the psychological toll of pandemics.

Vicarious Trauma, Compassion Fatigue, Burn-out

A parallel phenomenon exists in which a mental health clinician can experience secondary traumatic symptoms when treating traumatized people (Saakvitne, 2002). Secondary trauma, also known as vicarious trauma, can be described as indirect exposure to a traumatic event through the firsthand account or narrative of the trauma experience of another. During the COVID-19 pandemic, about 15% of therapists experienced high levels of vicarious trauma, a "cumulative and deleterious effect on therapists who empathically engage with traumatized clients" (Aafjes-van Doorn et al, 2020, p. 148). Some of the factors that have been associated with higher rates of vicarious trauma have been younger age and fewer years of clinical practice and experience, feeling more distressed and less competent, feeling less connected with the client, and experiencing a weaker therapeutic alliance than before the pandemic (Aafjes-van Doorn et al, 2020).

The accompanying emotional stress on the clinician may also manifest in symptoms of compassion fatigue which can include emotional reactions and responses that include sadness, depression, sleeplessness, and generalized anxiety (Tosone, 2021).

Experiences of burnout by mental health care professionals may be evidenced by exhaustion, depersonalization, emotional numbness, and increased arousal issues such as insomnia, increased anger and irritation, and nightmares (Restauri & Sheridan, 2020). Maslach and Leiter (2016) also identified signs of burn-out to be exhaustion, cynicism, feelings of inefficiency that could be attributed to work overload, breakdown of community, value conflicts (such as conflicts between job demands and personal goals) and blurred boundaries between professional work and personal life.

Evidence based strategies for treating vicarious trauma, compassion fatigue, and burn-out may include increased collegial support, mindfulness skills training, individual and group psychotherapy and enhanced psychotherapeutic interventions (Leiter and Maslach, 2014).

Shared Trauma and the Mental Health Professional

Shared trauma has emerged as a significant construct in more fully understanding the mental health consequences of clinicians working under the same traumatic conditions as their clients. Like vicarious trauma, compassion fatigue and burn-out, shared trauma offers an understanding of the impact of working with trauma on the mental health clinician. The construct of shared trauma can be defined as the "extraordinary experiences of clinicians exposed to the same community trauma as their clients" (Tosone et al, 2012, p. 231). Shared trauma was first introduced into the professional literature following the 9/11 terrorism attack when American perceptions about their felt sense of safety and security in the world suddenly and dramatically changed; shared trauma captures the experience of mental health clinicians working to provide

effective treatment and care to their clients who may be experiencing increased fears and stressors related to their own well-being and sense of safety, while also having to address these similar and parallel concerns and stressors in their own personal lives (Tosone, 2012).

Previous studies from the Hurricane Katrina 2005 disaster in New Orleans also looked at the shared traumatic reality of mental health clinicians. Studies shed further light on the challenges for mental health clinicians in being emotionally available to their clients due to also facing their own stressors related to the impact of the devastating storm and subsequent conflictual issues related to taking care of their own families or managing their own time constraints (Boulanger, 2013). Financial hardship in the aftermath of the storm forced many mental health professionals to return to work before they felt ready: "I don't want to listen, but I have to; it's my job…but everyone is so damn sad and scared" (Boulanger, 2013, p. 33).

The impact of COVID-19 and its soaring infection rates and deaths along with the physical isolation resulting from social containment has also created a shared trauma that has involved both patients and mental health clinicians (Ronen-Setter & Cohen, 2020). "A therapist might have an elderly relative intubated in a hospital, when the patient discloses that they are also afraid for an elderly relative intubated in a hospital, or a patient might disclose fear of financial loss, while the therapist is also struggling with patient retention" (McBride et al, 2020, p. 3). Therapists and patients alike are collectively facing the uncertainty of the COVID-19 pandemic together and may share similar emotional experiences of fear, lack of control, uncertainty about the future, and an inner conflict between responsibility to their patients and a sense of duty to protect and support their own families, relationships, and professional lives (Cenat et al, 2021).

Mental health professionals can also feel "deskilled" by shared trauma, finding it difficult as they are being expected to listen to and work with similar stressful, dissociated, and painful experiences as their clients (Saakvitne, 2002). There is a recognition that personal and professional lives cannot be kept separate during shared traumatic experiences along with a consideration of how this may impact the relational frame, self-disclosure and the intersubjectivity of the therapeutic alliance (Saakvitne, 2002; Tosone et al, 2012).

Post-Traumatic Growth, Self-Care, and Resilience

Post-traumatic growth can be defined as a positive psychological change due to experiencing highly challenging circumstances (Tedeschi and Calhoun, 2004). Considering the insights gathered from the aftermath of the 9/11 trauma in New York City, mental health clinicians experienced both benefits and vulnerabilities of working professionally in a shared traumatic reality (Saakvitne, 2002). Through shared trauma experiences, clinicians may have the opportunity for transformative intrapsychic and interpersonal growth (Tosone et al, 2012). Such benefits may include an increase in a clinician's sense of agency, dedication, satisfaction, and fulfillment in helping clients, leading to increased creativity. Self-care can be fundamentally defined as a deliberate professional or personal action or strategy undertaken by individuals to reduce stress (Lee and Miller, 2013). Clinicians experiencing the shared trauma of COVID-19 may also benefit from protective factors such as stronger self-care practices and enhanced peer and supervisory support put into place to manage stress and isolation (McBride et al, 2020; Serafini et al, 2020; Tosone et al, 2012). Clinicians may become more aware of resilience as they move through the pandemic (Tosone, 2021). "One starts to use something that has been there but has been dormant or distorted and therefore unable to serve one's needs for expansion, exploration, and the elaboration of one's true self" (Russell, 2015, p. 252). The wisdom of

trauma is to realize that its impact and imprints can be worked through and that those who have experienced these events can become more themselves (Mate, 2011).

Recommendations for therapists experiencing shared trauma have included seeking additional consultation, support, and addressing self-care needs (Redinger & Gibb, 2020). In addition, shared traumatic reality may also increase opportunities to potentially build stronger emotional intimacy in the therapeutic relationship through sharing the experience together (Boulanger, 2013).

COVID-19 remains an evolving disease with the extent and severity of ongoing long-term health consequences and acute manifestations remaining unclear (Iyengar et al, 2020). Raising awareness and addressing the ongoing and long-term impact of COVID-19 on emotional health remains a central cornerstone of caring for our collective and global humanity. Resourcing and supporting mental health services and understanding its impact on the mental health professional particularly as the pandemic's full economic and psychological consequences continue to emerge is highly indicated (Lancet, April 13, 2021).

Chapter II:

Transition to Telehealth

The Health Resources and Services Administration (2021) has defined mental health care that is delivered remotely, also known as telehealth, telepsychology, teletherapy or telemental health "as the use of electronic information and telecommunication technologies to support the long-distance clinical health care, patient and professional health-related education, health administration, and public health." The COVID-19 pandemic has resulted in a major revolution in the delivery of mental health care services worldwide, shifting most psychotherapy services to

telehealth platforms (Bekes, V. & Aafjes-van Doorn, 2020). On a global scale, the heightened dependency on technology has been unprecedented. According to clinical psychologist, Adam Haim, PhD, who heads the Treatment and Preventive Intervention Research Branch at the National Institute of Mental Health (NIMH), "the whole paradigm of sitting in a room with a clinician and receiving an intervention in a 45-minute session has essentially been flipped on its head" (American Psychological Association, 2020).

The provision of clinical mental health services through online platforms has been an effective and ethical response in addressing the emergency and global mental health crisis brought about by the COVID-19 pandemic, improving access to psychotherapy services worldwide (Luiggi-Hernandez & Rivera-Amador, 2020). It has also enabled continuity of care and an opportunity to address anxiety, depression, distress reactions and the increased loneliness brought about by social distancing during a global pandemic in which meeting face-to-face could be considered dangerous. Research to date shows that mental health care delivered through teletherapy is effective with a growing and substantial literature base (American Psychological Association, 2020).

According to a national public opinion poll conducted by the American Psychiatric Association (May 2021), the expansion of telehealth is welcomed by most Americans. Telehealth services have been widely used during the pandemic with nearly four in ten Americans (38%) reporting that they have used telehealth services to meet with a medical or mental health professional, up from 31% in the fall of 2020. Most of the survey respondents have been using telehealth through video platforms (69%), while 38% have used phone calls only. The percentage of Americans saying that they would use telehealth services for mental health treatment increased from 49% in 2020 to 59% in 2021. 66% of young adults (18–29-year-olds) reported that they

would use telehealth for mental health services compared to older adults (36% of those 65 years and older). In addition, 43% of the adults surveyed said that they wanted to continue using telehealth when the pandemic was over, with more than one in three adults sharing that they would prefer telehealth over an in-person doctor's office visit, up from 31% in 2020.

Another national survey conducted with licensed psychologists has documented the magnitude of this shift in clinical care towards telehealth, "finding that although 7.07% of psychologists' clinical work was performed via telepsychology before the COVID-19 pandemic, this increased 12-fold to 85.53% during the pandemic" (Pierce et al, 2021). These surveyed psychologists remained optimistic that their clinical work would still occur via telehealth platforms after the pandemic, indicating the high likelihood of significant and lasting changes in the delivery of mental health care in the United States.

Telehealth and the Therapeutic Relationship

The concept of the therapeutic alliance originated in psychodynamic theory and encompasses several components that include: the attachment bond or therapeutic relationship between the therapist and the patient, as well as the collaborative agreement between therapist and patient on both treatment goals and therapeutic tasks (Bordin, 1979; Horvath & Luborsky, 1993; Hatcher & Barends, 2006). Decades of psychotherapy research and a large body of empirical evidence supports the contention that the therapeutic alliance and the ability of the therapist to form a secure attachment relationship across a range of clients is the most reliable and accurate predictor of psychotherapy outcome (Norcross & Lambert, 2019).

In addition, those therapists that were higher in facilitative relational and interpersonal skills including such common factors as "verbal fluency, emotional expression, persuasiveness, hopefulness, warmth, empathy, alliance-bond capacity, and problem focus" have more positive

treatment outcomes (Wampold, 2019 p. 111). In addition, the most effective psychotherapists practice a clinical method or a particular treatment approach (grounded in a theoretical frame and perspective) in which they are not only passionate about and believe in, but are also skillful in implementing (Wampold, 2019).

Another common factor that has emerged in the literature and has also been significant in building a stronger therapeutic alliance and relationship that could lead to increasing therapy effectiveness is the construct of therapeutic presence (Geller, 2020). Therapeutic presence involves "how to be with clients" and how to "stay grounded and attuned within themselves" (Geller, 2020, p. 2). This presence enhances the working relationship and increases the felt experience of emotional safety for the patient (Geller & Porges, 2014). According to Rathenau et al. (2021), when psychotherapists hold positive attitudes toward online therapy, "the therapeutic presence increases by .31 points" and when therapists experienced difficulties in the perceived online experience, therapeutic presence might decrease "by .49 points" when perceived difficulties increase (p. 7). In an exploratory analysis, Rathenau et al., (2021), has hypothesized that therapists with more clinical years of experience can more easily establish therapeutic presence, even in an online context.

The abrupt shift to online psychotherapy in response to the COVID-19 pandemic has required some adaptations in these common factors that might affect the therapeutic relationship and its process (Bekes & Aafjes-van Doorn, 2020). For many psychotherapists, this pivot and sudden shift to teletherapy at the start of the pandemic was the first time being exposed to using technology to deliver clinical mental health treatment. Research studies to date indicate that a strong working alliance can be established in the context of telehealth (Watts et al., 2020). Many therapists, however, have had to rapidly teach themselves not only how to use the required

technology, but also understand how therapeutic interventions used might need to change in response to working through teletherapy (Taylor et al, 2020).

Disruption to the Therapeutic Setting

As the profession has continued to evolve and emerge, it remains significant that psychotherapy continues to change in order to meet the needs of those it serves and tries to serve (Wampold, 2019). Before the start of the COVID-19 pandemic and the accompanying shift towards telehealth, psychotherapists were slowly becoming more open to the consideration of how communication technologies could best serve the needs and interests of their patients. Prior to the outbreak of COVID-19 and particularly in the past decade, there has been an increasing interest in providing online psychotherapy. Not only has the amount of online psychotherapy increased due to the birth and widespread access of the internet, ongoing development of information technologies, and better image and sound quality of personal computers and mobile phones, therapists have also been attempting to respond to various convenience needs including making efforts to offer clinical services in more distant or remote areas (Ronen-Setter & Cohen, 2020).

"Psychotherapies have always been embedded in, and responded to, the prevailing social, historical, and cultural context" (Cundy, 2015, p. 99). According to the American Psychological Association (2021), telehealth has expanded out of a growing need to treat harder to reach populations, such as when a forensic psychologist completed an assessment on someone in a jail or a hospital and needed to refer them to geographically distant providers. Psychotherapy has long been difficult for many individuals to access, and "indigenous populations, deployed military members, incarcerated individuals, and those living in rural areas or having to commute to urban centers are among those known to have suffered longstanding treatment access disparities" (Watts et al., 2020, p. 208).

Historically, psychotherapists and the psychoanalytic world have been slow to openly engage with the possibilities enabled by new technologies of communication. Psychotherapists first started making use of videoconferencing over sixty years ago (Rohland, 2001). In 1961, videoconferencing started to be considered and used for group psychotherapy. Initially, making use of telemental health in the psychotherapeutic community seemed to stir up formidable anxiety and fears related to being judged or criticized by colleagues who held fixed beliefs and biases about moving away from or beyond more traditional ways to practice and make use of clinical theory (Yakeley, 2013). In addition, many therapists have also been deterred from using online platforms for therapy "due to the onerous process of navigating the complexities of licensure, state mandated telehealth training requirements, uncertain insurance reimbursement, risk management" that have since been relaxed due to the COVID-19 pandemic (Chen et al., 2020, p. 2). Furthermore, some have argued that if the physical body of the patient and the body of the therapist are not present in the same room (i.e., disembodiment), any so-called therapy that is presumed to be taking place in cyberspace cannot be real or even be effective (Scharff, 2014). A common theme in Scharff's three volume series, *Psychoanalysis Online* is that therapists need to develop effective ways to engage with the changing nature of mental health treatment online.

The telephone has also had a long history in counseling and crisis intervention (Irvine et al., 2020). Although the use of the telephone in psychoanalysis first began to appear in the psychoanalytic literature in the 1950's, empirical studies about the practice of telehealth, or conducting psychoanalysis through the assistance of the telephone or other high quality video connection have remained relatively scarce (Scharff, 2014). Since the onset of the COVID-19 pandemic, several systematic reviews have provided empirical support that telephone-delivered

psychological therapy could be clinically effective and lead to positive therapeutic outcomes (Castro et al., 2021; Irvine et al., 2020).

Changes in the Intersubjective Experience

Electronic objects such as computers, smart phones, and electronic tablets can alter the subjective and intersubjective space and act as a third object or what has been termed the "e third" (Stadter, 2013). The e-third can be defined as "the influence of an electronic object in addition to self and other- and we are just beginning to understand its evolving effects for both good and ill" and the impact on human relationships (Stadter, 2013, p.3). There are both advantages and disadvantages to using technology, which need not be either demonized or idealized as per Stadter (2013). Psychoanalyst Jessica Benjamin (2018) addresses how third space conversations are created, referring to this as "the process of creating thirdness … how we build relational systems and how we develop the intersubjective capacities for such co-creation" (p. 2).

Sherry Turkle, a psychoanalytically informed clinical psychologist and sociologist began publishing works and reflecting upon the relationship of human beings with robots and computers as early as the 1980's. Turkle (2004) reflects on how therapist and client can manage the flickering screens, loss of connection or "frozen" moments that occur in telehealth with a consideration of how therapist and patient can join together forces against the technological intruder and actually deepen the therapeutic alliance. In studying the present and future of e-technology, Turkle (2004) further reflects on needing a new object relations psychology that could support clinicians in understanding and navigating such relationships; "people may be comforted by the notion that we are moving from a psychoanalytic to a computer culture, but

what the times demand is a passionate quest for joint citizenship if we are to fully comprehend the human meanings of the new and future objects of our lives" (p. 29-30).

<center><i>Concerns about Loss of Intimacy and Emotional Connection</i></center>

Despite the convenience and potential benefits of providing online psychotherapy, many clinicians have been concerned about their ability to be as effective working through teletherapy as compared to working face-to-face (Rathenau et al., 2021). There are several factors that have been associated with this increased professional self-doubt and anxiety about telehealth effectiveness. Clinicians who are less experienced providing psychotherapy or do not have as many in-session relational experiences with clients may express higher doubts about teletherapy effectiveness (Bekes & Aafjes-van Doorn, 2020).

In addition, other factors that have increased doubt include concerns about technical glitches, confidentiality issues, and insufficient internet literacy. Psychotherapists who provide more psychodynamic and relational treatment have also expressed concern and anxiety about building a therapeutic alliance online and being able to communicate empathy and telepresence i.e., the extent to which individuals felt the presence, empathic resonance, and attunement of the therapist (Bekes & Aafjes-van Doorn, 2020; Fletcher et al, 2018). Some therapists have expressed concern and worry that, without the stable and containing environment of a therapist's office, the ability of patients to explore painful emotions more deeply during therapy might be impacted (Chen et al., 2021).

Current literature supports mounting evidence for telehealth and indicates that the therapeutic relationship is not negatively compromised, although mental health clinicians have held biases and negative views regarding its use (Rees & Stone, 2005). Attitudes that psychotherapists hold toward online therapy can negatively impact treatment effectiveness

(Rathenau et al., 2021). It has been found that, in telehealth or even in email communication, the sense of closeness in the therapeutic encounter does not depend on physical proximity but on the integrity and commitment of the therapist (Scharff, 2014).

Effectiveness of Teletherapy

The current results on the efficacy of telehealth are promising in supporting effectiveness and have been reported to be comparable to in-person treatment, despite the rate of improvement being slightly slower as evidenced in some research studies (Catarino et al., 2018; Egede et al., 2015). Although skepticism has been held by both psychotherapists and the general public, teletherapy can be used to efficaciously treat many common mental health issues that include anxiety, depression, and post-traumatic distress (Poletti et al., 2020) and for major depression, eating disorders, posttraumatic stress disorder, obsessive-compulsive disorder, panic disorder, and social anxiety disorder" (Watts, 2020, p. 208) providing "strong results, in terms of symptom reduction, to those obtained by conventional in-person psychotherapy. Providing telehealth may not be as useful with patients who suffer from more severe mental illnesses that impair cognitive abilities including schizophrenia (Reay et al., 2020).

Although some evidence exists in the literature that telehealth may be slightly less effective in comparison to in-person therapy (Gordon et al., 2015), studies demonstrate the potential of online therapy in preserving the therapeutic relationship and treatment effectiveness (Spijkerman et al., 2016; Turgoose et al., 2017). Systematic reviews also completed prior to the COVID-19 pandemic from Berryhill et al. (2019) and Norwood et al. (2018) have also documented that teletherapy can be consistently effective. Patients and psychotherapists who use online psychotherapy via videoconferencing generally develop good therapeutic alliance with online

sessions, not suggesting differences in effectiveness from in-person sessions (Bekes & Aafjes-van Doorn, 2020; Berryhill et al, 2018; Fletcher et al, 2018).

Lower familiarity and comfort with web-based forms of communication and technical issues might reduce the effectiveness of teletherapy (Poletti et al., 2020). As therapists gain more experience and training in using videoconferencing platforms, they may feel more at ease in providing psychotherapy online. Technical difficulties including brief interruptions have been claimed to be the most significant drawback of teletherapy; misunderstandings could compromise therapeutic interaction and need to be addressed and repaired (Cipolletta et al., 2018).

Overall, the opportunities for intimacy, flexibility and immediacy that online psychotherapy can offer is proving to be very appealing to many clinicians and to their clients, and the COVID-19 pandemic has ushered in a new reality of the delivery of psychotherapy (Shklarski et al, 2021). As many clinicians have shifted their practice to online platforms, they may be able to understand their clients more deeply in the context of their home environments, sometimes with the unconditional regard of their dogs, cats, and pets. "We are able to be just as relational, offer our affect-eliciting presence; explore somatic moment-to-moment experience, and accompany our clients as they venture into emotionally and relationally vulnerable territory," (Prenn & Halliday, 2020, p. 4).

COVID-19 continues to be a global health concern shaping how therapists provide services and impacting their decision about whether to return to in-person work. Positive attitudes about psychotherapy, feelings about vaccine effectiveness, clients' satisfaction with teletherapy, insurance reimbursement for psychotherapy and negative attitudes about wearing masks during sessions all influenced therapists' decisions on whether to return to traditional in-office treatment in the age of COVID-19 (Shklarski et al, 2021).

Telehealth using an Attachment, Relational and Emotion-Focused Lens

Throughout the life span, from the cradle to the grave, human beings need and long for a felt sense of connection to primary attachment figures who can help them to feel secure (Bowlby, 1988). The emotional stress of being locked down in quarantine and socially distanced from others, accompanied by increased anxieties and fears related to contracting the COVID-19 virus have all contributed to a collective trauma and a multitude of collective stressors (Tosone, 2021). Healing from the emotional and social strains of this global pandemic with a psychotherapeutic model that is grounded in attachment research and focuses on deep affective and relational healing can be hypothesized to result in more viable and effective treatment with better outcomes (Camargo-Borges & McNamee, 2020).

Specific Factors

Although a review of psychotherapeutic research studies has evidenced no theory or treatment approach to be empirically superior to any others, specific components of psychotherapy can indeed exert a beneficial influence on treatment effectiveness and treatment outcome (Stevens et al., 2000). The specific ingredients of a treatment approach that not only prioritizes the common factors of a strong therapeutic attachment between therapist and patient, but is also based in a psychotherapeutic approach that has a powerful theoretical rationale with consistent treatment strategies based on this rationale can lead to a positive outcome (Wampold, 2019).

Accelerated Experiential Dynamic Psychotherapy (AEDP) is a psychotherapeutic model that works to process emotional and relational experiences and prioritizes secure attachment through the therapeutic relationship. AEDP has been tested and found to be effective in research clinical trials through both in-person and telehealth platforms, alleviating depression and a range of symptoms in 16 sessions or fewer (Iwakabe et al., 2020). It may be a particularly relevant

psychotherapeutic approach in these unprecedented and changing times, targeting inner experiential-emotional processing, while reducing attention to temporary or concrete external conditions (Ronen-Setter & Cohen, 2020). Given the significant emotional and relational strains of COVID-19, this qualitative research study has focused on the AEDP psychotherapeutic model, and how the mental health professionals who practice this model have experienced the abrupt change from in-person treatment to telehealth through the COVID-19 pandemic. As per Ronen-Setter & Cohen (2020), "the mindful adoption of experiential and relational tools by therapists" such as those used in AEDP, may help therapists "become more teletherapeutic and overcome the potential limitations of online therapy" (p. 8).

Chapter III:

Accelerated Experiential Dynamic Psychotherapy

Accelerated Experiential Dynamic Psychotherapy (AEDP) is a highly integrative, attachment and emotion-focused, experiential mind-body therapy that makes use of relational and experiential-affective strategies of intervention. AEDP was developed by Diana Fosha, PhD in the late 1990's. AEDP is an ever-emergent model of psychotherapy that is grounded in the belief that human beings are driven towards health and wholeness, a deep desire to be seen, known, recognized, and are wired for the process of healing and self-righting (Fosha, 2021a). AEDP roots itself in the phenomena of transformational studies: "that field of endeavor devoted to studying the features, characteristics, dynamics, and phenomenology of discontinuous change processes" (Fosha, 2021b, p. 2). AEDP is based upon a transformational model of change and can be particularly effective in addressing the potentially longstanding effects of relational attachment trauma (Fosha, 2000). Transformance is a central philosophical underpinning of AEDP and posits

that trauma survivors have all they need to heal within themselves, awaiting conditions of relational safety to come to the fore (Fosha, 2017a). Transformance is "the overarching motivational force that strives toward maximal vitality, authenticity, adaptation, and coherence, and thus leads to growth, resilience, and flourishing" (Fosha, 2009, p. 175).

AEDP's theory of change predicts that relief from symptoms is accompanied by changes in both attachment style and affective experiencing, within an empathic therapeutic relationship that is secure, authentic, and collaborative (Fosha, 2000). When core emotions are dyadically regulated and processed to completion to more adaptive emotional states in the safety of a caring therapeutic alliance, they can bring about lasting transformation and healing from suffering. The goal is for patients to have different kinds of attachment experiences from past traumatic relationships, often referred to as corrective emotional experiences. AEDP clinicians work to establish a secure attachment relationship with the patient, while facilitating deep affective work, from the very first session of therapy.

Influences on AEDP

AEDP has been influenced by a multitude of nonlinear stances, techniques and theories which have all contributed to its affective model of change. "In its ethos, theory, stance, and technique, AEDP lives and breathes multiplicity: there is no one path, there is no one core affect, there is no one core dynamic in psychogenesis that can account for the phenomena encountered in the treatment of a wide range of patients by a wide range of therapists. There are different paths to different cores and different mechanisms of change are responsible for healing" (Fosha, 2003, p. 335-336). AEDP has been evolving for over two decades, accompanied by a concomitant wealth of research on the brain as well as a deeper understanding of the role of

emotion and the impact of developmental attachment trauma upon the behavior and personality of an individual (Tunnell & Osiason, 2021).

<center>*Short-term, Time-Limited, Psychodynamic Therapies*</center>

AEDP has been influenced by short-term, time-limited psychodynamic therapies, including Habib Davanloo's affect-focused work (1978, 1990) and David Malan's (1979) triangles of conflict and person paradigms. Davanloo is a psychoanalyst and psychiatric researcher who developed Intensive Short-Term Dynamic Psychotherapy (ISTDP) after he became increasingly frustrated with the length and erratic results of psychoanalytic treatment (Coughlin, 2017). ISTDP has a growing empirical evidence base with confirmed treatment effectiveness (Johansson et al, 2014).

Davanloo's approach exerted significant pressure on the patient to abandon defensive strategies, resulting in "a kind of internal crisis and upheaval required to gain rapid entry into the unconscious life of the patient" (Coughlin, 2017, p. 18). Davanloo collaborated and expanded his model of intensive short-term dynamic assessment and treatment with David Malan in the 1970's and 1980's. David Malan is a psychoanalytic psychotherapist and researcher who is noted for the development of the Malan triangles (1979). The triangles, comprising the Triangle of Conflict and the Triangle of Persons, have provided a map of the patient's internal world serving as a guide for many clinicians in more fully assessing the underlying mechanisms that might be contributing to a patient's difficulties. The Triangle of Conflict maps out how defenses and anxieties can block the expression of true feelings. At the bottom of the triangle of conflict are core emotions that include joy, anger, and grief. Malan's Triangle of Persons can depict ways in which "emotional conflicts, with their origin in the past, get replayed in the patient's current life, including in the relationship with the therapist" (Coughlin, 2017, p. 20).

AEDP further develops the Malan psychodynamic triangles. Representational schemas in AEDP include the Triangle of Experience, the Self-Other-Emotion Triangle, and the Triangle of Relational Comparisons. Although like Malan's Triangle of Conflict, the Triangle of Experience provides an understanding of red signal affects or affective experiences which inhibit deep emotional experiencing (and may lead to pathogenic or maladaptive and defensive states of aloneness) and green signal affects or affective experiences which open up to emotional experiencing and adaptive core affective experiences (Lamagne, 2021). The AEDP Self-Other-Emotion Triangle provides a template for the understanding of how patients have developed their relationship to emotion prior to treatment and during ongoing clinical work (Frederick, 2021). AEDP's Triangle of Relational Comparisons elaborates on how to look at significant relationships over time and compare them with each other, elegantly depicting the patient's experience of the Past, Current, and Therapeutic relationships to each other, embedding the Triangle of Experience and the Self-Other-Emotion Triangle together (Pando-Mars, 2021). In his work, Davanloo stressed the importance of rapidly accessing the visceral experience of core affective phenomena at the bottom of Malan's triangle of conflict, underneath experiences of anxiety and defense (Malan & Della Selva, 2006; Tunnell & Osiason, 2021).

Similarly, to experiential dynamic psychotherapies, AEDP maintains the fundamental belief that psychiatric conditions such as anxiety and depression result from trying to regulate the strong emotions associated with adverse childhood experiences that occurred in significant attachment relationships (Lilliengren et al, 2016). Although the short-term, time-limited psychodynamic therapies, especially the work of Davanloo and Malan, have influenced both the focus and scope of AEDP therapy, they are not relational or attachment-based models. The short-term dynamic psychotherapies rest upon a theory of psychopathology and views the therapist to

be the all-knowing expert without more fully recognizing and privileging a patient's existing capacities (Tunnell & Osiason, 2021).

In contrast, AEDP prioritizes building relational safety and secure attachment in the therapeutic relationship from the get-go, allowing patients to become more comfortable experiencing and expressing core affect (Fosha, 2000). "When a tight focus on present moment affective and relational experience is held, dyadically regulated, and experienced through to completion, the patient goes from being defensively closed off from genuine contact to shedding his defenses against closeness and allowing himself to be open and vulnerable and receive the therapist's real care and compassion" (Frederick, 2021, p. 14). The AEDP effectiveness study (Iwakabe et al, 2020) has provided empirical support for the effectiveness of AEDP in providing "meaningful and significant improvements across a range of psychological symptoms, including depression, experiential avoidance, general symptom distress, difficulties in emotion regulation, and patients' main target problems…with a significant decrease in negative automatic thoughts…and improvement in nonpathological measures that centered on positive capacities, such as self-compassion and self-esteem (Fosha, 2021, p. 10).

Relational Theorists

AEDP incorporates the tenets and values of such early relational psychoanalysts as Sandor Ferenczi (1932) and Otto Rank (1924/1986) who began to formulate and develop their own relational views, apart from the Freudian therapeutic stance of neutrality and passivity within the therapeutic relationship. Freud gave little attention to the real and explicit relationship between therapist and patient. Ferenczi and other relational theorists began moving away from a one-person to a two-person psychology, focusing on treatment based on relational authenticity with a human and fallible therapist actively involved in the relationship with the patient. They

began exploring explicit empathy and the self-disclosure of feelings towards the patient to facilitate and deepen the work. In addition, Salvador Ferenczi (1932) began to consider and explore the unbearable loneliness and abandonment that a patient may experience without having had the emotional holding of early maternal friendliness and delight.

Psychoanalyst Donald Winnicott (1974) further elaborated on a relational holding environment that could be created by the therapist to support and facilitate growth, exploration, and a sense of safety that supported and fostered a patient's "true self", i.e., the subjectively felt experience of authenticity and genuineness. AEDP further elaborates on Winnicott's (1960/1965) concept of a true self to identify the relational counterpart of a "true other". A true other "describes an experience-near construct in which one person responds to another person in just the right way" (Piliero, 2021, p. 273). AEDP holds hope that the therapist may be experienced by the patient as a true other. A true other can be instrumental in helping to actualize another's sense of true self (Fosha, 2005). Winnicott's psychodynamic concepts of "good enough mothering" and "mirroring" also find deeper meaning in the AEDP therapeutic relationship. As the good enough mother provides for her baby's emotional needs for care, the AEDP therapist also offers this same care and empathic resonance, both with the ability to make repair when misattunement happens. As Winnicott assigns special significance to the mirroring function of the mother's face in the development of the child's sense of self, the AEDP therapist uses affective mirroring and attunement to allow the patient to feel seen, recognized and known (Russell, 2021). The AEDP therapist seeks to rewire the brain by rewiring attachment experiences (Tunnell and Osiason, 2021). Other current theorists in the relational tradition that have been influencing AEDP are Bromberg (1998), Eigen (1980), Ghent (1990), and Grotstein (2004).

Experiential and Somatic Emotion-Focused Therapies

Fostering emotional experiences that are experienced as healing in a visceral and embodied way, tracked moment-to-moment, and worked to completion is the aim of experiential emotion-focused therapy, a theoretical approach to the field of psychotherapy first developed in the 1980's and early 1990's. Both Bessel van der Kolk (2014) and Peter Levine (2015), experts in the field of developmental trauma, underscored the importance of an experiential focus in working with the body in trauma. Trauma victims cannot recover until they become aware of and befriend their sensations and the way that their bodies interact with the world around them. Physical self-awareness is the first step in releasing the tyranny of the past (Van der Kolk, 2014). Resmaa Menakem (2017) further attested that trauma isn't destiny and that the body, not the thinking brain, is where we process most of what happens to us and where we do most of our emotional and psychological healing.

Neuroscience and emotion theory suggest that emotions are rooted in the body (Craig, 2015; Damasio, 2018). Philosopher Eugene Gendlin (1996) and psychologists Greenberg and Goldman (2019), among many others, developed specific techniques to working with the somatic experiencing of emotions in the body. Interoceptive awareness (Craig, 2015) and the felt sense (Gendlin, 1981) are both concepts that are used in experiential emotion-focused work to describe internal bodily awareness.

AEDP makes use of experiential processing, the privileging of "bottom-up experience and its felt sense, particularly that of adaptive core affective experiences rooted in the body, over top-down narrative and cognition" (Fosha, 2021, p. 4). "It is not sufficient for the patient to say that he is sad or fearful…the patient must feel the sadness or fear in his gut or his heart or his face or his sinew" (Fosha, 2000, p. 138).

Experiential language moves from vagueness to the specific, from speed to slowed down and waiting, from interpretations to short interventions processed just one at a time, from large words to small words, always affirming, asking the body to help, asking permission, and collaborating (Prenn, 2011). Although AEDP shares deep resonances with experiential and emotion-focused therapies, it works in more enhanced relational ways to ground experiential sensations, changes, and transformations more fully.

Interpersonal Neurobiology

AEDP has also been influenced by interpersonal neurobiology, an interdisciplinary field that brings together many branches of science to understand the human experience and interpersonal life. It has been developed by psychiatrist and researcher Dan Siegel (2003, 2015) and the work of psychologist Allan Schore (2003, 2019), and has explored the impact that therapy can have on the brain.

According to both Siegel (2015) and Schore (2019), children who grow up with experiences of abuse, neglect, traumatic aloneness, and distress will experience compromised neurological and psychological development. During early critical periods in an infant's life, frequent and unrepaired, dysregulated relational experiences are "affectively burnt in" to the child's right brain (Schore, 2019). The attunement between therapist and patient is "similar to optimal caregiver-infant dyads in which the caregiver's right brain is synchronized to respond to the ever-oscillating verbal and nonverbal emotional states of the infant" (Piliero, 2021, p. 273). New experiences of interpersonal receptivity and responsiveness can create new neural circuits, however, and can reduce reliance on old reactive patterns (Siegel, 2015). These new experiences help to create linkages in the brain which can build the capacity to make sense and meaning of one's life.

Chapter IV:

Theoretical Foundations of AEDP

AEDP is a non-pathologizing model of therapy that also rests upon a theoretical framework that integrates constructs and insights from attachment theory, clinical developmental research into mother-infant interaction, emotion theory and affective neuroscience. AEDP rests upon fostering experiences of safety, secure attachment, and healthy affective functioning that can lead to new relational learning and growth.

Attachment Theory

Attachment research is foundational to the theory and practice of AEDP. Attachment theory originates from the seminal ideas and study of John Bowlby, a child psychiatrist and psychoanalyst who worked with delinquent teens and began to identify and recognize patterns of early childhood neglect and abandonment (Bowlby, 1969, 1980, 1988). It is an empirically supported theory that explains how early experiences with primary caregivers shapes human development and behavior in interpersonal relationships. As human beings, our need to be in secure and nurturing attachment relationships is necessary for healthy emotional development and is fundamental to our existence, starting from birth and continuing throughout the lifespan (Bowlby, 1980). Bowlby asserted that the emotional and physical survival of infants depends on attachment and provided an in-depth description of what could go wrong during the critical stages of early attachment relationships.

Bowlby viewed attachment as a motivational system that was evolutionarily designed to support the survival of human infants and their need to be near their caregivers. In addition to physical protection, Bowlby theorized that the caregiver could provide emotional availability and presence, acting as a secure base for the child to regulate feelings and behaviors that manifest

when safety is threatened. The ability to form a safe and secure attachment bond was based on the actual experience and learning of the child through interaction with primary caregivers, challenging the psychoanalytic idea that attachment originated from intrapsychic conflict and the reduction of tension related to sexual and aggressive drives.

Children learned about attachment in the same way that they learned other skills from parents (Bowlby, 1969). He defined attachment behavior as any behavior that is meant to maintain proximity to their caregivers, including crying and calling out, or clinging and protesting if left alone. From the very first moments of life, an infant, unable to regulate any of her own states or fill any of her own needs, is entirely dependent upon caregivers to recognize, mirror and respond appropriately to these needs. Bowlby built upon the ideas of psychoanalyst and pediatrician Donald Winnicott (1971) and his theoretical frame that the mother's face serves as a mirror to her baby. "What does the baby see when he or she looks at the mother's face? I am suggesting that, ordinarily, what the baby sees is him or herself. In other words, the mother is looking at the baby and what she looks like is related to what she sees there" (Winnicott, 1971, p. 112). When the mother or primary caregiver is unresponsive, the baby will withdraw to avoid chaos, and will stop seeking out reflections of him or herself in others. The way that important others perceive and mirror a child significantly impact and shape personality (Bowlby, 1980). Bowlby theorized that these repeated emotional exchanges with early caregivers are basic building blocks that, over time, construct reliable templates of self and other. By the end of the first year of life, children have already begun to form models of attachment that were based on what was learned from their earliest interactions with primary caregivers.

As an infant grows into a child, adolescent and adult, her needs evolve and become more complex and nuanced impacting future relationships (Bowlby, 1980). Children who grew up in

anxious attachment will form adult relationships in which they may make constant demands for care and love. In an anxious relational style, an individual may pursue an emotional connection with a partner and become preoccupied with the threat of not getting their needs met, losing their partner or experiencing a constant need for help. Avoidantly attached adults may be more wary of closeness and become seemingly independent and compulsively self-reliant, avoiding emotional connection with others to prevent awareness of underlying vulnerability and attachment needs. In an avoidant relational style, an individual may keep their feelings hidden by distancing, numbing-out, shutting down or acting as if they are independent and don't really need emotional connection. Although internal working models of attachment may persist in relationships across the lifespan, they are not immutable. Bowlby believed that attachment styles can be updated through experiences in new relationships and through increased self-awareness, and that attachment can move from insecure to secure. The brain is neuroplastic, remaining malleable over a lifetime with an ability to reorganize itself in response to new relational experiences.

Developmental psychologist and researcher Mary Ainsworth based her study of mother-infant bonding on Bowlby's theory to create support for classifications of attachment patterns in children. Ainsworth's Strange Situation research focused on what occurred between caregivers and children during periods of separation and reunion (Ainsworth et al, 1978). In the Strange Situation procedure and research, a child is observed playing while caregivers and strangers enter and leave a room, recreating a flow of familiar and unfamiliar presence in a child's life. The situation varies in stressfulness, and the focus is on the observation of the child and their experiences and responses.

Ainsworth and her collaborators found that the attachment system was malleable and depended on the caregiver's behavior. Primary caregivers who build safety, security and are experienced as sensitive and responsive have babies who are "securely attached." These babies may experience the mother to be emotionally available when the infant seeks proximity and recover more quickly when the mother returns. In insecure attachment relationships, the child may show little distress when the mother leaves the room and may avoid her when she returns. Avoidant infants may deactivate their attachment system in response to mother's unavailability. They play independently and are not able to use their mother as a secure base from which to explore. Through these avoidant behaviors, children attempt to keep parents as close as possible. Anxious children may have a preoccupied parent who is inconsistent in their responses, which may sometimes be chaotic. Those who have an anxiously attached style may have experienced threats of withdrawal of love or abandonment. Anxious babies are more preoccupied with their mother's location and tend to be clingy or to push her away. Like the avoidant baby, they cannot use the mother as a secure base from which to explore the environment.

Mary Main (1990, 1999), an American developmental psychologist, further contributed to attachment theory. Main posited that attachment styles can be passed down through the generations, and that primary caregivers who have a more coherent narrative of their own early attachment experiences will have children who are more securely attached. She created the Adult Attachment Interview (AAI) and defined attachment classifications in adults after listening to the quality of adult attachment narratives in which parents are asked to recall and reflect upon their own relationships with their parents. Main found that these verbal narratives could be directly correlated with their own attachment style as children. Those with secure attachment experienced clear, consistent early attachment experiences and can regulate affect. Those with dismissing or

avoidant attachment styles may remember little about early attachments and minimize their importance with an idealized, superficial, or contradictory description of their childhood. Preoccupied or anxious attachment styles may dwell on early childhood conflicts without resolving them, remaining angry and preoccupied with earlier and/or current attachment figures. Earned secure attachment is a pattern noted by Main (1999) in the Adult Attachment Inventory to describe a person who grew up with insecure attachment, but who has experienced a relationship with another that has enabled them to rise above their insecurity and express themselves with the coherence and cohesiveness of secure attachment (Pando-Mars, 2021).

Main introduced disorganized attachment to the other three attachment styles after further reviewing the Ainsworth Strange Situation research. Disorganized attachment can be a result of serious abuse and neglect stemming from unpredictable or dangerous environments lacking a soothing caregiver. Safe attachment was not possible, and these children show disoriented behavior during both reunions and separations (1990). A more disorganized, fearful avoidant attachment style may develop marked by a craving for love and affection along with a reluctance or fear in allowing themselves to take in and receive emotional care. In this type of attachment strategy, commonly seen in trauma survivors, both anxiety and avoidance are high. There is an overall sense of needing someone and feeling untrusting of others.

Psychologist Arietta Slade (2000) has further expounded on attachment theory through her research on reflective parenting and the development of parental mentalization. She focuses on the clinical assessment of what to listen for when parents share their own experiences of early childhood attachment, i.e., language that conveys meaning in a clear and unambiguous way vs. language that is incoherent, distorted, or vague. The mother who has forgotten, repressed or remains overwhelmed by the effects of her own attachment experiences may find her child's

needs painful or intolerable and may turn away from her child's feelings as she has turned away from her own (Slade, 2000). Distortions in a person's attachment narrative may reflect the child's efforts to maintain connection to the caregiver, even if this requires fragmentation of feeling and knowing.

Peter Fonagy (2002) has further developed ideas about attachment theory as a framework for understanding and conceptualizing adult pathology and the therapeutic relationship. His work further considers the intergenerational transmission of attachment styles, mentalization and the reflective function. Mentalization is the ability to read the states of the other and to understand oneself, a way to make sense of one's own and other's experience, with the caregiver having a mind, the child having a mind and the recognition of two separate minds, self-reflective and interpersonal (Fonagy, 2002). Attachment security in the child is dependent on the capacity of the caregivers to mentalize and reflect upon their own early attachment history. When a person can identify and share their experiences and sources of upset, they can access their pre-frontal cortex to share understanding and mentalize, creating linkages between different parts of the brain, which can ease their disturbance; this remains significant and relevant to the healing of early attachment trauma and disorganization (Fonagy et al, 2005). Parents who have open, ready access to their thoughts, feelings and memories about their own early attachment can create secure attachment with their children.

Infant Developmental Research

AEDP is also based upon developmental literature and research on mother-infant communication and interactive regulation in infant-parent dyads. Infant developmental research integrates the contributions of clinical developmentalists that focus on the moment-to-moment interaction between mothers with their babies including the clinical research and theory of

Daniel Stern (1985), Beatrice Beebe and Frank Lachmann (2002, 2014), and Edward Tronick (1989, 2007, 2009, 2020).

Daniel Stern was an influential American psychiatrist and psychoanalytic theorist specializing in infant development. He was the first psychoanalyst to incorporate the emerging research and empirical microanalysis of mother-infant communication into developmental models. His work challenged the detached and self-absorbed "normal autistic" phase of Margaret Mahler's separation-individuation theory of childhood development (1975). According to Stern (1985), the developmental domains of self emerge continuously throughout the first two years of life. Human relatedness begins at birth along with a progressive accumulation of a sense of self, socio-affective competencies, and ways of being with others. The core self (2- 7 months) emerges as the infant begins to make eye contact and seek-out mutual gaze, becoming a highly social partner. The subjective (intersubjective) sense of self (7 -15 months) emerges as the infant non-verbally expresses affective states and intentions. The verbal sense of self (15-30 months) expands as the infant discovers the world of words and new ways to relate. The narrative sense of self (30 to 48 months) develops as children discover and create themselves in their stories.

The ongoing developmental research of psychologists Beatrice Beebe and Frank Lachmann has continued to provide a foundation for understanding how mother-infant communication impacts attachment and emotional development (2014). Infants form anticipations and expectancies about how interactive patterns with their primary caregiver will proceed, which are the early formations of internal working models and attachment styles (Beebe & Lachmann, 2014). Through careful observation of video-taped mother-infant interactions frame-by-frame and astute microanalysis of eye contact and gaze, body and head movement and orientation, facial expression, vocal rhythm and prosody of speech, Beebe and Lachmann have continued to explore

the process of communication and interactive regulation in parent-infant dyads. Largely out of awareness and in a split-second-by-split-second way, often imperceptible to the naked eye, babies and parents engage in this process of tracking, following, and matching the direction of affective engagement change in each other (Beebe & Lachmann, 2014). Dyadic patterns between infant and primary caregiver at 4 months can predict styles of secure, resistant, and disorganized attachment when the infant is one year old. Mothers of infants who develop disorganized attachment styles bring their own difficult attachment history into their interactions and can pass on unresolved trauma, abuse, or loss onto their babies. As the mother is a source of survival, the child cannot consciously acknowledge the mother's destructiveness or fragility which can result in a lifetime of self-blame, a sense of alienation accompanied by self-doubt with regards to the legitimacy of one's own perceptions and affects. "Early interaction disturbances inevitably color adult treatment" and how the therapist and the patient co-create patterns of relatedness, ways of knowing and being known, both verbal and nonverbal can either ameliorate or exacerbate current-day shadows of early interaction disturbances (Beebe & Lachmann, 2014, p. 59).

Edward Tronick is another developmental psychologist and researcher whose work and ideas ground infant and caregiver research and theory. Tronick's findings stressed the importance of affectively in-sync relational experiences in a secure attachment relationship. A caregiver who attends to the needs of her infant and provides a nurturing and caring environment can strengthen a child's sense of self and build secure attachment (Tronick, 1989). Infants and caregivers are in an effective communication system with the goal of the baby to maintain proximity to the caregiver and to maintain internal homeostasis and self-regulation. Infants and parents engage in a mutual regulatory system in which intersubjectivity and emotional connectedness are continually sought (Tronick, 2020). Intersubjectivity is the process whereby the subjective experience of each

member of the pair influences the subjective experience of the other. Infants are profoundly affected by the emotions and behaviors of their caregivers within the intersubjective space.

The roots of behavioral problems in an individual child's life can be found in the relationships with important people in that child's life. Tronick's still-face experiment (1978) demonstrates how the experience of disconnection between parent and infant can lead to an infant's withdrawal, frustration, anxiety, and hopelessness, and how this connection can be rediscovered and repaired. It remains one of the most replicated findings in developmental psychology attesting to the significance of building connection, attunement, and resonance, as well as focusing on the significance of disruption and repair in building and maintaining secure attachment. Rarely is attunement uninterruptedly flawless (Fosha, 2021), and according to Tronick's research findings, attunement is necessary only about 30% of the time for secure attachment to develop and be maintained. Disruption and repair can subsequently lead to resilience, or the self's differentiation from adversity and "the expansion of capacity through new and challenging experiences" (Russell, 2021, p. 260). Tronick's research demonstrates the profound importance of rupture/repair in the expansion and deepening of relational connectedness and the maintenance of secure attachment. With ongoing iterations of the rupture of connection and safety with its relational repair instills an increasing experience of resilience and security.

"In relationships, like mother (caregiver) and child, we are constructing neural networks in the brain, transposing maternal (caregiver) behavior into biological structure" (Cozolino, 2006, p. 87). Characteristic relational patterns of the infant-mother dyad can become internalized in psychic structure, and early negative interpersonal experiences in attachment relationships can become a primary source of the symptoms for which people seek relief in psychotherapy

(Cozolino, 2014). Neuroplasticity is the brain's innate biological capacity to grow and heal itself and can provide hope for changes that can be made in psychotherapy (Doidge, 2007).

<p align="center">*Emotion Theory and Affective Neuroscience*</p>

In addition to being grounded in attachment theory and the work of infant developmental research, AEDP has also been influenced by emotion theory and affective neuroscience. According to emotion theory, the accessing and experiencing of core emotions plays an important role in helping human beings to negotiate their lives, appraise their environments, and communicate to others how they experience themselves, each other, and the world. Emotions are innate and physiologically follow certain characteristics and expressions across cultures (Ekman, 2007). Charles Darwin was a British naturalist, biologist, and geologist, best known for his contributions to the science of evolution. Darwin (1872/1965) stressed the evolutionary significance of human emotions, considering them to be adaptive and necessary wired-in guides to living. He was the first to identify and describe the categorical emotions of anger, joy, sadness, fear, disgust, and excitement, in addition to the distinct phenomenology, dynamics and adaptive action tendencies of each emotion.

Neuroscientist and psychobiologist Jaak Panksepp (2009) expanded emotion theory through his research, articulating seven basic emotional systems that include Seeking, Rage, Fear, Lust, Care, Grief, and Play. According to Panksepp, emotions act as ancestral tools for living that not only support and sustain survival but are also involved in providing neural energy to support the organism's optimal engagement in the "mind-body-world connection" (Panksepp & Northoff, 2009, p. 203). Neuroscientist Antonio Damasio (2010, 2018) further asserted that all living creatures are evolutionarily programmed to not only survive, but also to develop, to grow, to flourish and to achieve a homeostasis of positive energy. The research of both Damasio (1999,

2010) and Panksepp (2009) introduced the neurobiological underpinnings of how emotional experiences are encoded in the brain.

Both negative and positive emotions serve an evolutionary function. Negative emotions require corrective action by an individual and can be energy-consuming (Craig, 2015). Negative emotions can encompass "arousal, danger, negative affect, withdrawal (aversive) behavior, and individual-oriented (survival) emotions" and can serve to assist human beings in directly addressing the challenges and dangers around them (Craig, 2005, p. 566). Contrastingly, positive emotions can broaden perspectives and expand possibilities for exploration and growth (Frederickson, 2013). Staying with the felt sense of positive emotional experience can contribute to positive neuroplasticity and brain change (Hanson & Hanson, 2018). Positive neuroplasticity refers to the capacity of the brain to adapt and develop new neural connections, and it operates from cradle to grave, just as the attachment system (Fosha, 2021b). AEDP seeks to operationalize the intersection of attachment and affective neuroscience to introduce innovations in its clinical practice. The more therapists facilitate affective experiences, the more clients feel better and improve (Lilliengren et al, 2016).

Chapter V:

Clinical Constructs in AEDP

Secure Attachment and the Significance of the Therapeutic Relationship

The therapeutic relationship is one of the most powerful sources of therapeutic change, and research clearly states that it is the quality of the relationship with the therapist and their ability to form a strong alliance across a range of patients that is the greatest predictor of successful treatment

outcome (Wampold & Imel, 2015). "Effective therapists are effective because they are better able to form alliances with their clients" (Wampold, 2019, p. 107).

AEDP "places the therapeutic relationship front and center in its mission to heal relational trauma and transform the self" and "simply put, in AEDP the therapeutic relationship- attuned, emotionally engaged, authentic, moment-to-moment present-is a sine qua non in healing trauma and the traumatized self" (Piliero, 2021, p. 269). Patients carry the effects of early developmental relating to their caregivers, and the child grown-up, is given a second chance at right brain to right brain attunement (Schore, 2019). Building a safe and secure attachment in the therapeutic relationship provides the base from which earlier attachment traumas can be mourned and worked through to completion freeing up energy and adaptive resources to be used for life in the here and now (Lipton, 2021).

Through relational processing, experiences between the therapist and patient are made explicit, experientially explored, and processed in the service of healing, transformation and maintaining secure attachment (Frederick, 2021). Working relationally can activate insecure attachment and bring up long-held barriers against emotional connection.

Furthermore, the AEDP therapist works to help patients relinquish defenses, regulate anxiety or fear responses, and address shame against relational affective experiencing. Signs and signals of defense may include avoiding eye contact, speaking rapidly or being excessively wordy, restlessness or moving the body away from the therapist, discrepancies between emotion-laden words and stone-faced expression (Hanakawa, 2021). Anxiety (also referred to in AEDP as an inhibitory or "red signal affect") may be evidenced by shallow breathing, trembling hands or legs, or rapid speech.

Therapeutic Presence

By promoting a therapeutic relationship that enables the patient to feel safe, core affective experiences can be pressed into immediate therapeutic service for the patient (Fosha, 2000). According to AEDP, therapeutic presence is a relational way of being with clients that can create safety, secure attachment, and optimize the doing of psychotherapy. It involves AEDP therapists bringing their whole self to the encounter and being available on multiple levels that include physical, emotional, cognitive, relational and spiritual (Geller, 2017). Like AEDP's concept of feeling and dealing while relating, therapeutic presence starts within the therapist and asks the question, "Am I in my body and open to my own physical and emotional experience?" (Prenn & Halliday, 2020, p. 4). Everything that the therapist can "do" in AEDP begins with "the ability to be present in body and mind, while remaining oriented to what is happening in the client and staying open to being explicitly impacted by what is happening in the intersubjective space of the moment between therapist and client" (Lipton, 2020, p. 1). Becoming centered can be difficult enough and "staying centered in the face of someone else's storm" can be a real challenge but is the essence of presence (Cozolino, 2004, p. 132).

Presence within ourselves allows us to attune to others (Lipton, 2021). The attuned and present therapist can mirror the affective experience of the client to interpersonal soothing to regulate overwhelming, disorganizing and painful emotional experiences (Geller & Porges, 2014). The polyvagal theory, developed by neuroscientist Stephen Porges, provides a biological understanding of how therapeutic presence and attunement can impact the therapy process and the way patients feel (Porges, 2011). Through a therapist's kind face, soothing tone of voice and intention to know, patients can engage with and use their social engagement or ventral vagus system to regulate internal states to negotiate experiences of threat or stress. This is a human

being's highest level of nervous system response strategy. When unable to use this ventral vagal system, people resort to more primitive survival responses to threat, including fight-or-flight or immobilization and freezing (Russell, 2021).

Therapeutic presence incorporates empathic resonance, referring to the caring openness and acceptance of whatever is coming our way from our patients both nonverbally and verbally, noticing physiological and emotional markers of coordination that include breathing patterns, heart rate, physical behaviors and gestures, posture, gaze alignment and emotional synchrony (Lipton, 2020). Empathic resonance asks, "Am I slowing down and allowing myself to be impacted by my client and to explicitly communicate this when helpful?" (Prenn & Halliday, 2020, p.4). "Resonance, in the form of a mutual coordination, can be seen between infant and mother in free play. The timing of responses is exquisite, facial expressions are synchronized, emotions are shared, and the intentions of the other are anticipated" (Johnson, 2009, p.273). The infant and early childhood caregiver-infant interaction research of Beebe & Lachman (2002, 2014), Stern (1985), and Tronick (2007, 2009) has provided a lens for understanding the significance of therapeutic presence and empathic resonance which is monitored in AEDP sessions.

Dyadic Affect Regulation

In addition to therapeutic presence, dyadic affect regulation can serve to build and maintain secure attachment in the therapeutic relationship. The ability to fully experience and tolerate one's feelings, particularly when they are painful and intense, can be greatly enhanced by the ability to do so with a supportive, empathic, emotionally attuned, and present other without needing to develop strategies to minimize or numb or mute feelings (Fosha, 2001). "Dyadic affect regulation refers to the therapist's help in regulating emotional experiences that felt, and still feel, too overwhelming to the individual to process alone. In such moments, the affect-laden experiences

exceed the regulatory capacities of the individual" (Fosha, 2021, p. 34). In working with emotion, the AEDP therapist provides dyadic holding and regulation of affect which consists of empathy, affirmation, and support of emotional experience. Affirmation of emotions can create enhanced safety in being oneself and increased openness in exploring all sorts of difficult and intense experiences without the pathogenic and inhibiting fear of being shamed or overwhelmed by the emotion (Fosha, 2004). When we feel safe and accompanied by another person, our capacity for growth is expanded (Bowlby, 1988; Schore, 2019; Siegel, 2017). Dyadic affect regulation is achieved moment-to-moment through right-brain to right-brain attunement to the patient's psychobiological state (Schore, 2019). Psychobiological attunement is an experience of sensing someone deeply, taking the experience of the other and allowing it to shape who we are in the moment, understanding the patient not only through language-mediated responses, but also through the therapist experiencing the patient in their own body (Bucci, 2012; Lipton, 2020; Siegel, 2017). "When the dyad is effective in processing what the individual could not process alone, not only is there learning by internalizing the regulatory strategies of the dyad, but there is also important relational learning. Individuals learn that when things are too much for the self alone, it is possible to reach out to others" (Fosha, 2021, p. 34-35). With our gaze, with our movement and posture, with our hearing, with the tone, pitch and pacing of our words we literally enter the "regulatory system" of our patients as mothers do and create attachment experiences in session (Prenn, 2011; Tronick, 1998). Meeting the patient where they are at and matching tone, pitch, pacing and depth of emotion are essential (Prenn, 2011).

To do deep affective experiential work, a therapist needs to trust the process of transformation and "that processing emotions to completion inevitably leads to a better place" (Russell, 2015, p. 315). Through dyadic affect regulation, the AEDP therapist "facilitates, deepens

and accompanies the patient riding the waves of affective experience" (Piliero, 2021). Tolerating the deep affective experiences of others and being able to regulate them when they are overwhelmed or bring patients to their underlying feelings if they are overregulated requires a therapist's own experiences of differentiation and remaining connected to themselves (Russell, 2015).

Undoing Aloneness

Trauma researchers and theorists have documented that the most salient aspects of traumatic experience tend not to be the trauma memory itself, but the felt experience of aloneness and nobody being there (Fisher, 2017; Fosha, 2000, 2003; Herman, 1992; Stolorow & Atwood, 1992; van der Kolk, 2015). AEDP rests on the theoretical foundation that "the most profound emotional injuries are not those that occurred during the moment of violation but those that result from the aloneness, desperation, demoralization, helplessness, and intrapersonal/interpersonal disconnection that followed and is subsequently rekindled by the mind thereafter" (Lamagne, 2021, p. 296). Psychopathology can be viewed as the maladaptive consequences which result from "an individual's unwilled and unwanted aloneness in the face of overwhelming emotional experiences" (Fosha, 2009, p.182).

A central mission of AEDP is to undo the patient's aloneness in the face of these overwhelming and unbearable affective experiences, through the therapist's active emotional engagement, implicitly and explicitly letting patients know that they are there, to bear witness and to stay with patients' core affective experiences (Piliero, 2021). Being with a patient and bearing witness to their pain has its roots in the caregiving system of attachment with an emphasis on "being there", promoting safety and being a "trusted companion" (Bowlby, 1988). The AEDP therapist takes many lessons from the mother-infant dyadic synchrony, attuning to gaze, providing

empathy, love and care, privileging the positive, and delighting in the patient in order to undo the aloneness of their historical and earlier experiences (Prenn, 2011).

Receptive Affective Capacity

Receptive affective capacity refers to the patients' ability to take in and accept the care that the therapist must give- feeling seen, feeling understood, feeling felt, feeling cared for, feeling helped, feeling loved (Fosha, 2000). It is not sufficient that empathy and help are given to patients. To work their potent magic and deep healing potential, these experiences of compassion and love must be viscerally experienced, internalized and taken in (Fosha, 2000). "If our patients cannot 'take in'…what we or others offer them…little characterological change can occur" (McCullough, 1997, p. 315). The AEDP therapist helps to build the patient's receptive affective capacity "to feel that which was here-to-fore warded off or unbearable" (Piliero, 2021). The clinical work involved in building receptive affective capacity involves experientially exploring and inquiring through metaprocessing and affectively charged experiential questions such as "What does it feel like inside to hear me say that I appreciate you?" "What happens inside when you take in this truth about yourself that you are a strong and multitalented person?" (Piliero, 2021, p. 277).

Moment-to-Moment Tracking

Moment-to-moment tracking is a foundational practice in AEDP. It can be defined as "the mindful recognition of emotional states in the client as well as in the therapist and the dyad based on observed or felt changes in facial expression, body movements, posture, tone of voice, gaze direction, and rhythm of breathing" (Hanakawa, 2021, p.107). Moment-to-moment tracking involves slowing down and detecting shifts in clients' affect, body language, manner of relating, and often making these changes explicit (Fosha, 2000). To minimize the risk that our attention might be monopolized by the patient's words, moment-to-moment tracking allows the therapist to

"read" the language of the patient's body which include the expressions on the face, the rhythm and tone of voice, the pace of the patient's breathing as well as the nuances of posture and gesture (Wallin, 2007).

"The moment-to-moment self-and interactive processes of relatedness documented in infancy are the bedrock of adult treatment" and longitudinal research studies attest that these modes of adult relatedness and face-to-face communication are built upon those of infancy (Beebe and Lachmann, 2014, p. 70). Moment-to-moment tracking leads to attunement and communicates to the infant that the parent can understand and share the infant's feelings. Moment-to-moment tracking and attunement are "indispensable to AEDP clinical work that depends on identifying subtle and not so subtle nonverbal cues of affective shifts in the emotional, relational, and transformational experience of the client, therapist and dyad" (Hanakawa, 2021, p. 107). The goal of moment-to-moment tracking, and micro-attunement is to support the AEDP therapist in making informed clinical decisions that lead towards the path of healing, flourishing and transformation (Fosha, 2021).

Corrective Emotional and Relational Experiences

Bowlby (1988) believed that the therapist's most important task was to provide a secure base from which a patient could begin a journey of self-exploration, and that secure attachment to the therapist could provide a corrective emotional experience for the client. The corrective emotional experience is a phrase that was first coined over 60 years ago by psychoanalysts Franz Alexander and Thomas French (1946/1980), defined as re-experiencing old, unsettled conflicts but with new endings. According to Piliero (2021), at the heart of suffering is self-rejection that is caused by reactions to traumatic experiences in which the patient internalizes self-hatred in the form of core erroneous beliefs and pathogenic affects (e.g., "I am unlovable", "It's all my fault").

Deepening into the relational work of Ferenczi and Rank, psychoanalysts Alexander and French believed that intellectual insight alone is not sufficient, and that "it is in this therapeutic experience that repair of the traumatic influences of previous experiences can take place" (Alexander & French, 1946/1980, p. 66). Internalized experiences of shame or self-hatred and deeply entrenched negative or inaccurate beliefs about the self can be emotionally healed and corrected. Alexander and French asserted that the greater the knowledge a clinician has of the intricacies of human behavior, the more effective and efficient treatment can be.

Both the terms corrective emotional and relational experiences emphasize the significance of working through painful and traumatic moments of development marked by "heretofore-unbearable affect…and the implicit memory of "nobody being there" with experiencing new and more adaptive feelings within a safe and empathic therapeutic relationship in the here and now (Piliero, 2021, p. 275). Being exposed to experience that is contradictory to one's habitual expectation is essential in producing deep and transformational change (Piliero, 2021). The AEDP therapist seeks to create a safe and affect-friendly environment from the get-go, and to activate a therapist-patient relationship in which the patient feels deeply valued and will not be alone with emotional experiences (Fosha, 2003). Providing corrective emotional and relational experiences, making use of both nonverbal and verbal means of experiential language, i.e., more evocative, embodied words and interventions, can all serve to expand the patient's emotional repertoire and be an important vehicle for both interpersonal and intrapsychic change that they can take into other relationships (Prenn, 2012).

The use of portrayals in AEDP allows further processing that can lead to corrective emotional experiences. Portrayals (originally developed by psychoanalyst Habib Davanloo in 1990 and further developed and enhanced in the work of AEDP) are real or imagined scenes from

childhood years or adulthood "where the patient can have a healing experience, providing in the here-and-now what they didn't get in the there-and-then (Piliero, 2021). Through the imagination, patients can undo the aloneness experienced by a younger version of the self, responding to their unmet needs in both action and words to help calm, relieve and soothe these parts (Medley, 2021). Ecker (2015) advanced the idea that the brain can process imagined experiences with similar circuitry to a person's lived experience, and that painful and traumatic memories can be healed and reconsolidated through imagination, as if they were experienced as real. Ecker et al. (2012) suggested that AEDP, as do other therapies that rest on recent research demonstrating the brain's capacity for lifelong "positive" neuroplasticity (Doidge, 2007; Hanson, 2017), makes use of mechanisms to alleviate suffering by "rewiring the brain".

In AEDP, the transformative action of healing through corrective emotional experiences can also be formulated using the tripartite conception of the self and making use of intra-relational parts (Piliero, 2021). The primary goal of intra-relational parts work is to allow deeper healing and corrective emotional experiences to take place (Lamagne, 2021). Parts work can help patients to develop self-compassion and a more cohesive autobiographical narrative. In the tripartite conception of the self, the core self is the unconditioned self that remains whole and intact and who we are at birth, the wounded self is the amalgam of all the child parts that are created in trauma held together by defenses including core erroneous beliefs and pathogenic affects, and the present-day self or the adult chronological self which might either be bound up with the wounded self or leaning back into the core self (Piliero, 2021). The AEDP therapist works to advocate for the patient's wounded and traumatized shame-based parts of the self while championing the patient's core authentic self.

Metaprocessing

The intervention of metaprocessing or meta-therapeutic processing is a unique contribution of AEDP. AEDP emphasizes the importance of bringing a patient's awareness and attention to mutative experiences, by acknowledging and labeling these experiences and specifying how and why they are different (Fosha, 2000). It encompasses the therapist's use of explicit inquiry and reflection and can be understood and defined as "how new experience can be encoded and integrated into explicit memory by reflecting on it" (Lipton, p. 3, 2020). Dan Siegel (2017) refers to an integrated brain as one in which the flow of information that happens between parts of the brain allow it to reflect on experiences while being in connection to the experience. Metaprocessing is used to assist patients in the integration and reinforcement of experiences and changes that may have been gleaned during a particular session and can result in transformational affects. Transformational affects include feelings of mastery, recognition and delighting in the self and are all associated with experiences of innate healing that can assist in broadening and building positive resources that otherwise might lie dormant within the client (Fosha et al., 2019; Frederickson, 2013; Russell, 2015).

Metaprocessing provides "an opportunity for distinct neural networks in the brain that were previously dissociated and deficient of necessary stimulation, to connect, and for new neural pathways to grow, thus increasing the patient's capacity for sustaining connection and integration" (Pando-Mars, 2021, p. 162). Functional magnetic resonance imaging studies (Burgdorf & Panksepp, 2006) have suggested that positive affects appear to activate the prefrontal cortex region in the frontal lobes of the brain; therefore, it can be hypothesized that the mechanism of meta-therapeutic processing is mediated by this area of the brain and reflected in transformational positive affects (Yeung, 2021).

Metaprocessing can be used at any time during an AEDP session. It keeps the therapy process relational and experience-near, making explicit all that is occurring in the treatment session, allowing the client and therapist to have an experience together and to make decisions on the roadmap for work ahead (Yeung, 2021). It can include cognitive inquiries on a client's experience in the moment: "How is it for you to think 'I can let go of this and move on?'". It can include affective inquiries asking a client to reflect on their felt experiences: "What is it like to feel sad after so many years of numbness?" It can consider somatic experiences: "What is it like for you to sense the strength in your arms?" "What does that feel like in your body as you tell me about it?"

Metaprocessing can also involve the explicit sharing and processing of doing the therapeutic work together with the therapist. Relational metaprocessing can help to strengthen secure attachment and affirm that the therapist and client are working together in the healing process, further undoing aloneness. "How does seeing me so moved by you affect you?" It can promote the revision and articulation of a new and more coherent and expansive internal working model of self and other. "How is it for you to sense our connection?" or "What's it like to share this with me?" (Karen Pando-Mars, 2021).

Metaprocessing can also be done near the end of a session to explore the patient's having had a successful session and the experience of changing with the help and accompaniment of the therapist. "What was it like for you to have done this work with me today?" Metaprocessing is a hallmark of AEDP treatment and is the vehicle through which change can happen on the deepest level" (Piliero, 2021). "In using the patient-therapist relationship to provide the corrective emotional experience, the AEDP therapist focuses not only on giving the patient what they need in any particular moment but also relationally processing and metaprocessing each aspect of the

healing experience as a way of further deepening and encoding the corrective emotional experience" (Piliero, 2021, p. 275). This focus on the phenomenological experience of the experience can provoke a continuing spiral of emerging experience, as metaprocessing can promote the accessing of emerging and new layers of experience that can lead to transformance (Fosha, 2000).

Judicious Self-Disclosure

In AEDP, judicious self-disclosure is a relational intervention that can help to build the trust and safety needed for deeper affective work but also serve to bypass defenses (Fosha, 2000). "AEDP's clinical stance demands at least as much from the therapist as from the patient: the patient cannot be expected to rapidly open up to a therapist who remains hidden and shielded" (Fosha, 2000, p. 213). Not responding to patients or judiciously self-disclosing in the service of patients can be likened to the experience of what happens to infants and children in Tronick's (1978) "still-face experiment," and it does not feel good for therapists or patients to keep important feelings from being acknowledged (Prenn, 2009). "As a security engendering attachment figure embodying strength, stability, and curiosity, AEDP therapists make explicit the specifics of a rupture, their experience of it, as well a wish for repair and re-coordination." (Lipton, 2021, p. 146). The active disposition towards addressing ruptures and making repairs works to privilege transformance strivings and to bypass or deactivate defensive strategies or reinforce pathogenic states of aloneness.

Three aspects of self-disclosure in AEDP include self-disclosure of affect and process as it unfolds in the clinical work, for example "I am proud of you, too!" or "I am also feeling angry towards your father, on your behalf." Self-disclosure of actual life experiences can be extremely helpful for patients to know about in undoing aloneness and the sharing of therapist vulnerability

and errors e.g. "I have also experienced loss in my life and know how hard it can be.", as well as anything that decreases therapist omnipotence and supports a collaborating partnership e.g. "I apologize for running late. Our time to do this work together is important for me too." Self-disclosure is only the first step of the intervention and needs to be followed wherever possible by the exploration or metaprocessing of the patient's reactions or experience to the self-disclosure (Prenn, 2009). In AEDP, the "unit of intervention is not just the disclosure or intervention itself but rather the therapist's intervention and the patient's response to it" (Prenn, 2009, p. 93).

In AEDP, self-disclosing can serve as an integral and "essential part of the fabric of every treatment" with it being neither bad nor good but instead the "quickest way to have an experience between two people" (Prenn, 2009, p. 89). The ability for a patient to know that they are making an emotional impact on the therapist can lead to an enhanced sense of agency in relationships for the patient and can be particularly healing for people, particularly individuals with histories of trauma, loss, abandonment, neglect, and helplessness (Fosha, 2004).

Four State Model

Although AEDP is not a manualized treatment, the process of healing change occurs through a four-state model, each state having a distinct phenomenology (Fosha, 2009). One of the central goals of AEDP's four-state transformational process is to develop a cohesive autobiographical narrative (Fosha, 2000). Mary Main (1999) deemed that a coherent narrative of one's own attachment history could then lead to the ability to create experiences of secure attachment. "Through moment-to-moment tracking and close-range affective attunement, the therapist helps the client-therapist dyad move through the four-state transformational process, experientially processing relational, affective and healing phenomena along the way" (Kranz, 2021, p. 55).

State One begins with how our patients arrive to the session, including the patient's glimmers of health, resilience and transformation strivings as well as their anxiety and distress. This first state involves the co-construction of safety, undoing aloneness, minimizing the impact of defenses and anxiety, and privileging transformance strivings of patients, even during psychopathology (Fosha, 2021). Transformance strivings may include the patient's strivings towards "maximal vitality, authenticity, and genuine contact" (Fosha, 2008, p. 292). When patients experience the safety, care, and compassionate acceptance of the therapist in State One, they may naturally begin to drop down into the experiencing of core affect.

State Two focuses on accompanying the patient into dropping down into a visceral experiencing of adaptive core affective experiences, which include working with the categorical emotions of sadness, anger, joy, happiness, and disgust. In AEDP it is a crucial aspect of treatment that core affective phenomena, when accessed, be experienced viscerally within the therapeutic relationship (Fosha, 2000). Signs and signals of categorical emotions of sadness and grief may include downcast eyes, tears, or a downturned mouth (Ekman, 2013). Anger may include drawn-together brows, tightness in the jaw, the experience of heat in the body (Harmon-Jones & Harmon-Jones, 2018). Joy and happiness may be evidenced by a Duchenne smile, laughter, eyes sparkling (Ekman et al, 1990). Signs of disgust may include a raised upper lip, wrinkling on the sides and bridge of the upper nose (Ekman, 2013).

It is in State Two that trauma processing and emotional processing take place and involve the "accessing, regulating, working through and processing to completion some of the patient's deep somatically based, wired-in core affective experiences" (Fosha, 2021, p. 44). The visceral experience of processing deep emotion can lead to adaptive action and newly emergent affects called transformational affects.

State Three is characterized by the emergence of the effects of innate healing associated with transformation and/or change for the better (Fosha, 2021). This state tracks and metaprocesses all affects associated with experiences of transformation e.g. "Where in your body?" or "What's that like?" When transformational affects come to the fore, the patient may experience a subjective sense of "truth" and heightened vitality and authenticity which can release enormous energy and thus provide the fuel for adaptive action (Fosha, 2009). Six meta-therapeutic processes have been identified in State 3 work, along with their corresponding transformational affects: *mastery-* overcoming past limitations; *mourning the self*, i.e. the current here-and-now good experience evokes the emotional acknowledgment of losses; *traversing the crisis of healing change*, i.e. processing new positive experiences which evoke tremulous affects of surprise or normative anxiety in the face of new and unfamiliar experience; *affirming recognition of the self and its transformation*, i.e. recognition and affirmation of the self-evokes healing effects of being touched within oneself or towards others; *delighting in the surprise of the emerging transformation*, i.e. involves delighting in the change that is taking place in the self yielding enlivening affects of delight or pleasure, and *taking in the new understanding,* i.e. awareness of the enormity of transformation with realization affects (Yeung, 2021).

The "steady oscillation between experience and reflection, between right-brain and left-brain, between insula and anterior cingulate, between limbic system and prefrontal cortex that is involved in meta-processing the high arousal positive transformational affects of State 3 leads to recursive cycles of transformation, culminating in State 4" (Fosha, 2021, p. 46). State Four, also known as Core State is an altered condition and experience of openness and self-attunement in which an individual is more deeply in touch with essential aspects of themselves, their relational experience and "other-receptivity" (Fosha, 2000). Core State promotes and fosters reflection and

the integration of this new meaning and allows patients to reflect upon new and personal truths. It can be a state of wellbeing, calm, confidence, and wisdom with deeply felt moments of vitality, energy, agency, and personal truth (Fosha, 2021a).

An experience of flourishing may grow out of experiencing deep emotional processing and core state, leading to a subjective experience of "being healthy" and "doing well" (Russell, 2015, p. 288). AEDP seeks to undo aloneness and transform emotional suffering into flourishing (Fosha, 2021). Helping clients to embrace and perhaps be grateful for the experiences and times of flourishing can be an important goal of AEDP (Russell, 2015). In Core State, patients may experience a more deeply felt and explicitly articulated experience of "this is me", hypothesized to refer to Damasio (2018) and Panksepp's (Panksepp & Northoff, 2009) identification of a neurobiological core-self (Fosha, 2021). The core self is "wired in", "dynamic and emergent", uniquely developing as it continues to epigenetically unfold over the course of a lifetime (Fosha, 2021, p 388).

Chapter VI:

Research Questions

1. *What has been the clinical experience of the AEDP therapist since the onset of the COVID-19 global pandemic and the accompanying shift towards telehealth?*
2. *How has the therapeutic relationship been impacted, if at all?*

All 15 research subjects are certified AEDP therapists who have identified as having their own independent and solo private practices. Each of the 15 subjects had made the professional decision to abruptly shift from in-person sessions to a telehealth platform within hours and days of the World Health Organization declaring COVID-19 as a global pandemic on

March 11, 2020. At least one subject shared that they had never stopped offering face-to-face or in-person sessions (always with a consideration of protective safety precautions against the coronavirus fully in place).

All 15 therapists used the Zoom video platform at the start of the pandemic. Twelve (12) of the therapists were already using a Zoom telehealth account prior to the onset of the pandemic. As per their report, these twelve therapists were making use of their Zoom platforms primarily to provide clinical supervision but also to offer some online psychotherapy. All these twelve therapists shared that working through online telehealth represented only a small percentage of their clinical practice.

All research interviews had been conducted and completed in the late summer and fall of 2021. At the time of their interview, 8 therapists had already started to see clients at their professional or home offices in-person, or in some cases at an outdoor location, often on a case-by-case basis. 13 therapists were definite about returning to the office to offer both in-person work (as well as a hybrid-practice of both telehealth and in-person work). 2 therapists expressed ambivalence about returning to do any in-person work and were not fully sure how or if they planned to return at the time of their interview. The findings of this qualitative study were in accordance with a recent fall 2021 survey conducted by the American Psychological Association which revealed that most psychologists were beginning to use a hybrid model and also continuing to see patients remotely.

Problem Statement

The COVID-19 pandemic has added to global mental health issues and continues to have profound mental health consequences for many people, exacerbating pre-existing mental health disorders and contributing to the onset of new stress related conditions (World health

Organization, 2020). The increase in social isolation, psychological distress and risk for negative

mental health consequences related to the pandemic have been accompanied by a disruption to

the therapeutic setting and a rapid shift to online technology. The pandemic has introduced a

unique set of challenges to the therapeutic process with therapists being impacted by the same

global health risks and social distancing mandates as their patients creating a shared traumatic

experience (Ronen-Setter & Cohen, 2020; Tosone, 2021). Therapists have been subject to

adaptations from in-person sessions onto teletherapy platforms during the collective trauma of

the pandemic and the negotiation of accompanying changes related to psychotherapy practice

and the potential impact on the therapeutic relationship and intimacy. Therapists need to be

prepared for how their clinical work will continue to change in the era of the COVID-19

pandemic and these unprecedented times (McBride et al, 2020).

Beyond the interventions used, preservation of the relationship is what really matters, and

deep relational therapeutic work is indicated during this unprecedented time of COVID-19 and its

aftermath, with the most effective psychotherapists being authentic, emotionally available, and

highly engaged in their work (Amorin-Woods, 2020; McBride et al, 2020; Prenn & Halliday, 2020;

Wampold, 2019). The experience of social isolation and emotional stress uniquely positions AEDP

as an integrative model of psychotherapy with a therapeutic approach that pays particular attention

to emotional pain, social disconnection and isolation and makes use of dyadic affect regulation,

focusing on undoing aloneness (McBride et al, 2020). Exploring the shift to telehealth on AEDP

psychotherapists and the impact on the therapeutic relationship is indicated in the age of COVID-

19 and its aftermath.

This qualitative research study will be phenomenological in nature, attempting to capture

the lived experience of AEDP clinicians in navigating an abrupt transition to providing

psychotherapy through online platforms after the COVID-19 pandemic and their subjective experiences of how these shifts impacted the therapeutic relationship and the effectiveness of treatment, if at all. To contribute to the literature on the therapeutic relationship and treatment effectiveness online, this qualitative study focused on therapists with extensive training in an attachment-based, experientially emotion-focused, and relational model of treatment that can be considered particularly effective in working with relational trauma and the collective stress of a pandemic.

Research Design

This researcher made use of a grounded theory approach and a qualitative research design that focused on the phenomenological experience of AEDP therapists who had all abruptly shifted their clinical practice to an online telehealth platform during the COVID-19 pandemic. These therapists made reflections about and considered the emotional and relational impact of the pandemic and the shift to working remotely on themselves, their patients and on the clinical work and therapeutic relationship.

Each subject was individually interviewed. "Interviews can give research participants a space, time – and human connection – to reflect on events anew and to clarify meanings and actions while providing rich data that spark analytic insights" (Charmaz, 2014, p. 80). Before beginning the interview, the researcher answered any questions that the subject might have for the interviewer related to their informed consent and to the request for permission to video record the full and entire length of the interview.

Intensive qualitative interviewing "focuses the topic while providing the interactive space and time to enable the research participant's views and insights to emerge" (Charmaz, 2014, p. 85). This researcher conducted a semi-structured interview which was self-designed (See

Appendix I) and lasted approximately one hour in length. The questions in the interview started with a warm-up section asking subjects brief demographic questions about their race, ethnicity and professional background and clinical practice, exploring how each subject came to be an AEDP practitioner and what they considered to be the most meaningful aspects of their AEDP clinical work. In addition to thanking each subject for their voluntary participation in the research study, subjects were asked to briefly reflect on the process of being interviewed and encouraged to reach back to this interviewer through email if there might be further ideas to be shared after the interview formally ended.

Setting

All interviews were conducted through this researcher's HIPAA compliant online Zoom platform. Verbal permission to record the interview session was received prior to pressing the Zoom record button. Permission was requested individually from each subject prior to beginning the interview (in addition to each subject being asked to sign the informed consent form).

All subject interviews were uninterrupted and were approximately one hour in length. Each subject was interviewed in their home office through this researcher's Zoom platform. The subjects lived and worked in a multitude of geographical areas which included Alabama, Florida, Massachusetts, New Mexico, New York City, upstate New York, Westchester County, a suburb of New York City, Oregon, Vermont, and British Columbia, Canada.

Sample Size and Recruitment Procedures

Fifteen subjects (15) were recruited for this qualitative study. Recruitment efforts and identifying research subjects was a relatively easy process since this researcher has also been a part of the professional community of AEDP therapists for approximately five years.

9 subjects were professional colleagues: 2 were peers that this researcher has known approximately five years through AEDP core trainings; 4 were lead experiential assistants in AEDP trainings that I had participated in as an assistant or workshop participant; 3 were AEDP consultants that I have professionally worked with and have known over the past five years. The remaining 6 subjects were AEDP clinicians whom I had directly reached-out to by email, all of whom had been recommended to me by one of my clinical supervisors (and all of whom I had not yet met prior to the interview).

Only research subjects who were licensed in their field of clinical practice and have received their certification in AEDP were recruited for this qualitative research study. AEDP certified therapists have completed advanced training and supervision in AEDP and have completed a certification process through the AEDP Institute (see *Certification Requirements* under https://aedpinstitute.org). The AEDP Institute is made up of a community of clinicians from the United States and globally throughout the world. Diana Fosha, PhD is the Director and Founder of the AEDP Institute, which is also helmed by Institute clinicians who serve as Faculty Members and as Supervisors. AEDP is a clinical, intellectual, and collegial community of therapists who hold shared values of working in this attachment-based, emotion-focused, relational psychotherapy model. There are many courses and trainings that foster and support community amongst all AEDP clinicians.

Inclusionary and Exclusionary Criteria

Only those clinicians who have been AEDP certified and who had also shifted their clinical practice to an online platform after COVID-19 had been officially declared a pandemic (on March 11, 2020) were considered for participation in this study. Recruitment efforts were made by email efforts throughout the entire AEDP global community. Emails were sent to

certified AEDP therapists as identified and recommended by AEDP Institute Faculty Member SueAnne Piliero, PhD and through word of mouth.

Therapists who did participate in this research study lived throughout geographic regions that included both the United States and Canada.

Analysis

All interviews were recorded directly on this researcher's Zoom platform. This researcher then had all 15 interviews professionally transcribed by a professional transcription service. The transcribed interviews were entered into NVivo software, which aided in the organization and cataloguing of the data. This researcher has analyzed the data using the principles of grounded theory. "Stated simply, grounded theory methods consist of systematic, yet flexible guidelines for collecting and analyzing qualitative data to construct theories from the data themselves" (Charmaz, 2014, p. 1).

Initial analysis of the data began with line-by-line coding of each interview. Following the guidelines of Charmaz (2014), this researcher focused on taking fragments of data apart, considering the meanings that could be gleaned from these fragments. This researcher also coded in gerunds which helped to more fully interact with the rich data that had been gathered through these interviews.

Participant Compensation

A $30 Starbucks gift card was given to each research subject for their time and participation in this study. The gift card was sent through email upon the completion of each subject's interview.

Instrumentation

This researcher communicated through email with each subject on scheduling a date and time for the research interview. Each subject was then sent the consent form (see *Appendix I*) through email in-advance of the interview along with further information about the research study (see *Appendix II*). Each subject was encouraged to ask all questions at any point prior to the scheduled interview. Each subject was encouraged to return the consent form through email prior to the interview. In meeting each subject at their scheduled interview time on Zoom, each subject was again asked if they had any questions about the consent form that they had signed and were again informed that their interview would be recorded. With their verbal agreement and consent, the interview began.

Data Management

This researcher managed all the data for this study. Any documents with participant names on them, including signed consent forms, have been kept in a file folder on this researcher's password protected computer. Data was collected in the form of 15 video-taped interviews which were professionally transcribed. Upon completion of this project, this researcher will erase all the videotaped interviews from her computer. Only this researcher has had access to the recorded interviews and documents stored on her computer.

Risks and Benefits Assessment

Subjects were not meant to benefit directly from participating in this study. However, many subjects expressed the value to them of having an opportunity to reflect on their clinical experiences of navigating COVID-19 and their subjective experiences of how online telehealth has impacted their work and relationships with their patients.

In approaching potential subjects, each expressed voluntary interest in the research questions and were open and welcoming to the opportunity to process their experiences related to the abrupt shift to telehealth after the COVID-19 pandemic along with sharing their reflections on how working online has impacted their work. **Most subjects** expressed some curiosity about how other colleagues were experiencing these recent changes in their clinical practices, and all subjects shared that they wanted to receive data analysis upon completion of this study.

There are no known risks of participating in a study like this one.

Human Subjects

This study followed procedures to protect human subjects. Participants were provided informed consent by signing a written consent form sent through email prior to the interview date (SEE APPENDIX II). By signing the consent form, participants were made aware of the benefits and risks of the study and all procedures to protect their confidentiality. The researcher received approval from the University of Pennsylvania Institutional Review Board for this study.

Research Participant Statistics

All fifteen subjects were licensed psychotherapists or psychoanalysts in their respective states or country. 9 subjects held masters degrees in social work, 3 subjects held masters degrees from counseling or motor learning programs, 2 subjects held a doctoral degree in Psychology, and 1 subject held both a doctoral and masters degree in clinical Social Work. 9 of the fifteen subjects each had between 28 to almost 40 years of post-doctoral or post-masters clinical experience. All subjects identified as solo and independent private practitioners with a focus on using AEDP individually to address attachment trauma.

All subjects were native English speakers. Subjects identified as first generation Canadian (of Portuguese descent), Caucasian, English immigrant, first generation Filipino, Irish,

Italian, Jewish, Japanese immigrant. Two therapists expressed male gender and thirteen identified as female.

All subjects were certified AEDP therapists with one subject working towards completion of certification. Two of the subjects serve as Faculty Members of the AEDP Institute. Eight subjects serve as both Certified AEDP Supervisors and Therapists of the AEDP Institute. All subjects had earned certification in AEDP within three to seven years of beginning training and supervision in AEDP.

Confidentiality parameters were reviewed with each subject. All agreed to give their written consent for this researcher to be able to include their names in publicly acknowledging gratitude to them for their participation.

Reflexivity Statement

I entered this doctoral program at the School of Social Policy and Practice (SP2) about thirty years after receiving my MSW as a young twenty-something. I have held many identities in my life as a mother, a wife, a partner, a friend, a teacher, a practicing clinician, but never as a researcher. Although I had taken two semesters of a Research Methods course in my graduate master's social work program, I had not been asked to fully carry out any research ideas that had been developed and proposed in the course. As I entered this SP2 program and switched out my long-standing role as a clinical social worker and stepped into the role of qualitative researcher for the very first time in my life and professional career, I did so with trepidation and caution with a notebook in-hand to reflect on my experience. The notebook supported me in keeping my feelings as a clinician and practicing therapist separate from what I was hearing and learning from the experiences of fifteen AEDP therapists whom I had the privilege to interview. Honoring the principles of grounded theory, I worked to keep my role as a clinician separate from my role

as research interviewer and did face some challenges in this area. As a clinician who offers a hybrid model of both online and in-person sessions, I have also honestly wondered and been skeptical about online Zoom therapy. When the therapist and the patient are not in the same room together, what happens to co-regulation? Do patients miss borrowing our nervous systems and the therapists' ability to be in their physical and energetic presence of staying slow and sturdy in the same physical space? What about our significantly depressed and lonely patients? Does online Zoom therapy have the physiological impact to deeply address loneliness and undo aloneness? I brought great curiosity and interest in studying the reflections and experiences of my esteemed colleagues and those of my own.

   My qualitative research professor in this SP2 doctoral program, Allison Werner-Lin (class lecture, second semester 2020) had shared and emphasized that interest in particular topics for a dissertation research study might be considered as a kind of "ME-search" instead of research. In other words, we choose an area of study that may be able to personally sustain enough of our interest and curiosity as a potential topic to dive deeply into and immerse ourselves for an extended number of years. It is understandable that social workers embarking on dissertation research choose an area of study that can generate enough energy and fuel such an undertaking. However, a concern is that we may be too close to our research topic and not be able to be aware and remain unbiased or hold objectivity in gathering and analyzing our findings and data. Hence, as both Professor Allison Werner-Lin and my dissertation chair Jane Abrams have asserted, there is a need for a reflexivity statement that can help us to reflect upon: previous personal and professional experiences related to the research topic, pre-study beliefs about the topic, motivations and qualifications of the researcher, and disclosure of any hypotheses we might have held prior to conducting the research.

I have a solo and independent private clinical practice in the Alpharetta, Georgia area and am currently working on my certification in AEDP. I have been involved in the AEDP community as a clinician for the past five years. I first learned about this model of therapy in early 2017 through colleagues in the Atlanta, Georgia EFT community (Emotionally Focused Couples Therapy). I had been training in EFT for several years and felt most effective working from an attachment-based and relational, emotion-focused model of treatment. EFT colleagues had shared with me that Dr. Sue Johnson (the founder of EFT) was deeply affirming of Diana Fosha's work and the transformational healing that can come from privileging the bottom-up experiencing of emotion. I knew that I wanted to learn how to work more deeply and relationally with emotion and was intrigued by AEDP. I began searching-up the AEDP Institute online and found a nearby essential skills training with esteemed mentors Natasha Prenn and Jeanne Newhouse that I could drive to in the Raleigh Durham area of North Carolina in early 2017, and then signed up to take an AEDP Immersion course helmed by Diana Fosha later that year in New York City.

AEDP is a model of psychotherapy that deeply resonates for me both professionally and personally. It is non-pathologizing and allows me to practice in an empathic, warm, and authentic way that feels close to my heart. As a clinician, I regard AEDP as my professional home. I value learning and growing alongside a community of other like-minded colleagues that practice from this attachment-based and relational frame. Personally, as a relational and attachment trauma survivor myself, I believe and have personally experienced AEDP to be deeply transformative and healing.

When I started the doctoral program in clinical social work at SP2 in August 2019,

I knew that I had wanted to study and explore some aspect of the AEDP model in my dissertation research. In entering the program, I brought with me the interest and passion that I held for AEDP, although at this time, I had not yet developed any clear focus for my research. Approximately six months into the program in March 2020, the World Health Organization declared COVID-19 as a global pandemic, and the inherent stressors of the pandemic brought both personal and professional challenges and transitions.

With some initial resistance, I prioritized my own health and the safety of my family and proceeded to transition my entire clinical practice onto a telehealth Zoom platform. I got support from my supervisor and other colleagues. My initial fear was that none of my patients would want to work this way online. My worst fear was that my practice would somehow just completely disappear into cyberspace if I were to no longer provide any in-person therapy. I wondered how other AEDP clinicians were experiencing the change in practice from in-person to telehealth during the collective trauma of COVID-19. I wondered how they experienced online work to be different and how the therapeutic relationship might change given a telehealth platform. I was curious and wanted to undo my own aloneness in such an isolating experience of social distancing and practicing in such a different way. Through further reflection and discussion with my dissertation chair, it felt timely to consider what the clinical experience of the AEDP therapist was like in the age of a global pandemic. I held much curiosity and wanted to further understand and explore the impact of the pandemic and the abrupt transition to telehealth on my AEDP mentors and esteemed colleagues. I was a clinician going through the same experiences both personally and professionally, wanting to undo some of my own aloneness in this time of transition.

After completely shifting my clinical practice online after COVID-19 hit, I was finally ready to make the decision to begin seeing some clients in-person at my office starting in July 2021. I was relieved and excited to be back in-the-office, at least part-time. I had really missed providing therapy in-person in my office. Like so many of my research subjects, my own personal preference has been to work in-person. Although my practice honors a hybrid model, and I continue to work with many clients online, I value the opportunity to meet with clients in-person, even if it might be just to get a sense of their body energy prior to doing online work. I have considered my own experiences and reflections about my effectiveness in providing therapy online and any differences that I may or may not notice.

As I have conducted fifteen interviews with certified AEDP clinicians, I considered it a strength that I have been training in the model for the past five years, and that I have developed a deeper understanding of AEDP theory and constructs as a practicing clinician myself. My clinical knowledge base in AEDP has given me the ability to understand and appreciate the nuances and depth of the reflections that have been so vulnerably shared with me by these 15 clinicians.

According to Charmaz (2014), during interviews professionals may sometimes offer "public relations rhetoric rather than reveal personal views, much less a full account of their experiences" (p. 73). Many of my research subjects were also esteemed colleagues and mentors. As I took on the role of researcher, I held the space for these colleagues and research subjects to reflect openly and honestly. They all had voluntarily expressed their willingness to be helpful in sharing their experiences with me, not only to support me in my dissertation research, but also to shed light on their experiences of shared trauma during a global pandemic and how the transition to telehealth impacted their clinical practices. I found my research subjects to be candid and,

oftentimes vulnerable, appreciative of a platform where they could reflect on their recent

experiences.

One research subject shared: "*You helped me to reflect. I'm enjoying this whole process of doing this with you. I mean, this conversation, it's really going to be thought provoking for me to think about my practice and to think about what I might want to do, going back to the office or not. Really talking about these things with you has been helpful for me. And I think your research project is really going to help all of us in the field think about these questions together…to start philosophically asking some of these big questions.*"

I felt honored and delighted to have had the opportunity to listen and hold their

experiences with great care, compassion and interest in open-ended and emergent dialogue that

was prompted by interview questions. I believe that my clinical skills and training have allowed

me to honor all shared experiences of these 15 research subjects. I embarked on this qualitative

research study with some healthy skepticism, questioning how clinicians could really be as

effective in providing an experiential emotion-focused and relational psychotherapeutic model

through telehealth as they could in-person. I wondered how AEDP skills really translated from

in-person to teletherapy.

I was aware throughout the interviewing research process that I held some biases about

teletherapy in my own work and in the work of my esteemed colleagues and mentors - How do

we continue to maintain deep therapeutic intimacy through cyberspace for each client? Despite

some initial resistance and biases against teletherapy, I worked to bring open curiosity about the

experiences and preferences of all 15 clinicians that I had the privilege to interview. I have

learned so much from their reflections and have made use of it in my own clinical work.

Chapter VII:

Findings

The purpose of this qualitative research study has been to explore the lived experience of psychotherapists during the abrupt shift and transition to telehealth during the COVID-19 global pandemic with a consideration of how the online therapeutic relationship has been impacted. The findings for this dissertation are derived from the content analysis of semi-structured interviews with 15 certified AEDP therapists.

As discussed in the literature review, AEDP is a healing-oriented, attachment-based and experiential mind-body treatment model that is effective in addressing relational and attachment trauma (Iwakabe et al, 2020). The reflections of psychotherapists who are well-trained and skilled in AEDP were chosen for this qualitative study. The COVID-19 pandemic has resulted in significant psychosocial stressors, and the AEDP treatment model is especially suited for these unprecedented times in addressing deeper relational and inner experiential emotional processing (Prenn & Halliday, 2020; Ronen-Setter & Cohen, 2020).

The interview questions began with some initial inquiry into the most meaningful aspects of practicing AEDP, preferences about working in-person or telehealth, and current satisfaction in clinical work. Interview questions then addressed the transition to telehealth, experiences of working online, and what it was like to move through a global pandemic alongside their clients. In addition, interview questions explored any experienced changes in the therapeutic relationship or in the way that they practice AEDP online. Impressions about the effectiveness of teletherapy and contemplations for future online work were also examined.

The findings of this qualitative study are organized into seven sections, each of which describes a major category of the study findings. *Section 1* summarizes what the fifteen therapists felt to be the most meaningful aspects of practicing AEDP. *Section 2* addresses the initial impact of COVID-19 on the therapists and their experiences of shared trauma with their patients during the transition to telehealth. *Section 3* addresses the disadvantages of telehealth. *Section 4* considers the advantages of telehealth. *Section 5* explores ambivalent experiences about working online. *Section 6* reflects on the effectiveness of teletherapy for different client populations. *Section 7* offers reflections on AEDP interventions used in telehealth. *Section 8* offers further exploration on the effectiveness of online therapy and concerns about the future of clinical practice online.

While these eight sections will be presented as distinct categories, there is some overlap in the richness and depth of experiences expressed. Supporting passages taken directly and verbatim from the voices of each of the 15 subjects have been chosen to illustrate the main ideas in each section.

Subjects have been assigned random numbers to protect their confidentiality and the experiences that they have shared. As previously stated, this researcher began interviewing these 15 therapists approximately one year and four months after the World Health Organization declared COVID-19 a global pandemic on March 11, 2020. The interviews had been scheduled and took place over Zoom during a five-month period beginning in late July 2021 and completed in December 2021. By the time of their interviews, 8 therapists had already seen at least some patients in-person either in their professional and home offices or at an outdoor location; 7 therapists shared that they had not yet provided any in-person work since the start of the pandemic (and at the time of their interview). 6 of those 7 therapists that had not yet provided

any in-person work were practicing in the New York City area, a geographic location considered to be at the epicenter of the pandemic by the Centers for Disease Control.

Section 1:

Meaningful Aspects of Practicing AEDP

Subjects offered a rich multitude of reflections as to why they felt it meaningful to practice AEDP, and how they became introduced and connected to this psychotherapeutic model of treatment. According to Wampold (2019), therapists need to believe in the treatment effectiveness of their theoretical approach as a common factor that can lead to successful treatment outcomes (with this contention being strongly grounded by empirical support). All the 15 therapists that participated in this qualitative study voluntarily reached back to this researcher, offering responses about what had initially led them to pursue clinical training in AEDP and why they felt practicing this psychotherapeutic model was meaningful to them.

The most frequent responses referenced the relational aspects of the model. Universally, all 15 subjects shared how the ability to work relationally felt meaningful to them. 12 subjects shared that the AEDP map and four state model of transformation allowed them to lean into and trust this way of working to create change, finding it meaningful to practice in a way that privileges core affective experience. Other responses included the value of finding and feeling welcomed into a therapeutic community of like-minded clinicians (13 subjects), as well as reflections on the significant personal and professional transformational growth that they have experienced because of studying and practicing this model.

Relational Aspects of the Model and Using Authentic Self

AEDP emphasizes the relational building of a safe and secure attachment with patients to support the deep emotional processing that can lead to transformational change. All 15 subjects expressed being attracted to this model due to the relational aspects of its healing and the use of authentic self.

Therapist 6: "I think the relational aspect is really powerful…I see my clients change because of those relational aspects of AEDP.

Therapist 8: "The model pulls that out of us, that it asks us to be as authentic and real as we are, because then that's when the work happens. It's in that genuine connection. It's in that authentic connection. It's in the meeting of two people at their most real that something happens."

Therapist 4: "I feel very much like I get to be myself and that's something I hear more and more from other people who've done other modalities where they've had to sort of either apologize for being themselves or not tell the full story of how they're themselves. I do feel like with AEDP, you just really get to be a person and I agree with that. I appreciate that about the model so much…coming from a stance of health and kindness, non-pathology."

Another therapist also reflected on how the use of authentically bringing in the resonant tone and dimensions of her own voice was meaningful to her and valuable in clinical work.

Therapist 3: "I think my willingness to really connect with people. I think my real affection for humans and my willingness to display that and explicitly state that…how I can use my voice in a lot of different ways, and I find it very effective in inviting people…particularly into State Two. When you can use your voice, it is like sitting at the bottom of the triangle and inviting people there with you…And what I was aware of…was that Diana (Fosha) was touching people without putting her hands on people…she was doing what I really wanted to do, but she didn't have to touch the people to do it."

Therapist 12: "You're allowed as a therapist to have feelings and to be able to listen to them…as much as it can be hard work because we're showing up authentically…You have the reward of the real sense of connection and communication and deep care for your clients. That

feels good…It feels helpful at reducing burn-out…the AEDP part of my work has enriched and boosted me to be able to stay connected to the work in a way that I would have burned out earlier."

Several therapists reflected on how the use of relational and judicious self-disclosure was meaningful.

Therapist 1: "Rather than being intellectual, I like working in emotion….and being empathic…intuitive and relational. I think where I've also stretched as a person…in terms of attachment, was how much more I had to be involved in the therapy than maybe I was earlier in my career…But now I must really be in it with my patients and be more transparent and make judicious disclosures about myself…it has really stretched me…I'm willing to do that, to be involved."

Therapist 5: "The freedom and permission to self-disclose in judicious and appropriate ways…these things really lend themselves to transformations in a way that I don't think other therapies do in my experience."

The Four States and Three State Transformation

12 subjects shared that working in the four-state model of change that AEDP maps out for them has been particularly meaningful. Some therapists also made references to how the metaprocessing of transformance resonated internally for them.

Therapist 1: "The four states and the state changes…looking at that phenomenology…I learned how to work much more finely with emotion. Like I understood affect and which affects are related to each other. There was a whole map for me to work with, and I enjoy that about AEDP, the map and the phenomenology…So we're looking for those shift changes, state changes, and that helps me feel good."

Therapist 2: "AEDP is like fresh air. It's a non-pathologizing model, and it really looks for the transformation in every person…when my clients are in core state, I am in core state…and physiologically it can be enhancing for the therapist."

Therapist 15: "It's really like work in the moment…I don't even have the vision of where they're going to go, but they go somewhere good. I mean…not every single time, but like just this idea of like, I know what to do in the moment. And then this thing happens…following the map of AEDP."

One therapist reflected on how the depth of transformational change led to her increased fulfillment in the work.

Therapist 3: "The way in which people change and the degree to which change occurs much more quickly…it was the accelerated rate of change, the depth of change and the satisfaction for me as a practitioner…it felt so much more alive learning how to do AEDP.

Finding a Sense of Community

13 subjects made direct references to finding a sense of community in AEDP. Many subjects shared that they found the AEDP community after practicing other models of psychotherapy which include classical psychoanalysis, object relations, gestalt, school psychology, biodynamic and craniofacial work, bioenergetics, self-psychology, and Emotionally Focused Therapy (EFT). 2 of the 13 subjects had learned about AEDP during their graduate programs and began their AEDP training early in their professional careers.

Therapist 1: "What people were looking for, what we were all looking for was a community of therapists where we could feel welcomed…We want a community and that was another reason to join AEDP…it was a motivation factor."

Therapist 5: "AEDP is my heart and my home."

Therapist 7: "What has been powerful about AEDP is the feeling of community…It gives me a lot of space to be myself as a therapist…the relational aspects of being able to show up as a human being."

Therapist 11: "It feels like such a cliché in our community, but really one of the most meaningful aspects is finding a home in a community of colleagues that speak the same language and are drawn to just a similar intention in their work…friendships that I've developed with people from all over the world…I've never dreamed when I began doing this work that this would be something that I can have."

Personal Transformational Growth

All 15 therapists offered direct reflections about the personal growth and transformation that they have experienced in practicing the AEDP psychotherapeutic model, elaborating on ways that AEDP "doesn't just change how you do therapy, it changes how you do life" (shared by AEDP Institute Faculty Natasha Prenn in teaching and Essential Skills Course in February 2017).

Therapist 1: "It's a therapy that helps me feel good…metaprocessing helps me to make sure that everybody is having a positive experience…and as people report a shift to me, I feel like I'm helping people and that feels good to me…I feel connected when I'm really connected to people. It feels so good when somebody has moved through to core state, and they're feeling relief, and they're feeling more relaxed. It's empowering. It does help with my fulfillment."

Therapist 8: "I think I'm better all the way around. I'm a better person…and this is a lifetime thing…but I'm a better wife, partner. I'm a better friend…it just accelerates one's growth and maturity. I think I grew a lot…I've matured a lot and not just because I've aged, but because the process has been transformative for me too. Yeah."

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5 therapists acknowledged a more disorganized attachment style, by history, and made direct references to how practicing the AEDP model supported them in earning secure attachment. One of these therapists shared:

Therapist 1: "I probably grew up with disorganized attachment…but I would say that in doing AEDP, that I know what secure attachment is and how to promote that and how to get that in all of my relationships including with my partner."

Section 2:

The Initial Impact of COVID-19 and the Transition to Telehealth

Therapists and Clients Experiencing Shared Trauma

The COVID-19 pandemic forced clinicians worldwide to abruptly shift into a whole new way of working and providing psychotherapy services. COVID-19 can be defined as a traumatic event or a shared trauma that was simultaneously experienced by both therapists and clients alike, threatening their sense of well-being and also their own mortality. Shared trauma acted as an added stressor during this time of significant transition.

Therapist 6: "New York was completely shut down…and clients asked, 'What will happen to us?' and 'I cannot sleep.' They were feeling dysregulated…then I felt the same, so I needed to stay there as the therapist and hold the space. But their energy just triggered my anxiety because my concern was the same. That was pretty tough, just to separate me as the therapist…because I was experiencing the same anxiety and trauma."

Therapist 10: "Sometimes the un-articulable impact of what so much aloneness can do…I think when you're living through a trauma, it's hard to fully assess all the impacts."

Therapist 13: "People do well in adversity. And I think the early months of COVID felt like adversity, where everyone rolled up their sleeves together and said, 'Okay, let's do this together'…and as Natasha (Prenn) says, "Getting lost is scary. Getting lost with a friend is an adventure."

AEDP therapists elaborated on experiences of the global pandemic. Those therapists that live in large urban areas, including New York City, faced different challenges than their colleagues in more suburban or rural areas.

Therapist 1: *"Places are shutting down. Broadway is shutting down. We're going to have to do this…People were already transitioning themselves out Thursday, Friday…but I didn't do it until Tuesday, when I said, 'I have to be home, I can't do this anymore.' My experience was that there was a scramble in the beginning, and I didn't even believe you could do this. I was really worried, how would my practice survive? Will the therapy survive online? I never imagined telehealth for myself…And it was a big scramble, and it had to be done. And we did what we had to do those first couple of weeks. And then I think that I was relieved after that. A month or two or three into it was like, wow, we survived this thing. We all did it. It works…We went through it as a world, but it was a shared social experience that we all went through and struggled with together. It was great to do the cultural trauma of that together, the social trauma of that together. And I think it benefited the therapy. And to do it together. And again, there was more transparency about, here's what I'm doing, what are you doing? Here's how I'm making sense out of it, how are you doing it? There was a lot more intimacy like that. We're all in this together."*

Therapist 5: *"I think just being immersed in so much sadness and pain all day, I mean, because there was certainly a period of time where it was everyone…everyone was coming in, in terror and panic and pain and losing people and not being able to be with them and all kinds of unprecedented things. When were people not able to go to a funeral? When did that ever happen? Being immersed in all that helplessness and pain…it felt like 1010 WINS news, all the news, all the time. That was hard. That was really hard."*

Some therapists expressed increased feelings of dedication and agency in helping their clients.

Therapist 2: *"Like at the beginning, the first four or five months in New York City was really terrifying…hearing ambulances like every 15 minutes…so I knew that I just had to show up for my patients no matter what. But I think for part of me…it was really a struggle."*

Therapist 3: *"I been running groups for doctors and a group for nurses since the beginning of the pandemic…which were excruciating at the beginning…they're still pretty tough, but they're not as tough the way they were back at the beginning of the pandemic where they were losing so many patients in a shift…they've seen so much death and serious illness that it's*

like doing battlefield medicine…I had several patients who lost both parents during COVID. That was hard. Losing three elderly parents…I have three people that it happened to. So doing things like helping plan COVID Zoom funerals, Zoom birthday parties with people. I felt like I was a party planner…a funeral director…the willingness to go way outside of the scope of what we do because it was such an extraordinary time."

Several therapists expressed being emotionally impacted when clients going through the same shared trauma reached-out to check on their well-being or experiences of feeling closer to their clients.

Therapist 3: "I felt really touched and connected when clients were reaching out to check on me."

Therapist 7: "We're in this together. We're both facing a trauma together. That helps bring you closer, I think, and I realize that I'm human too…and we're trying to figure this out together. So, it's a good experience of undoing aloneness. That's important, as far as AEDP."

Other therapists reflected on how the therapeutic relationship highlights the benefits of shared trauma on the therapeutic relationship:

Therapist 5: "What happens to a therapeutic relationship when you're all going through something together? I think there's something that actually helps a therapeutic relationship and solidifies it, really that sense of we get each other, even if many of us are swimming. We're in different boats, even if we're in the same ocean, we're still in the same ocean and we have that together. Because of the affect base and relational core of AEDP…you've got solid ways to make people feel safe…and you can make that happen."

Others reflected on the blurring of boundaries and taking on more clients without taking the time to process their own experience.

Therapist 8: "It was much later that I realized how much I held without processing my own experience. I felt like my whole focus and intention was to help get them through their crisis. And so, I probably took on more clients than I should have, was busier than I ever was. I just found that I didn't have a lot of opportunity or space to process what was happening for me…so that I barely realized that I was going through a traumatic experience too…because my focus was so much on what my clients were bringing to me. What is the thing about the frog and the pot…that the frog doesn't realize that they're in a boiling pot until they boil…so I was in the boiling pot and didn't know it until much later. So that's when the exhaustion hit me, the hours and hours on a screen."

Exploring Quality of Life Impact and Therapist Self-Care

In their study of Manhattan clinicians post 9/11, Bauwens and Tosone (2010) found that the trauma of the 9/11 experience served as the impetus to enhancing self-care as well as enhancing compassion and connection in the therapeutic relationship. Universally, all fifteen therapists reflected upon their enhanced self-care because of the collective trauma experience of COVID-19. Many shared that working on telehealth could be more physically demanding on their bodies. Others reflected on the value of meditation, limiting screens after work due to Zoom fatigue, creating self-care strategies like singing or various forms of exercise to manage physical and emotional stressors.

Therapist 1: "I would say I do more self-care at home than I did in the office…I go for walks. I take a bath in the middle of the day maybe if I need. I have snacks, healthy snacks. I'm not running out to buy an expensive lunch or coffee or something. I can lay on the floor. I can listen to music. I do things at home in terms of self-care. I'm probably doing better self-care at home."

Therapist 3: "I had to make sure I did things like my walks. Thankfully my yoga teacher was teaching online, my Pilates teacher…my sleep has not been great in the pandemic…so I've been trying to work on that some."

Therapist 10: "I actually increased my own therapy times per week and in the month. I have some friends that I do personal processing with, so I did that a little bit more. I really felt

like I had to…I just needed to seek other routes to get a little bit more support so that I could feel resourced and present to the hardships. I just had to keep doing a little bit more of my own to stay just a little bit ahead or to be able to be with in a meaningful way."

Therapist 11: "It just caught up to me…we all have been literally trying to stay alive for the past year and that collective kind of holding and trauma caught up with me at that time, for sure…I had to stop doing so much…I love being part of the institution, it's so meaningful to me…but my practice had gotten way bigger than I ever intended…so it was resetting those things and working less, seeing less people, doing less with training and supervision."

Shared Trauma and Concurrence with Racism and Political Unrest

The traumatic impact of the COVID-19 pandemic was further exacerbated by the failure of leadership to provide a sense of predictability and trust, which may have further contributed to feelings of helplessness and vulnerability (van der Kolk, 2020). The pandemic drew attention to racial and economic disparities. Therapists reflected on their experiences of the convergence of COVID-19 with the pandemic of racism in a climate of political unrest and unease.

Therapist 7: "It was a crazy time. You got a president who is telling us not to worry. There was just a conglomeration of issues with a lot of it around Trump that he was in total denial, and it became such a political situation…it really brought out that sort of craziness of like all of this is made up and all the conspiracy theories…and it brings up a lot of distrust issues and just a variety of things in terms of people in their family that have told them things, and they really couldn't trust it, a feeling of betrayal by our government…Who can we trust? We all have those kinds of things in our family of origin to some degree. But if you come through a lot of cumulative trauma and had parents that basically lied to us, and then at the same time told us that, 'we love you', then it's a lot of mixed messages and we don't know what to believe. And I'm trying to help people sort of begin to trust themselves and understand what they can do. It's like reliving the trauma for a lot of people."

Therapist 11: "Our whole downtown area was boarded up and there were demonstrations over the murder of George Floyd…there were riots and racial injustice protests and that was very alive for a lot of people and for myself and for my clients who are having these profound realizations of white supremacy and privilege….I have a little more experience and knowledge…because of the focus on anti-racism in the graduate school that I had attended and as a white woman with a reference point to white privilege…to hold space for others to express

their revelations and guilt and wondering what to do and how to make it better…how they can be better as well."

Another therapist shared conflicts that came up in working with clients who were opposed to COVID vaccinations.

Therapist 2: "I just wanted to be there for my clients. And I have recently had a few that are anti-vaxxers, and that's very challenging for me. Because I want to maintain therapy, the therapeutic alliance, and I am also scared for them. So, it's been horrible if I think about it."

Therapists and Clients Expressing Anxiety and Fear

The COVID-19 global pandemic confronted both therapists and clients alike with threats to their well-being in a multitude of ways. Therapists not only expressed fears about contracting the coronavirus and concerns for the safety and well-being of their clients' and loved ones, but they also shared some of their anxiety about how the abrupt shift to telehealth impacted their clinical practices.

Initially, therapists wondered about the effectiveness of their work online and if it could address the needs of their clients.

Therapist 11: "I had flickers of concern…that my work wouldn't be as good as it is in-person…that I wouldn't be able to accompany them through the screen…that my clients wouldn't be able to feel connected to me, to connect to do the work. So, it's just like a barrier through technology and I was concerned that it would really interfere with work. It was like the world stopped, but people's healing didn't."

Therapists shared anxiety around ethical concerns related to continuity of care and losing contact with clients who might be dysregulated and or in crisis, and how this needed to be handled clinically:

Therapist 1: "I was anxious in the beginning, thinking if Zoom doesn't work, then what? I need to say this to my own anxiety, like, there are other ways to connect. Even in the beginning, giving people my phone number so that if anything happens, you just call or let's text."

Therapists voiced their anxiety about their own livelihoods during the abrupt and

immediate shift to telehealth at the beginning of the pandemic.

Therapist 7: "It was like do or die. If I want to continue practicing, I better figure how to do this…And luckily, I had some experience in terms of using Zoom before…"

Therapist 2: "A few of the clients that had COVID, or their loved ones who had COVID, I really just tried to show up for them. And I don't know what I did with my fears. I really think I had a lot of fear that I didn't acknowledge…and I just wanted to be there for them."

Therapists expressed fears about their own health and safety and the well-being of both

their loved ones and their clients.

Therapist 7: "And I have to get away from just, this isn't all about me that I got into this profession…and yes, there's a certain amount of risk, but I'm not going to do it stupidly. I'm going to get all my vaccines…But I'm older with some pulmonary issues, and I really don't want to get COVID because I could die. The fear is a real one for me…what comes up in the moment is just a level of fear that I've lived with under COVID…and just being aware of that as a therapist and how that comes into my work. And the fear has hit me on many different levels. Me personally, seeing it around me with my patients and how do I sort of juggle that to be able to help them without getting so caught up in my fear and allow them to work through their trauma rather than intensifying it with what's going on."

Therapist 5: "Finding my own ways to release my anxiety in this pandemic and my own fears in the world…my daughter was getting exposed so often in the job she was doing working with people experiencing homelessness…and it was terrifying because I was fearful she was getting exposed before the vaccine came out. There was a lot of terror and anxiety about it, very close to home in many ways. I had to find lots of non-food ways to engage in self-care."

Therapist 10: "Even at the beginning, I had to see some people in-person. Very few, but I saw some people the whole time, except maybe during those first six weeks. I got into a

(quarantine) bubble with three or four clients for whom online work was just not going to cut it and abrupt cessation of (in-person sessions) was just not going to work. We agreed to be part of a bubble with each other."

Therapists also shared anxiety related to the current traumatic experience of COVID-19 triggering old trauma and fear in both patients and their therapists.

Therapist 2: "I don't want to pretend it hasn't stirred up fears for all of us. We have our own fears and our clients' fears…and how their fears intersect with their trauma histories, and how our fears intersect with our own trauma histories. Complicated."

Therapist 7: "We're all living through this trauma now with COVID at a time where a lot of people are trying to work on their old stuff, and not to tinge that with all the fear that I'm going through in my life."

Section 3:

Disadvantages and Challenges of the Transition into Telehealth

At the time of their interview in late 2021, 8 therapists expressed a preference for in-person work. Many shared how much they missed sitting in the same room with their clients and feeling their energy.

Therapist 2: "I just miss the person in the room. Like I recently met a client for the first time…because we had started during COVID. I've been working with him for 16 months, and…I recently met him in an outdoor setting, and we looked at each other for 10 minutes…wow, so that's the person on the screen…It was so touching, and it made me feel that I need to go back to the office soon…"

Therapist 5: "I always prefer in-person, and it is because of the energy field. It's a way you can sense others and feel them, and I think that gets lost in a screen…it's different…it feels less alive and less enlivening. It's almost like the difference between live theater and watching a movie. They're both fantastic, but when you're in a live theater situation, something else happens."

Many therapists expressed the value of being physically present with clients in the same space and preferred working in-person.

Therapist 7: "I prefer to work in-person. I can see a lot more…when you're with somebody, you see their whole body, you see their energy, you feel it in the office…The report that I get from people is that they really miss it. And then when I am in the office with them, they show a great deal of appreciation that they've really missed it as well…I think for people that have chronic depression, and they deal with a lot of aloneness…they really miss the personal contact…when I tried wearing a mask, people will cry and it's like, can I just take off my mask? It's like covering up a major part of their emotional system."

Therapist 8: "My preference would be for in-person…I mean I love the convenience of telehealth and that the bottom half of me is in my comfy jammies and all that I have to do is just dress half of me…and the convenience of not having to go schlepping around back and forth and going all over the place…but having said that, at the same time, the other side of the same coin is that there's something about not having those demarcations that is also really exhausting…my work life and my home life just blends…I feel like there are certain boundaries that are established…when I leave the office and come home, I shed the day and change my work clothes and I put on comfy clothes."

Therapist 10: "I love working in-person. There's just something about sitting in a room with another human being. I like really being able to read the whole body to watch what the feet are doing…even though I can sometimes feel or watch them shake online."

Therapists Sharing Grief, Sadness and Loss

All 15 therapists reflected upon the experience of grief and loss as they abruptly shifted their clinical practices to online platforms at the start of the COVID-19 pandemic and moved

through a transition into teletherapy. Therapists shared how they missed working in the same physical space with their clients.

Therapist 2: "There's a bunch of clients that really want me to go back to the office…so I think it's been hard for them…a bunch that really want me to go back…we all thought we were going back in September, people were like, 'okay, I can wait it out, I'll wait it out.' But it's not really the case here in New York, I don't know a lot of clinicians that are back very much…so I think there's a lot of disappointment there. I miss hugging my clients goodbye…looking at them in the eye, face-to-face where the eye gaze is really real…our eyes don't always match up on Zoom…I miss working in-person."

Therapist 6: "I miss in-person sessions…because this is a new way…Zoom sessions probably take more effort, and I do have to be mindful of the difference. I feel sad now…as I reflect on this…I feel really sad. I miss more effortlessly sharing space with my clients."

Therapist 8: "There's something missing. There's a lot about it that is different and new and helpful. But I miss the in-person…I miss the energy…something that gets missed in that intersubjective field that happens in-person is missing…it has affected my satisfaction with work. I prefer not to do it this way…I miss being able to read more of the non-verbals from the neck down. I miss seeing their hands…There's something about being in-person that is raw. There's not a barrier…the computer provides a bit of a barrier…it gives a client the option to be a little bit more reserved."

Others reflected on missing the opportunity to meet potential new clients in-person, expressing loss about getting to know clients "physically" and "how they move through the world".

Therapist 3: "I have this analogy…that I feel like I have an auditorium in my heart. And if I work with you, you have a seat with an engraved name on it, that you have a permanent seat. And that's your seat forever in my heart. And it's a weird thing to me…that I haven't really developed that in the same way with the people I've met online. I just don't feel them in the same way…I don't feel as close to people."

Therapist 11: "I miss being able to see a client…I mean even for the first session or two in-person…because I think it just helps me get a greater sense of them faster. I mean…just the

whole body gives more information to me, you know…all of that is just revealed in different ways later, but I do miss that first meeting in-person…"

Loneliness, Stress and Burn-Out

Therapists reflected on their experiences of loneliness and ambiguous loss with some

yearning for more community involvement.

Therapist 2: "There's this woman that started a café near my office and she was just so great. I used to go in there every day and get a coffee and chat with her and now the café is closed and I'm like, 'what happened to her'…it's sort of sad. Or I don't see someone in the elevator or chat with them anymore at my building…I know a lot of people and I just don't see them anymore. I have battled isolation, not so much now…but during the first half of COVID. For a long time, I really didn't go out. I was just sitting all day in front of a screen."

Therapist 7: "I think each of us have had our own experience…And so it's been a little bit disappointing that we're not providing more…more of a sense of community…and I've expressed that before."

Therapist 10: "I think I got a little more tired. It takes a little bit more out of me just sitting online all day…I often felt like I had to work really hard to deal with my own reactions and responses to this. I struggled. I struggled because the aloneness was awful a lot of the time. Really awful…I never revealed how deep sometimes the struggle felt…It's been lonely being a solo practitioner…although I'm not sure that I would feel as free or be as free to do AEDP the way I do it in an agency or in a more formal clinical setting. Everybody's so busy. It's hard to just find places to go talk to people…" I think I got a little more tired. It takes a little bit more out of me just sitting online all day…

Therapist 15: "I felt cut off from people and everything else in my life…other than my family…and I needed something beyond work and family."

Other therapists reflected on the increased fatigue and stress of working online.

Therapist 2: "I work really, really hard…to be present…maybe that's part of the fatigue, you have to work harder…I'm still very present for everybody. But there is a fatigue that I am working with, it's Zoom fatigue…that's what people call it. So, I want to, like see the body, feel the air in the room with the other person. I really miss it."

Therapist 3: "When I click off at the end of the day, and I close my computer, I feel much more fatigued. When I pack-up in my office at the end of the day…I put up my backpack, I turn-out the lights, I tidy up something…and I can still feel the energy of the people with me…I still feel a little buzzed. I don't feel that on Zoom. It's just click…and close…and it feels flat. So that is sad to me."

Therapist 11: "However, the lack of boundaries and separation has been a bit tricky for me…I really hit for the first time, severe burnout…I would say that I got just so burned out from the work…and I had realized it was, you know, because of the collected COVID trauma experience. I was saying 'yes' to so much more…'Sure, see you Friday…I'm going to be here. We're not going anywhere. No restaurants are open…And that just ended up really leading to massive burnout for me…so I kind of went back to more boundaries in my schedule which has helped a lot. So that's the other piece of the convenience being here…that you learn the lesson of, just because I'm here all the time doesn't mean I should be working all the time."

Therapist 12: "It was tiring. It was brutal. It was just like hours and hours and hours. Every client wanted to be seen, everybody's home, you know, stuck at home needing to talk about it. It wasn't a lot of therapy at first because it was really just everybody all processing COVID-19. So it was like debriefing. Much more sort of crisis, anxiety of the crisis. I think it was really emergent right in front of us. And that was hard because we were all, as therapists, going through it too."

Reflections on Disembodiment and Therapeutic Presence

Two therapists reported that therapeutic presence felt diminished online.

Therapist 3: "I can't give you a box of Kleenex. I can't take a shawl and give it to you and put it on. I can't pour you a glass of water. I can't move my chair closer if you need me to or move back if you need me to. I can't say, would you like to sit next to me on the cab ride? I just feel like I sit here…and I'm a talking head…a little bit. The sad part is…that on Zoom, speaking completely…honestly…it just does not feel the same to me. That no matter how hard I'm working or how much I know my work, I feel more surgical in my work in an odd way. On Zoom, I feel more technically proficient, like I create an experience, versus in the office I feel like we're in the experience together…the energetic piece for me is really missing on Zoom…the felt sense of

presence feels diminished to me. I sometimes feel like a champagne without the bubbles…My personal preference is to be in-person…like your energy comes into me, my energy goes into you…I have not been able to feel that on the screen."

Therapist 15: *"As a telehealth therapy patient…I know that I am a little less vulnerable…a little more contained…In-person, I'm very undefended…and there's something that happens in-person that doesn't quite happen online. Like when I see my therapist in-person, I'm suddenly dropping-down and it's a different feeling. Like when I see my therapist on Zoom…it's not the same. It's not the same."*

Two therapists shared their experiences that the quality of intimacy had been negatively

affected online.

Therapist 3: *"I try to replicate the conditions of being in the office because we both know that it's so rare to have this much attention that you give yourself and that's focused on yourself…so, let's protect it in all ways that we can. But the lack of that…background noise, multiple devices around them and things popping up on their screens…that effects the quality of their presence…'do you have the television on?' That, I think, affects the intimacy…For me, there is less of a quality of intimacy on screen.*

Therapist 10: *"I think over all in the arc of a therapy or the arc of a number of meetings that, in general, it's way better than nothing…I do feel that there can be these subtle issues of connectivity. I don't just mean technological. I mean, human to human, that must get worked out. Part of AEDP is to make it overt."*

Some voiced their concerns about what's missing in therapy when we have never met a

client in-person and might not have a full sense of their physicality or energy while working

online. Therapists reflected upon this experience of disembodiment and the significance of

inquiring about the whole person including their physicality in the world and the inherent value

of doing this.

Therapist 12: *"We have to also consider what we're missing when we don't see somebody in-person, or not know what they look like, how they move physically, how you sense a body and energy in your office."*

Therapist 13: "The other day I had a surprise because I was working with a young woman and, it was something like session number 15...and she mentioned that she's 6'2" tall...she's in California and I never met her. I would never have known. But that must have had an effect on all kinds of things in her development and how she sees herself in the world...and I'm working with a man who was severely bullied as a small boy and he's only 5'6"so maybe I need to start asking how tall people are."

Most therapists acknowledged and reflected upon missing the energy of meeting people online as compared to in-person experiences.

Therapist 1: "And there's something missing for me. For me, being an empathic person, there's something about the screen and my patients being in another place, that I'm not feeling as emotionally engaged as I would be in my body in person if both of us were in the same room. But there is something missing, and that's the in-person emotion body-to-body in the same room."

Therapist 10: "Again, there's just something about the experience of the field energy that's less obscured. I find that the screen, the technology, the electricity can, not in a huge or insurmountable way...but it can mute things. In person, it's in full and living color."

Therapist 11: "I'm totally amazed how much connection there can be and how much can happen and how much is not lost...but also to honor that there is a little loss there, of not being with their energy and the exchange of energy."

Some therapists elaborated further on the felt sense of a barrier, division, film or a screen between client and therapist online vs. in-person.

Therapist 1: "There is a divide for me with the screen. Again, I can watch your face or my patient's face. I can see emotion. You'll tell me your emotion. I'll feel something. Filtering it through a screen is something different than being in person."

Therapist 10: "I think that there's a film, a light film that once it's addressed and regularly addressed and ongoing-ly addressed in some periodic fashion that I think can be mitigated enough to make a therapy really still very good. I still think long term, it still isn't quite the same as sitting in a room...When people are really deeply emotional sometimes, physical presence can be more calming. I just have to really count on my voice and leaning in and really working to use this tool as best I can, but there is frustration especially in those moments of real high activation."

Frustration around Technical Issues & Distractions

Therapists expressed frustrations around technical issues that came up in their online

sessions, and how they worked with these distractions to maintain the therapeutic relationship.

Therapist 2: "The internet was going down...like every other day. And finally, I called the supervisor and I said, 'I'm a healthcare provider, and this is life or death.' I was very adamant about that...like it really stands out in my mind, like something very important is happening and then suddenly, the client freezes, or connection is lost. There is even more effort to make eye contact because of where the camera is and all that...And you can't see the rest of the body...And I also tend to find that I do more fiddling with my hands. I don't know what that is...if I'm sitting in front of you, face-to-face, I'm not fiddling with my hands."

Therapist 3: "The other thing that I have found disruptive is that people will have...especially if you have a Mac...iChat could come up on your phone. So, they're talking to you, but then there are texts coming up on the screen. I do say to people if I notice they're looking, 'Is your phone next to you?' And if so, I say, 'I have found it's best that when we're doing therapy, if you put your phone somewhere out of reach and out of eye shot so that it doesn't distract you, so that we can replicate what it would be like if we were together."

Therapist 7: "Some people have better connection than others...there's mountains...they might not have it or the resources to do it...in that case, I don't have much choice, but really try to bring them in the office if I'm going to continue to work with them."

Therapist 10: "I can lose track a little bit more of what they're saying and what parts might also be in the room. I do notice that I think it's a little easier for me to keep track of myriad parts in-person than it is online. The other thing that is hard is even if the visual is okay, the audio is not lined up or it freezes...the freezing...This is a metaphor for their nervous system or mine...Are we actually moving toward things that are...demanding us to slow down by literally interrupting the signal? Now, I have a belief system that would include the possibility...that there is more than meets the eye to what we are privy to and affected by...now, I don't think that way all the time. I mostly think it's just frustrating, but on the other hand, if we really are in a place where I can't help but notice the synchronicity of it...I make use of it."

Therapist 13: "I get tired of being kicked off the internet by the stupid service...and I have had to call my providers and say, 'what the heck's going on?'...but for most of my clients, we've kind of been humorous about it together and see it as like a mosquito in the room. Or it like with the parent...when you get stuck in a traffic jam...and you say to the kids, 'It's okay. We're stuck in a traffic jam'...you just kind of make it okay enough. So as the secure base for my clients, I can say, 'It's all right. We can handle this'...."

Some therapists expressed dissatisfaction using phone sessions which primarily centered around not having enough visual cues.

Therapist 7: "Sometimes for some elderly people I meet who don't have access to a computer...or in a nursing home, I've had to resort to phone. I don't like it as much and can't see them."

Therapist 8: "Thankfully I only have one client who I speak to over the phone. I don't feel like I can go very deep when I can't see who I'm talking to...although I've experimented with it, and I have done deep work...it was the adjustment to discovering that it could work and then it did...so it was fine."

Section 4:

Advantages of Telehealth

At the time of their interview in the late summer and fall 2021, at least 7 therapists responded that their preferred way to practice was primarily through telehealth or a more hybrid

approach. 2 therapists expressed ambivalence that they would ever return to doing any in-person work. Therapists shared that their preference for telehealth primarily rested on the ease, convenience, and quality of life aspects that telehealth offered.

Therapist 1: "Quite honestly, I might be lazy enough to want to do telehealth because it might suit me and my lazy patients who want to just do it from home. It's more about the convenience of it. And it works just as well for them and even better with their lifestyles. They're still getting helped by me. I think at their side of it, maybe they didn't expect it as much…I don't think people would say there's been a difference. Somebody said to me, I'd love to come back to your office, but I must think about that…like I'm going to commute an hour to you and spend an hour with you, and another hour commuting. There's three hours. And yet I can just be on Zoom and we're in each other's homes. I mean it's fast…although my preference is for telehealth, it's more for convenience. I feel that in-person is probably more therapeutic…and I feel that I could do a better job in-person."

Therapist 2: "I know lots of people like telehealth, and I think for the convenience…I do honestly love to roll out of bed and have coffee and sit at my computer and not fight the traffic."

Therapist 4: "I think my preference would be telehealth, but I think it's more because of the lifestyle and the other things that it provides for me, which is not having to commute, being able to make my own lunch, taking a walk in between. It just makes my life better…I can manage my life more."

Therapist 6: "Right now, I prefer telehealth because it's easier for me…I don't feel so much significant difference. I mean being in-person is more powerful sometimes, but Zoom is not bad either. If I can observe, I can track the person's body language and their facial expression."

Therapist 11: "I would say three-fourths of my case load either prefers telehealth or are really okay either way and would be just fine continuing this way."

One therapist shared how much she loved working online:

Therapist 13: "There are some things about being online that are so intimate that I really love it. I know a lot of people hate it…but I love it…I believe in the power of the imagination, and I know that inviting people to imagine things has the same effect almost as doing them. And

so, we can get pretty much everything we need…and now, there's the reduction in stress that's good…and I can see people all over the world, and I feel connected in a way that I couldn't otherwise, you know?"

Another therapist shared how she felt more effective working online than in-person.

Therapist 4: "My sense is in some way that I feel a little more effective by Zoom than I did in-person…this is what's curious to me. For me, there's something about the state one to state two work that is easier for me on Zoom…I'm not so confrontational, but I find on Zoom that I have an easier time taking a more active stance…I don't know why there's something for me about the distance that Zoom provides me…it allows a little more agency for me to just go in there…and lean in more…We're also much closer in this strange way. When I'm sitting with someone in-person, they're much further away from me. So, to me, I'm very close to them…I haven't seen any reduction in quality of therapy because of technology."

Positive Experiences Working on Zoom

Therapist 2: "I really like the fact that I don't have to get dressed-up, and I really like that I can just go make a cup of tea, and I don't have to run out and buy coffee. I don't know there is something relaxing about working from home. I actually do feel more relaxed in my body in my own house. My office building…there's always so much noise, hallway noise. This is peaceful…like rolling out of bed and going to work."

Therapist 3: "If people are fortunate enough and privileged enough to have a safe, private environment to be in, they don't have to transition from work to therapy…they are already in a safe place, home, surrounded by things that make them feel comfortable. I find that people can much more easily talk about things that sometimes took much more warming-up to get to."

Universally, therapists expressed gratefulness that the technology to harness online work was readily available during a time of fear, isolation and aloneness brought about by a global pandemic. Therapists reflected upon and shared many of their positive experiences as they transitioned and made the shift into online work.

Therapist 1: "I think it shifted in me…knowing that I could do telehealth. I mean everything has changed…Zoom opened up the entire world to me. And it was amazing to do workshops with people from around the world. I did so much during the pandemic, even in terms of training and workshops, things I could never have participated in…in person, I did all kinds of things online."

Therapist 2: "I had clients reach out to me that I hadn't heard from in five or ten years just to see if I'm okay…which was so touching…it was beautiful…and you know, the beauty of it is that we all have access to each other all over the world, and for me there is a sense of global community…it is about my teaching workshops because you get people from all over the world, and that's just really beautiful."

Therapist 5: "I feel grateful to be able to still do work, to have good work still happening. It's not my favorite way to work. I really prefer feeling an in-person energy field than the Zoom energy field which I do think is different, but it's tricky because when you look at what's happening in the world, I'm so grateful to have a place that I can work, a way to work, a practice that has gotten even busier during the pandemic…where I can work safely."

Therapist 11: "I just felt incredibly grateful and privileged that we have the technology that I was able to be with people when they were really feeling alone…that I was able to be on the COVID journey with them. I am thanking my lucky stars that I was able to do this…and some healthy trauma bonding occurred…by going through this together…when COVID disrupted almost every single facet of all our lives."

Therapist 13: "I am so incredibly grateful that COVID happened now and not five years ago…it's kind of remarkable that we ended up in lockdown right at the same time as Zoom was available and we were able to meet with each other online. It's a miracle…cause if out of the blue, we were completely unemployed, all of us who are self-employed…that would've been really kind of a problem…That's why when people complain about Zoom, I think, well…consider the alternative."

Phone Sessions and Groups Online

Therapists reflected on how the shift to telehealth has also impacted other ways of working clinically with clients, including the increased use of the phone. Two therapists shared

that the freedom from visual sensory information allowed them to work more deeply with their

patients and one reflected that their client felt more at ease working by phone.

Therapist 1: "Zoom is too face-to-face really. It's too intense. My eyes are tired from all the visual. So, I have added in some phone sessions, and I actually enjoy phone sessions even more than the telehealth…I feel like there's a sense of reverie for both me and the patient in a way that doesn't happen face-to-face. Like if something happens with the technology, let's have a phone call or let's text. Let's work it through together. Actually, in terms of attachment, this is another place where we just do it together…I do find phone sessions have a different depth…you don't have to worry about the visuals and the screen, and you're just hearing the voice and a quality of voice. You can hear even more emotion in the voice in a way that you're losing on the screen. Honestly, we can get distracted on the screen. I mean, emails can drop in or messages can drop in for them too. I find phone sessions have another deeper quality which I like."

Therapist 4: "Sometimes when I switch to phone sessions, those sessions can sometimes be even deeper in a way that I think frees people up a little bit. It frees me up sometimes a bit."

Therapist 7: "Some people really had a hard time getting used to Zoom and actually working online…And they felt more comfortable talking by phone…"

Therapists shared many positive reflections on the changes that they experienced working

with online groups.

Therapist 2: "I think that I'm somewhat shy…so groups are a little challenging for me, but on Zoom they're really fun. Group work stuff seems to work really well for me online."

Therapist 13: "I can work with people all over the world…and I really love it because I feel connected in a way that I couldn't otherwise, you know."

Positive Experiences of Intimacy Online

Several therapists shared that they experienced the online therapeutic relationship to be

even more intimate, in some ways than in-person work.

Therapist 12: "In some ways…more intimacy…being able to see people's faces up close is quite powerful. Intimacy in that we're seeing into their homes. We see their backgrounds…we see their pets come in…we hear the noises of their household. So, all those kinds of ways, have very much enhanced intimacy in some ways."

Therapist 13: "There are some things about being online…that are so intimate that I really love it. I know a lot of people hate it. I love it…and can see people all over the world…any technical problems and we've kind of been humorous about it together and seen it as kind of like a mosquito in the room…and I believe in the power of the imagination…and I know that inviting people to imagine things has the same effect almost as doing them. And so, we can get pretty much everything we need."

Therapists Sharing Resilience and Adaptative Strategies

According to Tedeschi and Calhoun (2004), post-traumatic growth can be defined as the positive psychological changes that can have a quality of transformation and bring about a qualitative change in functioning. Similarly, the transformational affects of AEDP are essential to the "mining, broadening, and building of positive resources that otherwise might lie dormant" (Yeung, 2021, p. 354).

The majority of therapists reflected upon their own resilience and the development of adaptive coping strategies in overcoming some of the technical challenges of working online and continuing to feel more confident that telehealth was an effective platform for therapy.

Therapist 1: "But honestly…Zoom worked…and the internet worked. And I had alternatives to Zoom, if it was to crash, I could go to FaceTime. I could go to Skype. I could have phone calls. I'm amazed that it did work actually. The little glitches, whatever the little glitches are…were little bumps…we all worked all of that out basically."

Therapist 5: "In AEDP we talk about how the work transforms you as much as it transforms your patient…there are transformational moments that work both ways because…we have this trauma that we're sharing together and we're both getting through it together and it's been helpful to you in your transformation being able to hold somebody there when they're dealing with trauma…People would say to me, 'I want you to tell me that's it's all going to be

okay, and I know you can't' and then I just have to say, 'I know.' And then we sit with that together…that's where my Buddhist teachings have been very helpful to me."

Therapist 10: "I feel like I'm growing…getting better and deeper in being able to work on Zoom."

Therapist 12: "The technology problems would be ranging from…the elderly client who had no idea how to work on Zoom….and it would be a transformance victory at learning how to get the mute button to go off and we would celebrate that and…me helping her to do something else in her life and connect that way during isolation…and AEDP helped to reframe that."

Section 5:

Ambivalent Experiences of Online work

Although working online opened therapists up to increased interaction in the global

AEDP community, there were other more nuanced reflections related to online groups and

training. One therapist expressed their concerns that the quality of online training might be

different than in-person experiences.

Therapist 7: "And in supervision, it's been ideal because I can meet people all over the world, or I can do groups and bring together people that wouldn't ordinarily talk with one another…it's allowed me to be involved in trainings and assist instead of doing it in-person. But there's a downside of that…but I don't think that you get the quality that you do when you're in-person. Probably faculty would say there are less problems than in-person, but I would say problems are okay…whereas things get held over, like in-person, someone might come up during the break in-person and say, 'Hey, you mentioned that it's sort of struck me and then you'd work it out. Whereas online you might not hear from them for a month, or you might get it in some other form…it just evolves and gets worse…and with prejudice and racism, there's other issues that get highlighted online probably because you're not in-person, and it's much easier to misinterpret where the person is coming from…you'd be able to address it more quickly in-person."

Therapist 5: "What I really miss is doing group work in person because I do group work too. And I love group process and…I don't know. There's something about being in person for that too."

Therapists also offered more nuanced reflections on intimacy in the therapeutic

relationship when working online.

Therapist 1: "I have a strong alliance with anybody that I've seen online. There's been some people that I've only met online and only had online therapy with…I've never met them in person. But I mean, we have a good bond. We're connected. The intimacy is good…But if I saw them in person? Would I even recognize them on the streets if I met them? I think there's something missing there…but we have had intimacy."

Therapist 14: "I think that intimacy is something that we create. We like explicitly create the environment where someone can be more direct with us…more open. I don't know if there's a difference…I've experienced moments of intimacy that are comparable…to moments of emotional intimacy, in-person…AEDP just pulls me into the process and makes me fully present, fully involved…there's something about it that just engages me in just a more full-hearted way…"

Therapist 5: "There are all kinds of disruptions that can break moments of intimacy. I lean back into the idea that if you have the intimacy already, these things don't break it at a core level, but moments do happen. I feel like a good therapeutic relationship is a good therapeutic relationship…I always see a therapeutic moment, no matter what it is. I sort of turn the lemon into lemonade…and say, 'Let's just take a moment to appreciate that we just got through this annoying thing together and that we hate this, but we're getting through it.' I'm acknowledging it. I'm not ignoring it. I'm not glossing over it. They're not alone with it…and we laugh together, and I think when people laugh together, that brings us closer."

Current Fulfillment in Clinical Work

Therapists reflected upon both positive feelings as well as more frustrating experiences

that contributed to their current level of fulfillment in their online clinical work. Some shared

that it was hard to tease out how moving through the collective trauma of COVID-19 and the

abrupt shift to telehealth may or may not have impacted their current level of satisfaction.

Therapists acknowledged and shared some of the very personal and multi-layered aspects that

contributed to fulfillment.

Therapist 5: "It's multi-layered…It's not my favorite way to work and I really prefer feeling an in-person energy field…but if we focus on the actual work continuing to go well and even expanded for the first time, then I've liked this. Everything that's happening in the world is happening in the clinical room, whether it's the murder of George Floyd, whether it's COVID…and I find it also very satisfying to have that brought into the clinical work, that expansion."

Therapist 7: "It's a little mixed. It's tough being away from the office. I mean, it's sort of like a love-hate relationship with telepsychology. It's definitely allowed me to practice during these times and actually expanded my practice. I'm busier than I've ever been, and I've been able to do more supervision, which I hadn't thought about that being a possibility…so it has really been a boon that way…but it is taking a toll on my body. Being older, it's brought some issues with my back, and I have gotten a lot stiffer…and it's been tough that way."

Therapist 12: "AEDP has enriched my work…and boosted me to be able to stay connected to the work in a way that I think I may have burned out earlier…It feels real and we're able to show it more authentically…therapists and myself included, we're freaking exhausted. It's been a tiring time, this pandemic. I mean, it's just relentless hours and demands and requests for therapy…people weren't canceling because boom, you're on Zoom and can do therapy from your own car, your living room, your bathroom…so I got very few cancellations…but at first, Zoom was utterly exhausting…somehow that muscle has gotten strengthened."

Therapist 15: "You know, we all have our days…but I can still say that I love my work…but there's some Zoom fatigue…there's a way in which the days just kind of start to blur together a little bit."

Section 6:

Clinical Indications for Telehealth with Different Client Populations

Some therapists reflected that those clients who have a more avoidant attachment style seem to prefer telehealth.

Therapist 2: *"I can see that for clients who are more avoidant, it's more relaxing…and I don't know what that is, but I really, really notice that…and one client who is very dissociative who is happy to come on telehealth and seems less inhibited…so this works with his attachment style, very comfortably."*

Therapist 3: *"I would say that those who have a more avoidant attachment style do like this better. Even though the eye contact could be harder, but they don't feel the need to constantly make eye contact with me on the screen. For people who are more avoidant, it is more comfortable..."*

Some therapists believed that those clients with significant histories of depression, social isolation and loneliness could benefit from in-person therapy over online work. Therapists reflected upon issues related to the ethics of teletherapy. Considerations need to be made about what each patient might require clinically vs. teletherapy being provided for all patients. Clinical decisions that place the treatment needs for each client front and center need to be nuanced.

Therapist 7: *"I think the general factor of a lot of early relational trauma and attachment issues…probably more depression and a lot of loneliness in their lives…these clients clinically need in-person…Some people clinically, I think just do better when you're in-person. One patient that comes to mind is someone who had a lot of early, both big T and relational trauma. I mean, there are a couple of reasons, one being the place where she was doing it, her kids were around, and she didn't feel the privacy. I think that was a big issue. The other issue was that she was pretty well out in the rural area and really the connection was on and off, so that was frustrating. And then I think probably the overall issue is really feeling the need for my presence in the room to really feel it in person, my sense of emotional holding. And we articulated and talked about it and eventually agreed. I'm glad that I did. I think I would've lost her."*

Therapist 12: *"There are some clients that I have felt telehealth has helped us go way deeper…somehow they are doing better work on telehealth than they ever did in-person…whether they're more comfortable in their own home, whether there's a bit of that separation that helps them…there's people that…it's much better to see in-person and I feel just so much closer to…you get all the information…accessing their whole bodies…it's different…People that are socially anxious or it's hard to leave their home, they've really benefited…people who don't like technology, some of my older clients, like they couldn't even*

like…literally we would have half the session just learning how to turn the volume on or off…they would rather see me in-person.”

Therapist 1: “You can’t guarantee a person’s regulation online, through telehealth. And I had this client who was really dysregulated in terms of trauma and maybe even on the borderline personality spectrum. And she would actually interrupt the session and sign off, and then I had no way to get in touch with her. So, we must be careful, maybe even about the patients we interview to see if they have enough safety to not be in person.”

Therapists shared their nuanced responses and experiences working with more dissociative clients.

Therapist 1: “I have a client who’s on the DID spectrum and he actually prefers telehealth because he’s in the safety of his own home. And he has let me in, into his interior world, much more on telehealth than he ever would in the room. It’s safe for him. So, the telehealth has even been better for him.”

Therapist 13: “I work with pretty dissociative people…and for some really dissociative people, it’s absolutely not ideal…with two people in particular, the active processing of trauma has stopped because it doesn’t feel as if given their tendency to check out totally, it’s safe…so that’s definitely affected it…and one of them now actually is coming out to see me, but it still feels a little like I need to be really careful. But they’re so much happier now that they can just be in my physical presence…but those are, you know, in the bell curve…those are the most distressed. On the other end, I think most people don’t even notice they’re doing it anymore. I think it’s just part of what we do.”

Section 7:

Reflections on AEDP Interventions Used in Telehealth

Subjects were asked to reflect upon how they have used AEDP interventions as they have shifted into working online through Zoom. They reflected upon AEDP skills that were particularly useful in their current work. They also shared relief about the ease of recording online.

Undoing Aloneness

Undoing aloneness is the most basic tenet of AEDP psychotherapy. AEDP takes the position that the deepest and most traumatic emotional experiences and injuries are not those that occurred during the moment of the traumatic experience or attachment injury, but those that result from the unbearable feelings of aloneness, desperation, and intrapersonal/interpersonal disconnection that followed and may get later stirred up and retriggered in memory feelings. Therapists reflected upon how they have worked to "undo aloneness" of the clients when they are working online and not physically in the same space.

Therapist 10: "I often say, 'Look, we can't fix this, but we don't have to leave you alone in it. I know what you need because I feel it, too. I can't imagine any mundane therapy that isn't so relational and attachment oriented. It would feel so unbearably lonely. I guess overall, I would just say thank God for AEDP. If there were a modality to lean into during these days, it's this. Because of the ethos, because it's really about human-to-human connection in a time where the physicality of that was enormously limited. When we're really in trouble, we just want to know we're not alone and that there's hope…It's like okay. I'm right here. I'm right here."

Therapists reflected upon AEDP skills that they were aware of using more intentionally and more explicitly. These skills included slowing down and dyadic affect regulation, moment-to-moment tracking, making the implicit explicit, bringing attention to somatic internal awareness, judicious self-disclosure, and meta-processing.

Slowing Down and Dyadic Affect Regulation

Research subjects reflected on helping clients with self-regulation and slowing down, joint breathing, and grounding.

Therapist 1: "Okay, take a breath. Let's handle it. Here's what you need to do…look in the left-hand corner…look in the upper right-hand corner. Let's do this together."

Therapist 10: "There's something about that coming together that's so powerful…the dyadic regulation, but maybe to the power of two or three online…it's upping that."

Therapists reflected on the need to intentionally slow down even more in telehealth sessions.

Therapist 10: "The advantage of telehealth is that sometimes, you must go a little slower, right? Because really it takes a little more time to suss and ferret things out…I've not only had to really up the moment-to-moment tracking…in terms of slowing things down and nuancing…I think slowing down is the holy grail of life, not just clinical practice…and we really do have to slow the whole thing down…that way, pieces become really bite size, and we can chew on them for a longer time and make use of it."

Therapist 13: "And I have really taught myself to slow down…I would say to myself, slow down about 50 times a day! It was not my natural bent, but now I know how dramatic slowing down is for the whole system for me and the client…"

Moment-to-Moment Tracking

Moment-to-moment tracking is a foundational interventive strategy in AEDP. The universal truth for the therapists in this research study was the recognition of a more enhanced and nuanced focus on attunement and the micro-tracking of facial expressions online.

Therapist 1: "I do more moment-to-moment tracking. If I can see people online, I'm watching for facial shifts or something that I might not do in person maybe."

Therapist 2: "I do more tracking of the face because that's all you can see…but then I also really fill in what I don't see…try to fill in what I think is happening from here down…but the face is so close…that really brings in the social engagement system in a different way. So I

really try to work with that and really use that…their eyes did something that I might not have caught or the feeling state is in their face. It feels like relational mediacy."

Therapist 3: "What has been pretty enhanced is the ability to track people. I can't track your whole body, but it's pretty tough to miss anything that happens on somebody's face…You would have to have another screen open on your computer to not really see tears, see grimacing. We can really track this very well. It has been my sense that we can all become excellent facial trackers."

Therapist 6: "Moment-to-moment tracking…I focus on facial expression because I can't see the whole body…and I can see more subtle changes of a facial expression more than I used to…slowing down is sometimes more difficult online…I have to pay attention to that more and because the person is not physically in front of me, I can go faster too when I'm using Zoom."

Therapist 10: "I think the moment-to-moment tracking has become…can I say more refined?"

Making the Implicit Explicit

Therapists shared examples of how working online required bringing greater presence to experiences that might be more implicit and the significance of bringing these implicit experiences intentionally into a more explicitly named focus.

Therapist 3: "It has been good to really make the implicit explicit. And then, make it relational. So as soon as I met people on screen, I'd say therapy is a weird experience…which it is…it's weird to go to somebody's office to meet with someone that you might not have ever seen or heard of before. You walk-in and start talking to somebody and telling them things about yourself without really knowing them. It's a weird thing going to therapy. And now it's even weirder to do the magic carpet ride. Boom. You just instantly appear, right? So now I just name it…and I might say…I'm making a house call to your home, and you don't even really know me."

Therapist 5: "I've also really inquired more about certain kinds of tearfulness. There are some people who are just on the brink, and it's harder to see through a screen than it is in

person. I've said, 'I'm not sure if I'm getting this right, but I think that I'm seeing some tears brimming. Am I right about that?' I've had to bring in something more proactive about somatic markers to get a good read on them."

Therapist 7: "I think just being online…it's sort of a barrier in some ways. And I think it's just important to be aware of the impact we're having on a person. So, really checking with them…being aware of the relational factors. Not just assuming that it's going to be exactly the same as being in-person."

Therapist 9: "Sometimes the screen is blurry and difficult, and a tear comes up or certain facial expressions…and sometimes I just ask more, if I'm right or not…Those shifts…I might ask more questions than I used to do…Yeah, there's more intention to ask questions, to ask certain things that I'm not sure of because I can't really see or I can't really tell."

Therapist 13: "If I find myself and my client both grieving the loss…of a dog that just died or find myself and my client both still struggling with the outcome of being raised by alcoholic parents…well, that's all part of what we're dealing with. In the case of the COVID pandemic, it was everyone all at once and me. So, it was a lot. But making it all explicit and talking about it together, felt comforting to me."

Somatic and Internal Awareness

Therapists reflected on how important it can be in remote work to explicitly work with the body.

Therapist 5: "Especially for people who I started new with who didn't know me, and maybe for those who do, sort of gentle reminders that really, when you don't have the full body to see, and often, the bottom half of the body could be expressing a feeling…gently reminding people to keep in mind to notice when parts of your body that I don't see might be moving and let's be curious about them because they may be wanting us to know something…and so gently reminding people about certain somatic markers that I won't get…I've had to do that more because I don't have the visual cue of that. I mean, I always paid close attention to this, but somehow, it feels like I've placed more of an emphasis on the somatic markers that I can see or really attuned to in breathing, or changes in breathing patterns.

Therapist 10: "I'd say that what it has done is it's brought me more to the body, even if it's not hands on. That might be how it's upped my game in terms of AEDP, the somatic element…just inviting people…to notice whatever's happening in the body and just dropping in…about really, really, really going in slower, staying with, pixelating in the best way possible."

Therapist 13: "I think there's a qualitative difference in how I inquire about internal experience…but maybe that would've evolved anyway, whether we're doing it online or not. Maybe because I can't see someone's body, it makes me more likely to inquire…which would be a good thing, you know? Not so much that I get the information, but so they reflect on it themselves because that's the reason we ask those questions. What do you notice in your body…do you feel a shift in energy? Do you feel something? As you say that, where do you notice it happening inside your body? I think that I might be doing more of that because I can't see them."

Judicious Self-Disclosure and Meta-processing

Therapists reflected on how working online, especially at the beginning of the pandemic, brought about increased judicious self-disclosure and meta-processing.

Therapist 3: "I think the pandemic brought it to the forefront because people were sharing…so here's what's happening. Here's how I'm dealing with this. And what does that sound like to you…I think it was easy to use self-disclosure in a way that felt effective. And then to make sure that I meta-processed."

Working out of their homes, therapists shared how self-disclosure had increased.

Therapist 2: "I think in terms of the self-disclosure, I think there is more intimacy in a way because client and therapist are both in their home, or their car. And there is a kind of mediacy to it. I've seen other parts of their house…and sometimes they've seen other parts of my house…I've seen their spouse, I've seen their pets, their children…"

Therapist 3: "I felt like if I'm going to enter your home, and I'm going to see your home as it is, you may as well see I'm in my son's former bedroom and that Mickey Mantle is on the wall behind me."

Therapist 8: "They have access to my private world more than they might have before. I've had to do much more self-disclosing. And I think that's probably the biggest part...it's given me permission to become a little bit more vulnerable and be exposed."

Therapists also shared further reflections that their increased self-disclosure served to decrease anxiety and enhance treatment effectiveness.

Therapist 1: "I'm much more transparent now. I will be willing to be much more transparent and much more willing to be engaged as a person coming back, having had this experience, but I'll bring that back in-person. And I won't be so afraid to talk about my kids and my dog and my partner to my clients where I might not have before in person, as if that would infiltrate the treatment."

Therapist 10: "I think maybe I've done a little more revelation because I think the more dysregulated and distressed people are, the more that it helps to know that I've gone through things like this. I totally understand what they're talking about. I've maybe done a little bit more self-disclosure. I probably have done more of that."

Despite recent pandemic and world stressors, almost half of the research subjects expressed a high level of satisfaction in their current clinical work.

Therapist 11: "I'm highly satisfied. I love my work. I feel really solid in my work right now, more than I ever have, especially with my AEDP journey...I am in a really, really great place...I've just got a real ease and confidence that things will unfold...the convenience of being home is great...more time to claim for myself."

Therapist 13: "I probably would say that on a scale of zero to 10 with 10 being the most satisfying, I would say it's pretty high. I'd say it's like a 9 or 9.5, like really high. It's been two years now since the pandemic started and in those two years I have learned so much more about being an effective AEDP therapist...so I suspect no matter where I was or how I was doing it, it would be the same. There are some things about being online that I really love it."

Section 8:

Therapist Reflections on Future Impacts

Effectiveness of Teletherapy

Although all 15 therapists believed in the effectiveness of their clinical work through

telehealth, each therapist also referenced how the online work is different.

One therapist who expressed a strong preference for providing therapy through telehealth

and had expressed ambivalence about returning to any in-person work (primarily due to

convenience) also shared:

Therapist 1: "AEDP therapy is effective, and you can measure the effectiveness…but there is something missing and that's the in-person emotion body-to-body in the same room…there would be a deeper experience for me personally in-person, even though telehealth is effective…I'm not feeling as emotionally engaged as I would be with my body in-person, if both of us were in the same room…Filtering things through a screen is something different than being in-person."

Another therapist who expressed a strong preference for in-person work and looked

forward to returning in-person work shared:

Therapist 3: "No matter how hard I am working or how much I know my work, I feel surgical in an odd way. I feel more aware of what I'm doing than when I'm in the office where it feels like I'm in the experience, not creating an experience."

Every therapist believed that what they offered clinically through an online platform was

effective and useful for their clients, some explicitly acknowledged the differences between these

two ways of working.

Therapist 5: "I think there is something about all the potential technical challenges and just the ethos of technology and what people are used to using it for. I think it's harder for people to really drop down in significant ways. I really do. I've heard people say that also."

Therapists elaborated on how they experienced their online clinical work to be effective.

Therapist 1: "I think the therapy is as effective or maybe even more effective online through telehealth…AEDP therapy is effective, very effective. I've been involved in the AEDP research project, so I can think of at least two patients, if not three or four, that I've had research projects during COVID only online. That's 16 weeks of therapy, all measured by statistics, and we've had great measurable success. The therapy has been effective, and it's been perfect AEDP therapy. And it's measurable."

Therapist 2: "In terms of clinical work, sometimes it gets interrupted by doorbells…but I don't think that much has been sacrificed. I really don't. It's interesting. Because my preference is to be in person, but the actual work itself hasn't changed…I have found it to be satisfactory, and I don't think it compromises the treatment, I really don't which is surprising."

Therapist 3: "I've gotten feedback from people that this is so helpful. It's so convenient. They never miss therapy where before they might miss. Very few people miss sessions, and I hardly ever get cancellations because it's pretty hard to miss…and nobody's late."

Therapist 7: "I've gotten generally positive feedback…that they've appreciated it…and appreciated the fact that they can continue to see me. Most of the time, it's better than they thought…it's actually worked out better. And then over time, even those who have resisted it, some of the blocks seem to go away…Maybe technically there's not a whole lot of stuff out at this point in terms of outcome measures, in terms of a significant difference between telehealth and in-person…but I think there is a difference. I think they can do consistent work on telehealth, and I think it is not necessarily an issue…but I think with some where they really need the in-person contact, it has a major impact on them."

Therapist 12: "The therapy itself…I've been pretty impressed how good therapy we've been doing on telehealth."

Curiosity and Concerns about the Future of Psychotherapy Online

A multitude of reflections were shared about the changes in providing therapy online and the consideration of using a hybrid approach of both online and in-person work. In addition, therapists also shared more broad challenges of their work and identity as psychotherapists.

Therapists reflected upon long-term changes in providing psychotherapy primarily through telehealth.

Therapist 1: "9/11 changed us in ways, and even the AIDS crisis changed us as a society in ways we didn't know at the time. In terms of 9/11, we have lots more security at airports…And…in terms of the AIDS crisis, we practice safer sex. In terms of the pandemic…how to keep ourselves healthier in terms of masks or social distancing or handwashing. So how that will affect us long-term I think needs to be unpacked and will be interesting to see, for me personally and for us as a society. It's really been thought provoking for me to think about my practice and think about what I might want to do, going back to the office or not…How will I either initiate or sustain telehealth if it's not necessary or required. If I ever did retire to some other foreign place, could I do telehealth? It's going to be interesting to see the impact…all of us in the field will need to think about these questions together. Start philosophically asking some of these big questions."

Several therapists reflected upon ethical concerns that included privacy and confidentiality issues when clients are in their cars or in their bathrooms or their children or other family members are nearby.

Therapist 7: "There will be more that comes out about the ethical stuff and all the boundary issues, just the changes all this has caused…there's the factor of family members being around…sometimes that's good and sometimes it's not so good because they don't have such great boundaries. And then how do you deal with that when you have a family member around and they don't have a great place? And then the boundaries…you're getting into some tough issues…that would be another choice point for me of…do I think that telehealth is going to be the best venue for them to use therapy if they don't have a good place…so there's a lot of different factors and I think over time, some of that will be spelled out and sort of like…under these conditions, it may work better and under these conditions, we probably need to pay attention to these kind of variables. At least that's what I'm hoping as time goes on. I'm winging it!"

Therapists remarked on the impact of increased online work and expressed curiosity

about its potential health effects on the body and the brain.

Therapist 10: "I have to even wonder about the impact of all these rays on the functioning of the brain. I don't know it. I don't want to even know it. I don't want to research and find out that I'm frying my brain. I don't even use my cellphone that much…I think these things are not innocuous or benign or necessarily horrible, but I think they're impactful to degrees that we are fully aware. I hold that…"

Universally, all 15 therapists acknowledged that teletherapy was here to stay as a viable

mode of therapy, and that they are learning how to do it and getting better at it. However, they

also expressed a more existential concern about what may be lost in the human interaction by not

meeting in-person.

Some voiced their concerns that convenience factors would be prioritized over what

might really be most helpful or even clinically indicated for a client:

Therapist 3: "I have grave concerns that psychotherapy has changed permanently to be much more Zoom focused…As I query my patients…the ones who are not wanting to come back in-person, it's not because they're afraid of COVID, it's because they're young and none of them

are going back into their offices anymore. And when they used to be in Midtown and hop on the train…now, they're in Brooklyn and in their pajamas working. Why would I want to get dressed and go to therapy when I can just do this…And unfortunately or fortunately, I'm doing a good enough job online that people are having enough good experience and things are happening so they're happy to stay remote…This is so much easier…my life is so busy…I don't have to come and travel…but I'm worried about that."

Therapist 15: "For me, if we lose in-person, that's heartbreaking because I think there is something about being in a room with someone…that's really important…the human contact."

Chapter VIII:

Discussion

Has the technology explosion spurred on by COVID-19 acted as an aid or a hindrance to effective mental health treatment that is so needed in our world today? The field of psychotherapy has been dramatically changed due to the global pandemic and the abrupt and unparalleled shift from in-person sessions onto telehealth platforms. Psychotherapists need to identify any factors that might strengthen or negatively impact their clinical work and be prepared to address these factors.

The primary purpose of this qualitative research has been to study the lived experience of mental health clinicians moving through the COVID-19 pandemic with an exploration of how they perceived the therapeutic relationship and their clinical work to be impacted by the abrupt transition and adjustment into online technology. The experience of psychotherapists who practice Accelerated Experiential Dynamic Psychotherapy (AEDP), an attachment based psychotherapeutic model that has proven to be effective in clinical trials (Iwakabe et al., 2020)

and has specific factors considered to be particularly useful in addressing the emotional and relational upheaval impacting our world has been considered (Prenn & Halliday, 2020; Ronen-Setter & Cohen, 2020). The AEDP therapists in this research study were asked to reflect upon these phenomena during this extraordinary time.

The findings of this qualitative research study address many of the issues that were presented in the literature review of this dissertation, including topics related to shared trauma and the therapeutic relationship and post-traumatic growth and resilience of the therapist. According to the findings of this study, many concerns were raised and identified in relation to how the online therapeutic relationship could potentially be negatively impacted, despite telehealth being deemed to be effective by all the clinicians in this study. These concerns included: any issues that might decrease therapeutic presence (a variable that appears in the literature as a common factor associated with a stronger therapeutic relationship), technical difficulties and Zoom fatigue, and the effect of therapists' attitudes and perceived beliefs about providing online therapy. In addition, recognition of ways to enhance teletherapy, the benefits and limitations of working online, and future concerns about telehealth are addressed from an AEDP lens.

Implications for theory, practice and social work education will be discussed. Suggestions will be made for future research and the limitations of the study will be addressed.

Implications for Theory

Online teletherapy has been demonstrated to be as effective as in-person therapy (Baker & Baker, 2021; Carlbring et al., 2018; Castro et al., 2020; Vogel et al., 2014) and has comparable outcomes to in-person (face-to-face) treatment (Dunstan & Tooth, 2012) with yet further

research suggesting equivalence of the therapeutic relationship between telehealth and in-person delivery (Simpson & Reid, 2014). In contrast, there has also been some research in the literature to suggest evidence that online work can be less effective when compared to in-person therapy (Gordon et al., 2015).

Some of the findings reported in this qualitative study have replicated those in previous studies, while other findings add context to a new and burgeoning area of study: how to address factors that could negatively impact the online therapeutic relationship and potentially impede treatment effectiveness and outcome. A review of the literature has revealed that research on how to improve online psychotherapy is still relatively scarce and warrants further study (Rathenau et al., 2021). This qualitative study is timely and can shed light on strengthening online clinical work using an attachment-based, relational and experiential-emotion focused lens.

Attachment Theory in the Age of COVID-19 and Online Technology

We are wired for connection and the biological instinct to reach out to other human beings in times of potential danger, threat, anxiety, or illness persists from cradle to grave (Bowlby, 1989). As discussed in the literature review, the COVID-19 pandemic has served as a threat to the attachment systems of human beings. Therapist 5 captured some of the pain and helplessness experienced by both therapists and clients: "*Everyone was coming in, in terror and panic and pain…and losing people and not being able to be with them…and all kinds of unprecedented things. When were people not able to go to a funeral? When did that ever happen? Being immersed in all that helplessness and pain…it felt like 1010 WINS news, all the news, all the time. That was hard. That was really hard.*"

The global pandemic has also more fully entrenched technology into our lives. According to clinical psychologist Michael Stadter (2013), "we need to study not only what technology can do for us but also what it does to us" (p. 1). Recent research has suggested that the human brain can be changed by excessive computer use (Cundy, 2015). Therapist 10 shared: "*I have to even wonder about the impact of all these rays on the functioning of the brain. I don't want to research it and find out that I'm frying my brain. I don't even use my cellphone that much. I think these things are not innocuous or benign or necessarily horrible, but I think they're impactful to degrees that we are not fully aware. I hold that.*" Technology has acted as a third element or "e-third" in two-person relationships, serving to mediate between the exchange of information and the expression of our deepest emotions, attachment longings and needs. As Stadter (2013) points out, we do not yet have even one generation of people raised from infancy to old age with digital technology as this third element or "e-third". Therapist 3 shared the experience of loss in the online attachment: "*Do you want to take a few minutes and sit in the waiting room and just settle a little bit before you put your feet back out on the sidewalk? That doesn't happen on screen. I have no idea whether when you and I hang up…and when we click off. What if you're miserable? I won't know that little bit of transition because I won't see it. And so I don't really like that. It feels to me like an important part of closing a session is when somebody leaves.*"

Attachment theory and the human beings that John Bowlby (1989) has worked so hard to understand both internally and externally through their relationships have now been fully immersed by yet another external and potent influence: technology. The findings from this study offer nuanced reflections by experienced and skilled AEDP therapists on how to strengthen and

maintain secure attachment in an ever-changing and insecure world. Findings of this study acknowledge this increased reliance on technology.

Attachment Theory and the Online Therapeutic Relationship

As elaborated upon by Wampold (2019), one of the characteristics of effective therapists is their ability to form a strong therapeutic alliance across a broad range of clients. As discussed in the literature review, the therapeutic alliance consists of three components: the relationship or secure attachment bond between the therapist and the client, as well as collaborative agreement with the client and goals and tasks of the therapy (Bordin, 1979; Horvath & Luborsky, 1993; Hatcher & Barends, 2006). The therapeutic relationship along with the therapeutic presence that can deepen the therapeutic attachment bond are both considered to be common factors that contribute to the effectiveness of treatment. With the abrupt transition to telehealth brought about by the COVID-19 pandemic, effective therapists not only need to be able to form a secure bond and therapeutic relationship across a wide range of clients, but also across a wide range of practice environments that include both in-person, online through technology and hybrid settings.

John Bowlby (1989) believed that the therapist's role as a secure base from which the patient can explore both his internal world and his external relationships was at the foundation of an effective therapy. The psychotherapy relationship may provide an important mechanism to support clients in moving from insecure to secure attachment. As the findings of this research have suggested, the pandemic stirred up attachment experiences in both client and therapist. Therapist 7 shared: "*We're all living through this trauma now with COVID at a time where a lot of people are trying to work on their old stuff, and not to tinge that with all the fear that I'm going through in my life.*" Therapist 7 further reflected on the COVID-19 pandemic and issues of mistrust stirred up. "*If you come through a lot of cumulative trauma and had parents that basically lied to us, and*

then at the same time told us that 'we love you', then it's a lot of mixed messages and we don't know what to believe. And I'm trying to help people sort of begin to trust themselves and understand what they can do. It's like reliving the trauma for a lot of people."

Therapists in this qualitative study reflected on how the specific needs of trauma survivors were important to consider, and that future and ongoing post-pandemic research needed to bring further understanding of how the psychosocial crisis of the pandemic and its ongoing subsequent stressors could stimulate a re-emergence of the social isolation and sense of powerlessness, helplessness and threat that shaped their childhoods (Taggart et al., 2021). If the therapist, herself/himself is not feeling secure in this challenging age of COVID-19 or questioning and doubting teletherapy and themselves, therapeutic effectiveness and outcome may change (Rathenau et al., 2021). As reflected upon Eileen Russell (2021), when we feel secure in our work, we are better able to act with self-agency. Agency has been defined by Russell as the sense of and energy for the self's ability to act and to do and to have an impact on others, on oneself, and on the world. Therapist 7 shared: "*It was like do or die. If I want to continue practicing, I better figure out how to do this and luckily, I had some experience in terms of using Zoom before.*" Therapist 1 shared anxiety: "*I was anxious in the beginning, thinking if Zoom doesn't work, then what?*" Therapist 2 shared: "*I don't want to pretend it hasn't stirred up fears for all of us. We have our own fears and our clients' fears…and how their fears intersect with their trauma histories, and how our fears intersect with our own trauma histories. Complicated.*"

Bowlby's (1989) theory of attachment offers a useful frame to further explore the therapeutic relationship in telehealth during the age of COVID-19. A therapist's attachment style and the interactions that occur due to the attachment styles of the therapist and the client can also have the potential to influence the therapeutic relationship; there has been an increasing number

of empirical studies and growing recognition that the deepening of client attachment security through the psychotherapeutic relationship is associated with a stronger therapeutic working alliance and can result in more favorable treatment outcomes (Degan et al., 2021). One therapist shared: "*I probably grew up with disorganized attachment, but I could probably lean into more avoidant attachment rather than anxious attachment. I know how to do avoidance attachment well. I've also grown a lot in terms of attachment and developing secure attachment in my own life and helping clients understand secure attachment as one of the main ways I work.*" Another reflected: "*I used to think that I had an anxious attachment, but I really think that I have disorganized attachment, and it's predominantly anxious. But I think knowing my own personal history, there's no way it could not be disorganized. And I'm really drawn to working with people with disorganized attachment. And I just think that it's because I really understand it.*"

Research subjects shared their reflections related to their own attachment styles and how they experienced changes in the therapeutic relationship in terms of attachment styles with their patients as they moved through the COVID-19 pandemic and shifted into telehealth. One therapist shared: "*Different clients illicit different stylistic responses in me. I kind of move between a little bit of anxious attachment and a healthy dose of avoidant attachment but keeping an eye on both so I can be present. Does that make sense? So, if I'm with a client who's dismissive and avoidant, it elicits my anxious attachment style. If I'm with an anxiously attached person, I slip right into secure attachment because that brings on my nurturer. But mostly these days, I'm pretty secure.*" Therapist 3 shared her preference for working in-person and wondered if therapists with more avoidant attachment styles preferred working online: "*I have much more of an anxious attachment style and am definitely wired for anxiety. The therapists that I know who are working on Zoom and who love working on Zoom have more avoidant attachment*

styles…It may feel okay to them, but for me…it's like, oh my God, I'm missing the essential

ingredient. There's something different and that can make me feel anxious…I prefer in-person

work." Therapist 4 shared her more avoidant attachment style and how it related to work with

clients: "*I would say that I have an insecure attachment style that I work hard to make secure. In*

terms of how I show up with patients, I can have more of an avoidant style... When someone's in

State One, Zoom has somehow helped me be in terms of interrupting. One of the harder things

for me about AEDP was becoming much more actively engaged…and I can't explain why Zoom

helps me interrupt people and I needed to grow in that area."

Clients with a predominately avoidant or more dismissive attachment style, who may

tend to downplay their distress and take pride in managing symptoms on their own, may feel

more comfortable with online therapy options that they may experience to be as less relational

(Cundy, 2015). When asked further about their experience using telehealth, research literature

shares that some clients may perceive telehealth to be less intrusive and intimidating as

compared to in-person psychotherapy (Simpson et al., 2005; Watts et al., 2021). Findings from

this qualitative study concur. Therapist 2 shared: "*I can see that for clients who are more*

avoidant, it's more relaxing online…and I don't know what that is, but I really, really notice

that…and one client who is very dissociative who is happy to come on telehealth and seems less

inhibited, so this works with his attachment style very comfortably." Therapist 3: "*I would say*

that those with a more avoidant attachment do like this better. Even though the eye contact could

be harder, they don't feel the need to constantly make eye contact with me on the screen. For

those people who are more avoidant, it is more comfortable." Therapist 6 noted how it appeared

to be easier for some clients to make eye contact without feeling that it was "*staring eyeball to*

eyeball." Therapist 13 shared: *"Some people are avoidant and a bit skittish, and some have severe trauma histories...and online they seem to be more willing to take bigger risks."*

Therapist 4 shared that some clients who may have more anxious attachment styles may also feel more comfortable with telehealth: *"I feel like for some people with anxiety, it's better for them on telehealth. The relational piece that can make them anxious...they may have a little more distance online."*

Conversely, those whose attachment styles are more preoccupied or disorganized, considered to be "high reactors" who produce higher levels of cortisol at the least provocation (Gerhardt, 2004), may demand a more relational response and deem online therapy to somehow be inadequate (Cundy, 2015). Therapist 13 shared that she needed to stop the active processing of trauma with several patients given their tendency to dissociate because it didn't feel safe online and that she now sees these clients at her home office in-person. Another therapist shared: *"We must be careful about the patients we interview to see if they have enough safety to not be in-person."*

According to Mateescu (2020), the emotional intimacy and secure attachment in the therapeutic relationship can be more easily created in telehealth if the therapist had an opportunity to meet the client initially in-person. In the findings of this research study, some therapists concurred: *"If I have worked with you in-person, you have a seat with an engraved name on it, that is a permanent seat...and that's your seat forever in my heart. And I haven't really developed that in the same way with the people that I've met only online. That's a weird thing to me. I definitely feel like I have less affection for them. I'm happy to do the work I've done with them, but I don't feel the same closeness."* Therapist 4 shared a different experience in not being able to meet new clients in-person and the experience of emotional closeness: *"We're*

helping patients from the very beginning to have an authentic experience...a drop-down

experience. I think...technology falls away because we're just having this moment together and

they feel seen and heard and moved. I just think after that initial, really couple of moments...it's

different, but we're here."

Threats to the Online Therapeutic Relationship

As discussed in the literature review of this research study, the therapeutic relationship is a common factor that plays a significant role toward psychotherapeutic treatment effectiveness and outcome. Furthermore, the client perception and experience of the therapist as emotionally present can serve as a common factor to deepening a therapeutic relationship.

According to the research findings of this qualitative study, threats to the online therapeutic relationship that could impact treatment effectiveness include diminished therapeutic presence online and an experience of disembodiment. According to Rathenau et al. (2021), "both attitudes towards online therapy and difficulties perceived by therapists in online therapy can have a significant effect on their therapeutic presence" (p. 1). Therapists in this research study reflected upon their attitudes towards online work. In addition, technical issues and Zoom fatigue were also shared in the findings of this study as potential threats to the online relationship.

Exploring Diminished Presence and Disembodiment

How might our clinical work be impacted when our bodies are not in the same physical space with our clients due to telehealth? Can the Winnicottian holding environment still hold and contain as well over a screen as it can in our offices?

As discussed in the literature review and according to Geller (2020), therapeutic presence is one common factor that can strengthen the therapeutic relationship, and patients who rated their therapists to be present are also more likely to rate the therapeutic relationship and overall therapeutic alliance and session outcome positively, as well. Rathenau et al. (2021) defines therapeutic presence as using body-to-body nonverbal cues to communicate presence which could include having a prosodic vocal tone, leaning forward, gesturing, having an open body posture, and soft facial features. As Geller (2020) shares, trust is generated in the therapeutic relationship "through the synchronization of physiological rhythms and bodily movements, expressed through mutual eye gaze and therapists' mirroring of gestures and expressions of the client" (p. 5). Some studies have found that trust could be more delayed and fragile in video and telephone conferencing (Bos et al., 2002).

Following the abrupt shift to online platforms due to the pandemic and its subsequent physical distancing restrictions, many therapists in this research study expressed both frustration and worry about how they were relating to clients online without the ability to see the full bodies of others, concurring with previous research studies that have begun to explore the complex series of embodied and sensory renegotiations of online therapeutic relationships (Downing et al., 2021). As has been reported in the teletherapy literature (Roseler, 2017), attending to clients' non-verbal communications and emotional experiencing could be particularly challenging online with an identified presence of a digital wall. The research findings of this study concurred with these challenges that can arise online that are different from in-person clinical work. Therapist 8 shared: "*There's something that gets missed in that intersubjective field that happens in-person…There's something about being in-person that is raw…there's not a barrier…the computer provides a bit of a barrier.*" Therapist 1 concurred: *"There's something missing for me. There's*

something about the screen and my patients being in another place…there is a divide for me with the screen…that I'm not feeling as emotionally engaged as I would be in my body in person if both of us were in the same room. But there is something missing, and that's the in-person emotion body-to-body in the same room." Therapist 10 shared: "*I think that there's a film, a light film there…and it isn't quite the same as sitting in the same room."* Therapist 3 expressed what is different online: "*I can't give you a box of Kleenex. I can't take a shawl and give it to you to put on. I can't pour you a glass of water…like your energy comes into me and my energy goes into you. I have not been able to feel that on the screen…the loss feels like it's bigger than the gain."*

Therapeutic presence and the psychobiological attunement that accompanies it is an experience of sensing someone deeply with the therapist experiencing the patient in their own body (Bucci, 2012; Lipton, 2020; Siegel, 2017). The inability to welcome our patients' physical bodies into their offices and sit together in the same space has been perceived and experienced by many therapists in this study to be a significant loss and area of concern. Many therapists reflected on this loss. Therapist 12 shared: "*We have to consider what we're missing when we don't see somebody in-person, or not know what they look like or how they move physically…how you sense a body and energy in your office."*

Some therapists reflected on explicitly asking clients about their physicality since they are not able to meet them in-person and view their full bodies. Therapist 13 stressed the importance of inquiring about the physicality of clients: "*The other day I had a surprise because I was working with a young woman and, it was something like session number 15…and she mentioned that she's 6'2" tall. She lives in California, and I had never met her. I would never have known. But that must have influenced all kinds of things in her development, and how she*

sees herself in the world. I'm also working with a man who was severely bullied as a small boy and he's only 5'6"so maybe I need to start asking how tall people are." Therapist 3 reflected: *"It's weird to me. I don't even know how tall the clients are, or if they have feet or legs. I don't know what they do with their feet or how they're sitting."*

Therapists further reflected on how important it can be in remote work to explicitly work with the body: *"What it's done is brought me to the body, even more than if it's hands-on. That might be how it's upped my game in terms of AEDP, making use of the somatic element. Just inviting people to notice whatever's happening in the body and just dropping in…it's about really, really, really going in slower and staying with."* Therapist 5 shared: *"When you don't have the full body to see, I may use more gentle reminders for people to keep in mind to notice when parts of your body that I don't see might be moving…I've had to do that more now because I don't have the visual cue of that. I mean, I always paid close attention to this, but somehow it feels like I've placed more of an emphasis on the somatic markers that I can see or really stay attuned to the breathing or changes in breathing patterns."* Therapist 13 concurred: *"Maybe because I can't see somebody's body, it makes me more likely to inquire, which is a good thing, you know? Not so much that I get the information, but so they reflect on it themselves…'What do you notice in your body? Do you feel a shift in energy? Do you feel something? As you say that, where do you notice it happening inside your body? I think that I might be doing more of that because I can't see them.*"

As Geller and Greenberg (2002) have also identified, "it's just not listening to the words, listening to the tone, listening to what the person's bodily experience is…but somehow listening with my body to their bodily experience." Similarly, as Sheryl Brahanam (2014) has observed, it is the therapist's ability to use their own body and finely attuned sensing capacities, that can truly

pave the way for authentic therapeutic presence. Research demonstrates that humans in close physical proximity can and often do sync and co-regulate in heartbeat, cortisol levels, respiration, even brain waves (Zhang et al., 2020). Physical bodies unconsciously communicate with each other and can contribute to felt experiences of well-being; when human bodies are not together, co-regulation changes and nervous systems can be distressed (Galbusera et al., 2019). Many of the therapists also wondered aloud about how not being in the same physical space with their patients and how this might somehow influence the work, considering how patients are not able to use physical proximity to the therapist to regulate their nervous systems. How are patients affected by the lack of enhancement, that is, not being able to borrow from the energy of clinicians' nervous systems and the slow, low, and sturdy presence of being in the same physical room? As reflected upon by *Therapist 3*, *"humans are wired to not feel safe alone; it is part of our primitive architecture to physically regulate each other."*

Therapists in this research study missed the physical body and energy of clients in the same room, feeling that the screen might act as a barrier, explicitly naming their felt sense of the change in the intersubjective energy field in the telehealth experience. The findings of this qualitative study concur with research that considers embodied relationality to be a necessary and significant part of effective mental health treatment since it provides the client with the opportunity to feel felt, met, and more fully understood and allows the therapist to stay grounded within difficult emotions (Gellar, 2020).

Some of the therapists in this qualitative study experienced therapeutic presence to be diminished in online platforms. Therapist 3 addressed this experience of diminished presence, *"Sadly, the felt sense of presence feels diminished to me...'Can we replicate the conditions of being in the office together because we both know that it's so rare to have this much attention*

that you give yourself and that's focused on yourself…so, let's protect it in all ways that we can. But the…background noise, multiple devices around them and things popping up on their screens…that definitely affects the quality of their presence…'do you have the television on?' That definitely, I think, affects the intimacy…For me, there is less of a quality of intimacy on screen." Therapist 10 shared*: "I do feel that there can be these subtle issues of connectivity. I don't just mean technological. I mean, human to human, that must get worked out."*

As reflected upon by the findings of this qualitative study, considerable difficulties could potentially arise if there is an assumption that the embodied nuances of in-person treatment can be effortlessly transported into a two-dimensional space. Traditional embodied forms of relationality could get lost within technologically mediated online spaces.

Enhancing Presence and Embodiment Online

As COVID-19 was declared a global pandemic and psychotherapists rapidly shifted their work to online technology, it became immediately apparent that clinical skills may need to change or be adapted for online work (Prenn & Halliday, 2020). Therapeutic presence online can be strengthened in many ways (Geller, 2021; Prenn & Halliday, 2020).

The findings of this qualitative study concurred with previous reflections and research studies and offered suggestions on how to increase therapeutic presence online. Therapist 10 offered: "*I just have to really count on my voice and leaning in and really working to use this tool as best I can…I think there's a film that once it's addressed and regularly addressed and ongoingly addressed in some periodic fashion that I believe can be mitigated to make a therapy really still very good."* In addition, Therapist 10 shared: "*I think slowing down is the holy grail…and we really do have to slow the whole thing down…and in that way, pieces become*

really bite size, and we can chew on them for a longer time and make use of it." Therapist 13 concurred and reflected on slowing down in online clinical work: "*I know how dramatic slowing down is for the whole system for me and the client."* Therapist 14 shared: "*AEDP just pulls me into the process and helps me to be more fully present and fully involved…There's something about it that just engages me in just a more full-hearted way...and we can explicitly create an environment where someone can be more direct with us and more open."*

Technical Issues

MacMullin et al., (2020) report that a therapist's comfort and experience with technology or a lack of technological expertise could lead to negative views about telehealth treatment and effectiveness. The therapists in this study shared a multitude of nuanced reflections about how technical issues arose in online therapy and how they addressed these issues. As shared by Therapist 4: "*I haven't seen any reduction in the quality of therapy because of technology. What I have noticed with telehealth is that sometimes people are just more distracted."*

Research subjects shared that the technical challenges they encountered could be distracting for both clients and therapists, including the computer freezing, pop-ups on the screen, lost connection, weak internet access. Therapist 3 shared: "*The thing that I have found disruptive, especially if people have a Mac, is that iChat could come up on their phone…and then there are texts coming up on the screen."* Therapist 10 referenced other technology challenges: "*The other thing that is hard is even if the visual is okay, if the audio is not lined up or if the connection freezes."* Therapist 13 reflected: "*I get tired of being kicked off the internet by the stupid service…and I've had to call my providers and say, 'what the heck's going on?'*

Every subject in this qualitative study was asked explicitly if they felt that the technical issues that they experienced affected the therapeutic relationship. Universally, all the therapists acknowledged the technical issues that they faced, but also offered strategies on how they made repairs. Therapist 13 shared: "*For most of my clients, we've been kind of humorous about it all together and have seen it as like a mosquito in the room. Or like getting stuck in a traffic jam and you say to your kids, 'It's okay. We're stuck in a traffic jam' and you just kind of make it okay enough. So as the secure base for my clients, I can say, 'It's all right. We can handle this.'*"

Although all therapists in this qualitative study reported technical issues, especially early in the pandemic, they also universally felt that these issues could be repaired and that secure attachment in the therapeutic relationship could be addressed and maintained. Therapist 5 elaborated on therapeutic relational intimacy: "*There are all kinds of disruptions that can break moments of intimacy. I lean back into the idea that if you have established the intimacy already, these things don't break it at the core level. I feel that a good therapeutic relationship is a good therapeutic relationship…and I always see a therapeutic moment, no matter what it is. I sort of turn the lemon into lemonade and say, 'Let's just take a moment to appreciate that we just got through this annoying thing together and that we hate this, but we're getting through it.' I'm explicitly acknowledging it. I'm not ignoring it. I'm not glossing over it. They're not alone with it…and we laugh together, and I think when people laugh together, that brings us closer.*"

Békés & Aafjes-van- Doorn (2020) found that therapist experiences of feeling tired with technology could also influence attitudes about online psychotherapy. Many therapists in this qualitative study shared how they experienced Zoom fatigue, particularly during the pandemic, but how they made use of enhanced self-care to address some of these effects. Therapist 3 described: "*When I click off at the end of the day and close my computer, I feel much more*

fatigued…When I worked at the office, I might put on my back-pack, turn-out the lights or tidy-up something and I can still feel the energy of the people with me and still feel a little buzzed. But I don't feel that on Zoom. It feels flat and that is sad to me." Therapist 10 shared: *"I just needed to seek other routes to get a little bit more support so that I could feel resourced and present to the hardships. I just had to keep doing a little bit more of my own self-care to stay just a little bit ahead or to be able to be with in a meaningful way."*

Exploring the Impact of Negative Beliefs about Telehealth

The therapeutic relationship has been considered a significant aspect of treatment dating back to Freud and his early writings on the value of maintaining "a friendly atmosphere" in collaborating with patients (Freud, 1953). What do mental health therapists think about the impact of technology on creating and maintaining intimacy in the therapeutic relationship? Some debate has existed as to whether an adequate therapeutic relationship can be formed between therapist and client, when therapy is delivered through telehealth (Norwood et al, 2018). Do mental health clinicians hold negative attitudes that interfere with their willingness to use telehealth? As discussed in the literature review, most psychotherapists were immediately challenged to abruptly shift their clinical practices to telehealth after the World Health Organization officially declared COVID-19 as a global pandemic. According to Bekes & Dorn (2020), many initially viewed online work with negative skepticism. The findings of this research study supported concerns that therapists believed that their clinical work might suffer online and that their work might not be as effective: *"I had flickers of concern that my work wouldn't be as good as it is in-person…and that I wouldn't be able to accompany them through the screen, that my clients wouldn't be able to feel connected to me and connect to do the work."*

As discussed in the literature review, psychotherapists have held longstanding negative biases against telehealth oftentimes with minimal enthusiasm for online work (Richardson et al., 2019). Despite the growing empirically supported literature on the effectiveness of telehealth, there still exists some reluctance for mental health clinicians to fully embrace telehealth (Norwood et al., 2018; Rathenau et al., 2021). It has also been suggested that therapists may underestimate the quality of the relationship in telehealth (Connolly et al., 2020; Rees & Stone, 2005). According to Rathenau et al. (2021), negative beliefs could decrease therapeutic presence and negatively impact the therapeutic relationship. However, attitudes towards working online have been shown to improve with use for both clients and clinicians (Reay et al., 2020).

From the findings of this study, 8 therapists preferred in-person work and 7 therapists expressed a preference for telehealth (or a hybrid approach). It could be surmised that with ongoing use, more therapists may come to prefer this way of working or begin to experience decreased negative attitudes or beliefs about telehealth. According to the findings of this research study, some therapists expressed views that their clinical work in-person work might be better as evidenced by the reflections of Therapist 1: "*I prefer telehealth for the convenience…but feel* that *in-person is probably more therapeutic…and I feel that I could do a better job in-person*."

Research suggests that clients can not only benefit from online therapy but can also develop a positive online therapeutic relationship (Cook & Doyle, 2002; Reynolds, Stiles & Grohol, 2006). Yet, despite this research, findings from this qualitative study and other previous studies confirm that therapists tend to hold more negative view towards telehealth therapy and the possibility of developing a positive alliance online (Baker & Baker, 2021; Rathenau et al., 2021; Rees & Stone, 2005; Wray & Rees, 2003). According to Rees & Stone (2005), negative views about online therapy could potentially impact how therapists approach online work and

bring with them biases that might serve to inhibit the potential to generate a deeper therapeutic online relationship. According to Rathenau et al., (2021) when attitudes toward online therapy increase by one point and are more positive, therapeutic presence (which is a common factor that can enhance the therapeutic relationship) also increases. The research suggests that these beliefs or attitudes held by therapists about the online experience can influence psychotherapy and the therapeutic relationship and bringing awareness to these beliefs can be useful (Aafjes-van Doorn et al., 2020).

As Reay et al. (2020) suggest in their research, therapists begin to become more comfortable with telehealth with initial reservations dissipating over time. Findings from this research study concur: "*But I did that struggle and I just kept being with it. I think that was heartening. That was the thing to do…just be with it rather than fight it or try to fix it. Just turn toward it. If anything, one of the things I said a lot was just turn toward it. Let's just turn toward it.*"

Specific Factors of AEDP Online

According to Prenn & Halliday (2020), as the COVID-19 pandemic spread across the world, it started to become immediately apparent that the AEDP therapist community might need to adapt skills for online psychotherapeutic work. They also shared that the very qualities that make a good AEDP therapist can make a more than "good enough" AEDP teletherapist and that the same skills and interventions that enable accelerated attachment, connection and processing of material translate well to establishing positive therapeutic relationship through online platforms.

During the COVID-19 pandemic, online therapy was often the only or most viable option, and any comparisons between online and in-person interventions were less meaningful (Sloan et al., 2011). Research subjects in this study expressed gratefulness and relief for telehealth being a way to not only reach clients who might otherwise be alone, and they themselves be unemployed. Therapist 5 shared "*I'm so grateful to have a place that I can work, a way to work and a practice that has gotten even busier during the pandemic...where I can work safely.*" Therapist 13: *"It's kind of remarkable that we ended up in lockdown right at the same time as Zoom was available and we were able to meet with each other online. It's a miracle...cause if out of the blue, we were completely unemployed, all of us who are self-employed...that would've been really kind of a problem...That's why when people complain about Zoom, I think, well...consider the alternative."*

The utilization of online therapy will most likely continue to develop and expand long after the current global crisis has ended. As findings from this and other research studies have revealed, it may be significant for therapists to substantially reflect upon or rethink how they believe their ways of practicing through telehealth may be different from their ways of practicing in-person. (Downing et al., 2021; Geller, 2020). It also may be helpful to view online therapy as a unique therapy approach vs. as a secondary or merely alternative way to deliver mental health treatment.

Research subjects openly reflected on the different relational experience that they also felt to develop when therapeutic relationships begin online, without any earlier or prior physical acquaintance which concurs with findings from other studies (Ronen-Setter & Cohen, 2020). One therapist in this qualitative study shared that the sense of closeness that she experienced with clients online was significantly different from those she had welcomed into her office,

bringing curiosity to her feelings that somehow, she felt more emotionally invested in those clients with whom she had met in-person: "*I have this analogy…that I feel like I have an auditorium in my heart. And if I work with you, you have a seat with an engraved name on it, that you have a permanent seat. And that's you seat forever in my heart.*"

Universally, therapists in this qualitative study shared that AEDP clinical skills translate well to the online setting and experienced their clinical work online to be effective. One therapist experienced herself to be even more effective online than in-person which is contrary to research literature in which many therapists initially viewed the transition to telehealth pessimistically and may have believed themselves to be more effective in-person (Bekes & Doorn, 2020; Rathenau et al., 2021) Therapist 4 shares*: "My sense is in some way that I feel a little more effective by Zoom than I did in-person…this is what's curious to me. For me, there's something about the state one to state two work that is easier for me on Zoom. I'm not so confrontational, but I find on Zoom that I have an easier time taking a more active stance. I don't know why there's something for me about the distance that Zoom provides me…it allows a little more agency for me to just go in there…and lean in more. We're also much closer in this strange way. When I'm sitting with someone in-person, they're much further away from me. So, to me, I'm very close to them…I haven't seen any reduction in quality of therapy because of technology.*"

At the time of their interview last fall 2021, some subjects reported no significant difference in how they used their clinical skills through in-person sessions vs. telehealth while other therapists had more nuanced reflections about how they used AEDP online. Working through telehealth is not totally comparable to in-person work and there are some differences in therapeutic interventions (Connolly et al., 2020; Hunter et al., 2020). The findings of this qualitative study concurred with some therapists sharing more nuanced differences in the way

that they practiced online. As Therapist 7 expressed: "*I think just being online can act as a barrier in some ways. And I think it's just important to be aware of the impact we're having on a person. So really checking with them and being aware of the relational factors and not just assuming that it's going to be exactly the same as being in-person.*"

As discussed in the literature review, moment-to-moment tracking is a foundational AEDP intervention and clinical skill. Many therapists shared how they had become more proficient in noticing more subtle movements and changes in facial expressions. Therapist 2 shared: "*I do more tracking of the face because that's all you can see, but then I also really fill in what I don't see. I try to fill in what I think is happening from shoulders down. The face is so close and that really brings in the social engagement system in a different way. I really try to work with that and really use that…their eyes did something that I might not have caught, or the feeling state is in the face.*" Therapist 3 expressed: "*What has been pretty enhanced is the ability to track people. I can't track your whole body, but it's pretty tough to miss anything that happens on somebody's face. It has been my sense that we can all become excellent facial trackers.*"

Another foundational tenet of AEDP discussed in the literature review is making the implicit explicit or bringing into dyadic awareness the moment-to-moment phenomena of the therapy process (Lipton, 2021). Making the implicit explicit was also shared by research subjects to be an AEDP skill that they made use of even more frequently than online. Many research subjects acknowledged that online work requires them to be present and active in more explicitly expressed ways. Research subjects concurred that "it may be essential that we make our implicit presence explicit with our words and our breaths and our faces and our embodied selves" (Prenn & Halliday, 2020, p. 2). Therapist 3 shared: "*It has been really good to make the implicit explicit. And then to make it relational. So as soon as I meet people on screen, I might say therapy is a*

weird experience…which it is…it is weird to go to somebody's office to meet with someone that

you might not have ever seen or heard of before. You walk-in and start talking to somebody and

telling them things about yourself without really knowing them. It's a weird thing going to

therapy. And now it's even weirder to do the magic carpet ride. Boom. You just instantly appear,

right? So now I just name it and I might say, 'I'm making a house call to your home, and you

don't even really know me.'"

    According to Prenn (2011), the therapist's being explicit about her personal emotional

experiences and being able to use judicious self-exposure can contribute to the forming of a joint

process of shared experiences that can support the client's progression towards healing. A meta-

analysis of 95 psychological studies documented that self-disclosure could lead to a greater sense

of emotional closeness (King, 2018) and many research subjects elaborated on how they made

use of this skill during the pandemic. Findings of this qualitative study concurred with the value

of judicious self-disclosure with therapists sharing nuanced reflections. Therapist 1 shared: "*I'm*

much more transparent now. I will be willing to be much more transparent and much more

willing to be engaged as a person coming back, having had this experience, but I'll try to bring

that back in-person. And I won't be so afraid to talk about my kids and my dog and my partner to

clients where I might not have before in-person." Therapist 10: "*I've done more revelation*

because I think the more dysregulated and distressed people have been, the more it has helped to

know that I've gone through things like this. I totally understand what they're talking about. I've

done more self-disclosure."

Disadvantages of Telehealth

Cantore & Milacci (2008) report that online therapy has many disadvantages as well as potential advantages. As previously discussed, factors that might negatively impact the online therapeutic relationship include diminished presence and disembodiment, technical distractions and Zoom fatigue, and negative beliefs about telehealth (Rathenau et al., 2021). The most frequently acknowledged disadvantage of telehealth that was reflected upon by the findings of this qualitative study was associated with the therapist not being physically present in the same room as the client with several therapists reporting a diminished experience of therapeutic presence online. As discussed, therapeutic presence is a common factor that contributes to building a stronger therapeutic relationship and secure attachment.

Therapists in this research study offered a multitude of nuanced reflections concerning the disadvantages of not being in the same physical space as their clients and not being able to experience clients' energy in the room or see their full body. Therapist 15 reflects: *"If we lose in-person, that's heartbreaking because there is something about being in a room with someone that's really important…the human contact."* Therapist 7 offers: "*I think the general factor of a lot of early relational trauma and attachment issues…with more depression and a lot of loneliness in their lives, these clients clinically need in-person treatment…Some people clinically, I think just do better when you're in-person. The overall issue is really needing to feel my presence in the room, my sense of emotional holding."*

According to the research findings of this qualitative study, teletherapy is not indicated for all clients. Telehealth has been a significant way to maintain social connection and reduce experiences of isolation, particularly during a global pandemic where the ethical mandate was for

prioritizing the safety and physical well-being of both therapists and their clients. As the risk for COVID-19 infection has been significantly reduced and therapists are returning to their offices, the findings of this research study highlighted that choices could now be made between in-person or online work. As therapist 13 shared: *"I think there are some people who really just need to be seen in person. Like I have a couple of clients who are at a place in the work where they need to do a lot of effective, direct affect processing…and I think they are really helped by being in the same room with the therapist."* Therapist 7 elaborated further on the difference between in-person and telehealth: "*Maybe there's not yet a whole lot of stuff out at this point in terms of significant difference between telehealth and in-person, but I think there is a difference. I think some clients really need the in-person contact, and it has a major impact on them."*

Replacing all in-person sessions with teletherapy could lead to negative consequences on the mental health and emotional well-being of individuals who suffer from significant social isolation, loneliness, depressive and potentially suicidal symptoms that might need and potentially require an in-person setting (Luiggi-Hernandez & Rivera-Amador, 2020). As discussed in the literature review, the loneliness epidemic was exacerbated by the COVID-19, and the public health intervention of social distancing contributed to loneliness. Therapist 4 reflected: "*I can think of two people who are both single, live alone and are now working from home. There's a loneliness. They miss the physical presence of being in the room with me."*

Using teletherapy primarily for convenience or ease could potentially pose the risk of eliminating the social and physical contact that some bodies might require for an embodied closeness that can facilitate deeper healing, potentially more rapidly (Luiggi-Hernandez & Rivera-Amador, 2020). Therapist 11 shares: *"I have a handful of clients that are really explicitly saying, 'Are you gonna come back? I feel like I do better work in-person.' I'm getting self-*

reports that some clients just feel safer and more connected to really do deeper work in-person."
Therapist 5 concurs: *"I think it's harder for people to really drop down in significant ways. I really do."*

According to Baker & Baker (2021), therapists need to screen clients for online suitability since it might not be effective for everyone. According to Simpson & Reid (2014), some of the disadvantages of telehealth include its unsuitability for certain types of patients with schizophrenia, psychotic disorders, or those with more paranoid traits, for patients with significant histories of childhood abuse with symptoms of more severe emotional dissociation, or for patients who may be suicidal or in the presence of an intimate violence partner perpetrator. Simpson & Reid (2014) have suggested that online therapy may be unsuitable for clients with symptoms of dissociation and emotional dysregulation. Therapists in this study shared more nuanced responses and experiences working with more dissociative clients. Therapist 1 shared: *"I have a client who's on the DID spectrum and he prefers telehealth because he's in the safety of his own home. And he has let me in, into his interior world, much more on telehealth than he ever would in the room. It's safe for him. So, the telehealth has even been better for him."* Therapist 2 concurred: *"I have one client who is very dissociative and is happy to come on telehealth and seems less inhibited."* While *Therapist 13* expressed that for some dissociative clients, in-person treatment may be indicated: *"I work with pretty dissociative people…and for some really dissociative people, telehealth is absolutely not ideal…With two clients, in particular, the active processing of trauma has stopped because it doesn't feel as if, given their tendency to check out totally, it's safe…One of them now actually is coming out to see me, but it still feels a little like I need to be really careful. But they're so much happier now that they can*

just be in my physical presence…but those are, you know, in the bell curve…those are the most distressed."

In concurrence with the research literature as discussed in the literature review of this study, therapists also reported increased experiences of loneliness as a disadvantage in telehealth work. Therapist 7: "*I think just not having the personal contact as much for me. I mean…it's just different, at least for me that I really appreciate the contact in my office."* Therapist 2: "*I don't see someone in the elevator or chat with them anymore at my building. I know a lot of people and I just don't see them anymore. I have battled isolation, not so much now but during the first half of COVID. For a long time, I really didn't go out. I was just sitting all day in front of a screen."* Therapist 15: "*I felt so cut off from people and everything else in my life other than my family and I needed something beyond work and family."* Norcross & Phillips (2020) report that the use of helping relationships and seeking support from a community of peers is positively correlated with psychotherapist well-being, just as social support does with laypersons.

Advantages of Telehealth

Telehealth has improved access to mental health treatment reducing potential barriers that might include the inability to take time off work for appointments, family responsibilities, or lack of transportation. As shared by the President of the American Psychiatric Association Vivian Pender, MD "the quick pivot to providing telehealth services at the start of the pandemic was vital to providing continued access to care and shows the important potential role for telehealth going forward." (APA press release May 27, 2021). As discussed in the literature review of this dissertation, the expansion of telehealth has been welcomed by most Americans. While some studies suggest that clients favor in-person therapy over online therapy (i.e., Berle et al., 2014),

other studies suggest that clients generally do not have a preference between in-person or online therapy (Simpson & Reid, 2014). Some research studies are indicating that clients may not have the same expectations of forming an affective bond and connection with the therapist through telehealth that they would have through in-person therapy (Berger, 2017). Therapists in this research study also shared reflections that many of their clients had no real preference for in-person or online work. Therapist 11 attested: "*I would say three-fourths of my case load either prefers telehealth or are really okay either way and would be just fine continuing this way*." Clients who have received internet-delivered interventions have reported that they are satisfied or very satisfied, describing the advantages of telehealth, such as its accessibility and convenience (Reay et al., 2020). Therapist 3 shared: *"I'm doing a good enough job online that people are having a good enough experience and things are happening. So, they're happy to stay remote."*

According to the findings of this qualitative study, all the therapists have universally attested to the convenience and accessibility of telehealth as advantages for both themselves and their clients. Therapist 1 shared: "*Quite honestly, I might be lazy enough to want to do telehealth because it might suit me and my lazy patients who want to just do it from home. It's more about the convenience of it. And it works just as well for them and even better with their lifestyles.*" Silver et al. (2020) points to early evidence that show a decrease in missed or cancelled appointments upon switching to telehealth sessions which might be due to increased need for connection, particularly timely moving through a global pandemic or barriers to attendance are significantly less. Therapist 3 in this qualitative study reported fewer cancellations or missed sessions: "*They never miss therapy where before they might miss. Very few people miss sessions, and I hardly ever get cancellations because it's pretty hard to miss…and nobody's late.*"

Federico (2020) shared that telehealth allows some clients to express their emotions and difficult experiences more readily in the safety and comfort of their own homes, allowing them to access private inner aspects of themselves and do deeper work. A growing number of researchers have been reporting that some participants have even shown a preference for an online therapeutic working alliance rather than a relationship which involves being in the same room as a psychotherapist (Richardson, Reid, & Dziurawiec, 2015; Simpson et al., 2005). Online therapy can offer novel ways to form strong therapeutic relationships with a variety of clients and may possibly facilitate an even stronger therapeutic intimacy than face to face therapy and unknown possibilities for closer emotional experiences that perceived distance and greater space may potentially evoke (Chen, 2021; Kocsis & Yellowlees, 2018). Therapist 13: "*There are some things about being online that are so intimate that I really love it…And I know that inviting people to imagine things has the same effect almost as doing them…and we can do that online. We can get everything we need online.*" As reflected upon by therapists in this qualitative study, communicating by way of technology could facilitate an experience of an emotional distance which might allow some clients to feel more comfortable and thereby develop a stronger therapeutic relationship. Therapist 2 shared: "*I can see that for those clients who are more avoidant, it can be more relaxing.*"

Simpson & Reid (2014) have suggested that the physical distance and use of online technology may provide clients with more control and authority over the session. Mateescu (2020) addressed the power imbalance of social class and how telehealth may help people to feel more at ease to express themselves. Suler (2004) references the phenomenon of disinhibition which may help clients feel more uninhibited or free to express themselves more openly online. Therapist 12 shared: "*There are some clients that I have felt telehealth has helped us to go way*

deeper…somehow, they are doing better work on telehealth than they ever did in-person…whether they're more comfortable in their own home, whether there's a bit of that separation that helps them."

According to Ehrlich (2019), telehealth may serve to enhance the depth, connection and intimacy between therapist and patient. Several therapists explicitly stated that they experienced enhanced intimacy in the online therapeutic relationship. Therapist 12 shared: "*In some ways there is enhanced intimacy online…being able to see people's faces up close is quite powerful…There is intimacy in seeing into their homes and seeing their backgrounds and their pets and hearing the noises of their households.*" While other therapists expressed different views about the experience of intimacy online and did hold views that online therapeutic presence was diminished: "*I feel more surgical in an odd way. On Zoom, I feel more technically proficient, like I create an experience vs. in the office I feel like we're in the experience together…and the felt sense of presence was diminished to me. I sometimes feel like a champagne without the bubbles.*" Chen (2021) reports that the online intimacy may understandably evoke skepticism and negative beliefs among therapists who pride themselves on their clinical skills of warmth, empathy, and authenticity.

As the findings of this qualitative study concur, there may be advantages for some clients in feeling the comfort of their home environment during clinical sessions. According to Prenn & Halliday (2020), pets and companion animals may promote unconditional positive regard and bring comfort to clients as well. One therapist in this study reflected: "*I have a guy that has a huge dog. He used to bring the dog with him to the office, but now the dog has cancer, and he can't bring it with him. But he can still hang out with the dog while he is doing the session online*

and that's been very comforting for him." In contrast, therapists also expressed concern that their clients have a private place to attend their sessions at home. Therapist 7 elaborated on some of the ethical issues that might be related to telehealth at-home sessions: "*There will be more that comes out about the ethical stuff and all the boundary issues…there's the factor of family members being around. Sometimes that's good and sometimes it's not so good because they don't have such great boundaries. And then, how do you deal with a safe place when you have family members around, and they don't have another place to meet? There's a lot of different factors and I think, over time, some of that will be spelled out, and we probably need to pay attention to these kinds of variables."* According to the American Psychological Association (2020), best practices start with ensuring that the client is in a safe and private location, and in a quiet space where they won't be overheard.

Previous research studies also suggest that telehealth can be advantageous for clients with significant histories of shame linked to eating disorders, body image disturbances, and self-consciousness about their body, with telehealth facilitating a degree of safe engagement or distance (Baker & Baker, 2020; Simpson & Reid, 2014). In concurrence with this research, therapists expressed the view that the online space might, in some ways, free patients from experiencing the inhibitions or constraints of the physical body. *Therapist 2* shared her own bodily experience: *"I guess if I consult my body, my body feels more comfortable at home. And maybe if I look at it a little deeper, nobody has to really look at my body. I never thought of it like that."*

Recent studies comparing in-person and telehealth sessions showed comparable therapeutic alliance and treatment outcome for working with panic disorder and agoraphobia

(Bouchard et al., 2020), and a stronger alliance working online with individuals who have generalized anxiety (Watts et al., 2020). The physical distance of remote work might provide clients with more authority or a sense of control over the session with clients who experience social anxiety to feel more empowered through telehealth (Cipolleta & Mocellin, 2018). Findings from this qualitative study show support as shared by Therapist 12*: "People that are socially anxious or it's hard to leave their home, they've really benefited from teletherapy."*

Nagarajan & Yuvaraj (2019) have suggested that online therapy is more appealing for younger adults who are comfortable using online technology. Findings from this qualitative study concur: "*I would say definitely the college students and ages up through their 20's and up through their 30's love it because they're all online anyway. For them, they would all prefer it…but whether it's the best for them is debatable.*" Therapist 3 agreed and expressed similar concerns: "*As I query my patients…the ones who are not wanting to come back in-person, it's not because they're afraid of COVID, it's because they're young and none of them are going back into their offices anymore. And when they used to be in Midtown and hop on the train…now, they're in Brooklyn and in their pajamas working. Why would I want to get dressed and go to therapy when I can just do this…And unfortunately or fortunately, I'm doing a good enough job online that people are having enough good experience and things are happening so they're happy to stay remote and it's so much easier…but I have grave concerns that psychotherapy has changed permanently to be much more Zoom focused. I'm worried about this.*"

Treatment conducted over the telephone suggests advantageous and positive benefits across a wide range of studies (American Psychological Association, 2020). Systematic reviews offer findings to demonstrate that teletherapy delivered by video and by phone are both effective

for anxiety, depression, and adjustment disorders (Irvine et al., 2020), and that telephone-delivered psychotherapy has an adequate treatment adherence that is like in-person psychotherapy (Castro et al., 2020). According to Cundy (2015), the freedom to limit visual sensory information and stimulation can be experienced by some therapists as a way of enabling work at a deeper level. When a clinician does not have the visual stimulation of a patient in front of them, more focus and attention might be given to tone and rhythm of voice or their breaths.

Therapist 1 shared: "*I find phone sessions have a different depth…you don't have to worry about the visuals and the screen. You're just hearing the voice and a quality of voice. You can hear even more emotion in the voice in a way that you're losing on the screen. Honestly, we can get distracted on the screen. I mean, emails can drop in or messages can drop in for them too. I find phone sessions have another deeper quality which I like.*" Therapist 4 concurred: "*There is something about the Zoom and the staring at the screen and just the intensity of eye-to-eye, moment-to-moment tracking…With a phone session, I can just close my eyes and just listen…and track by listening…Sometimes when I switch to phone sessions, those sessions can sometimes be deeper in a way that I think frees people up a little bit. It frees me up sometimes a bit…those sessions can end up being very deep.*" While other therapists have expressed reservations about the delivery of psychological therapy by telephone with apprehensions focusing on the quality of the therapeutic relationship and concerns about treatment in the absence of visual cues, reflected upon by Therapist 8: "*Thankfully I only have one client who I speak to over the phone. I don't feel like I can go very deep when I can't see who I'm talking to.*"

Group therapy has also transitioned to telehealth and there is limited evaluative or comparative research of online group work (Weinberg, 2020, 2021). Therapists in this qualitative

study shared that they miss providing in-person group therapy and also "*find that on Zoom groups can be fun…and work really well.*"

As discussed in the literature review, online therapy initially began to accommodate the needs of clients who lived remotely or had limited mobility (Sloan et al., 2020). Telehealth has the distinct advantage of opening access to all who may need treatment, although there might still be internet connection barriers or socioeconomic concerns. As discussed in the literature review of this dissertation, inequity and inequality abound in this age of the COVID-19 pandemic. There are important socioeconomic barriers that may impact the provision of effective teletherapy services. People with lower financial resources may not be able to access the Internet or own home computers, while many might not be able to afford psychotherapy or the health insurance that could assist them in paying for treatment. As noted by Therapist 7: "*Some people have better connection than others…there are mountains…and some clients are pretty well out there in the rural area where connection might be on and off. Others might not have the resources to do telehealth.*" Other therapists shared how online platforms open the global community. Therapist 13 reflects: "*I really love it because I can work with people all over the world and feel connected in a way that I couldn't otherwise.*" Therapist 7 shares: "*I can meet people all over the world or do groups and bring people that wouldn't ordinarily talk with one another together.*"

Although telehealth has been experienced to be effective by both therapists and clients in this research study, there are further ethical implications to unpack and more deeply consider. From this qualitative study, there have been no findings that teletherapy should replace the face-to-face and in-person therapeutic encounter. Teletherapy might not necessarily be the right

model of care for every client, and considerations need to be made in providing the appropriate level of care for all clients.

Shared Trauma and the Therapeutic Relationship

As discussed in the literature review of this dissertation, shared trauma or shared traumatic reality describes the experiences of professionals who are exposed to the same community trauma as their clients (Nuttman-Schwartz, 2016; Tosone, 2020). During COVID-19, all therapists shared the same collective trauma of the pandemic as their clients in the global community. Therapist 6 shared: "*New York was completely shut down and clients asked, 'What will happen to us?' and 'I cannot sleep.' They were feeling dysregulated and then I felt the same…but their energy just triggered my anxiety because my concern was the same.*"

As discussed by Ronen-Setter & Cohen (2020), during unstable times like the COVID-19 pandemic, sharing by both therapist and client can contribute to the building of a more stable and intimate relationship, thus promoting more endurance and resilience. Undoing the aloneness of the pandemic can support both patients and clients in tolerating the shared traumatic reality (Tosone, 2021). As evidenced by the findings of this research study, the parallel process of shared trauma served to strengthen the connection between therapists and their clients. Therapist 7 shared: "*We were facing a trauma together and it helped to bring us closer…it felt good to experience of undoing aloneness together.*" Therapist 5: "*Clients would say to me, 'I want you to tell me that it's all going to be okay, and I know you can't…and then I just have to say, 'I know'. And then we sit with that together. That's where my Buddhist teachings have been very helpful to me.*" Several therapists reflected how they felt during the pandemic when clients reached out to check on them: "*I felt really touched and connected when clients were reaching out to check on*

me." Therapist 5 reflected on how the therapeutic relationship has been strengthened through the pandemic: "*What happens when you're all going through something together? I think there's something that actually helps the therapeutic relationship and solidifies it, really that sense of we get each other, even if many of us are swimming. We're in different boats, even if we're in the same ocean, we're still in the same ocean and we have that together. Because of the affective base and relational core of AEDP, you've always got solid ways to make people feel safe and you can make that happen.*"

On the other hand, in a shared traumatic reality, a therapist can also develop an altered perspective wherein the line between professional concern and personal caring is seen as superfluous (Tosone, 2006). According to a 2021 survey by the American Psychological Association, 46% of clinicians expressed some feelings of fatigue or burn-out (up from 41% in 2020). The findings of this qualitative study also share the reflections from several therapists related to increased experiences of burn-out or the increased fatigue related to the blurring of boundaries during the pandemic and subsequent working remotely and at-home and burn-out. Therapist 11: "*The lack of boundaries and separation has been tricky for me, and I really hit for the first time, severe burnout. I would say that I got so burned out from the work…and from the collective COVID trauma we were all facing. I was saying 'yes' to so much more… 'Sure, see you Friday, I'm going to be there. We're not going anywhere. No restaurants are open. And that just ended up really leading to massive burnout for me. So, I went back to more boundaries in my schedule which has helped a lot. I learned the lesson that just because I'm here all the time doesn't mean I should be working all the time.*" Therapist 8 shared: "*I just felt like my whole focus and intention was to help them through their crisis, and so I probably took on more clients than I should have and was busier than I ever was…so I barely realized that I was going through*

a traumatic experience too because my focus was so much on what my clients were bringing to

me…what is that thing about the frog and the pot, that the frog doesn't realize at first that

they're even in a boiling pot and didn't find out until much later."

Some of the therapists in this qualitative study also shared that practicing AEDP and having the ability to be relational and authentic in their work supported them in feeling decreased burn-out. Therapist 12 shared: "*You're allowed as a therapist to have feelings…and to show up authentically. You have the reward of the real sense of connection and communication and deep care for your clients. That feels good and helpful at reducing burn-out. The AEDP part of my work has enriched me and boosted me to be able to stay connected to the work in a way that I would have burned out earlier."*

Post-Traumatic Transformational Growth

As defined by AEDP and discussed in the literature review, transformance is the "overarching motivational force, operating in both development and therapy, that strives toward maximal vitality, authenticity, and genuine contact" (Fosha, 2008, p. 292). The COVID-19 pandemic and accompanying shift to telehealth has not only served to transform the dimensional field of psychotherapy and how it is offered but has also fostered transformational experiences in both clients and clinicians. According to Callahan (2020), psychotherapists have been no more immune from transformational experiences than their clients in facing significant and life-changing experiences in the age of COVID-19. Drawing on the research of vicarious post-traumatic growth and vicarious resilience, Nuttman-Schwartz (2014) and Tosone (2006; 2021) have described how shared trauma can lead to numerous positive outcomes including i.e., "greater self-confidence, sensitivity, compassion and hope that can impact the therapist's outlook and therapeutic work" (Nuttman-Schwartz, 2014, p. 189). The findings of this qualitative study

reflected this transformational growth for therapists. Therapist 1 shared: "*I think it shifted in me…knowing that I could do telehealth, and I mean everything has changed and Zoom opened the entire world to me. And it has been amazing to do workshops with people from around the world. I did so much during the pandemic, even in terms of training and workshops, things that I could never have participated with in-person. I have done all kinds of things online.*"

Therapists also reflected on clients who might have faced isolation and a lack of access to mental health treatment and now have been empowered through telehealth. Therapist 12 shared: "*The technology problems would be ranging from the elderly client who had no idea how to work on Zoom, and it would be a transformance victory to learn how to get the mute button off and we would celebrate that…and me helping her to do something else in her life and connect that way during isolation…and AEDP helped to reframe that.*"

As supported by the research findings of this qualitative study, the therapists in this study have continued moved through numerous transformational spirals since the pandemic first hit the world in March 2020. Impacted by the psychosocial stressors of the pandemic and abruptly shifting to online platforms, research therapists shared their increased feelings of Zoom fatigue and, for some, experiences of burn-out. The increased and enhanced implementation of self-care practice strategies was shared by AEDP clinicians to be essential in their well-being and evidenced by research literature (Norcross, 2000; Tosone, 2021). Therapist 1 shared: "*I would say that I do more self-care at home than I ever did at the office. I go for walks. I take a bath in the middle of the day. I have healthy snacks. I'm not running out to buy an expensive lunch or coffee or something. I can lay on the floor. I can listen to music.*"

It is critical for therapists to remain open to the understandable mourning and frustration that has been associated with losing the long-standing and routine ways of relating in-person

with our patients (Chen, 2020). According to Ronen-Setter & Cohen (2020), sharing the loss and mourning the changes of the transition to remote clinical work is significant. Most research subjects have expressed feelings of loss, mourning and even heartbreak when they no longer were able to meet with their patients in the same shared space of in-person office experiences. Therapist 2 shared: *"I miss hugging my clients goodbye…looking at them in the eye, face-to-face where the eye gaze is real. Our eyes don't match up on Zoom. I miss working in-person."*

Universally, all the research subjects have expressed a desire to overcome the challenges of this unprecedented and unexpected time with transformational strivings. Telehealth was not dismissed as unworkable and active engagement in developing new therapeutic relationalities with their clients and engaging in new ways of connecting to clients online has been explored (Downing, 2021).

Implications for Clinical Social Work Education

One of the core theoretical approaches of the social work profession is the significance of the person-in-environment or how important it is to understand the individual with a consideration of the multitude of environmental influences in which that person lives and acts. With this emphasis and understanding, it could be considered a professional mandate to explore more deeply how our increasing technology has impacted the embodied experience of those we serve (Jarrette-Kenny & Jaffe, 2022).

The social work adage of "starting where the client is" has been most acutely and accurately addressed in considering the unprecedented shift of the psychotherapy field from in-person sessions to telehealth platforms brought about dramatically by COVID-19. As discussed in the literature review, the psychosocial implications of the pandemic abound. If clinical social workers are truly invested in the mental health and well-being of their clients and society at

large, advocacy efforts toward substantial social changes to decrease people's suffering must be considered along with the provision of mental health treatment for clients with the most effective and enhanced telehealth options to meet their needs (Luiggi-Hernandez & Rivera-Amador, 2020).

Future Research

Further research that goes beyond the question of "is the therapeutic relationship impacted by the shift from in-person to online work?" and moves towards a consideration of "under what circumstances" and "for whom" and "at what moment" may the therapeutic relationship be strengthened or impacted may be a more refined qualitative inquiry for future and ongoing research. The potential to further enhance and deepen the therapeutic relationship and the ever-changing ways of working with clients through technology is timely and significant and indicated for further study. Matching client characteristics that might include presenting problems, level of comfort with technology, client characteristics and personality style with different modes of treatment delivery may be useful (Simpson & Reid, 2014). More enhanced training and preparation for online context and difficulties that may come up could be beneficial with some studies suggesting a consideration of telehealth with immersive extended reality (XR) technologies that could foster enhanced engagement and presence for both therapist and client (Riva, 2004).

Mitigating any of the negative aspects of telehealth is an emergent area that warrants further study and ongoing research. Supporting therapists to accept the differences in these ways of working yet also acknowledge the benefits may all help improve their attitudes and reduce their difficulties about this modality, thus improving their therapeutic presence while working online (Rathenau et al., 2021). According to Jarrette-Kenny & Jaffe (2022), clinicians must

continue to survey the cyber landscape of the intersubjective, cyber co-created space of telehealth, reflecting on its nuances and differences both individually and amongst other clinicians, before speaking with any certainty about how to navigate the way through this new terrain or to effectively guide others.

Although online therapy has been a rapidly growing field due to the global pandemic, skills needed for online therapy have only marginally included been included in the research literature (Rathenau et al., 2021) and more dissemination of useful information and material in the curriculum of professional therapy programs is needed. When reflecting upon the issues coming up throughout the pandemic and transition into telehealth, *Therapist 7* succinctly attested, *"increased and enhanced ways to write about these experiences and open up community platforms for ongoing reflection and discussion might be useful."* Other therapists in this study also shared their desire for ongoing and enhanced training and peer support, thereby undoing their aloneness of remote work and strengthening community discussion and writing platforms to explore issues. Several therapists reflected on the need for the future of longer-term studies on the differences in the therapeutic relationship that develops in-person vs. online.

Limitations

The purpose of this qualitative research study was to bring further understanding to the impact of the unprecedented transition to telehealth during heightened psychosocial stressors brought about by the COVID-19 pandemic. The limitations of qualitative research can be its strengths. The purpose of this dissertation research study was not to produce findings that could be broadly applied, but instead to bring more understanding to the clinical experience of therapists moving through a global pandemic and transitioning into telehealth, exploring the

impact on the therapeutic relationship, and reflecting on advantages and disadvantages of online clinical work with an attachment lens.

Although the sample size of 15 certified AEDP therapists was small and homogeneous, many of the findings replicate the findings in other research studies. This indicates the possibility of some transferability. Several core categories emerged from the data analysis that describe the phenomenological experiences of the AEDP clinicians and is backed by the literature. These categories fit the theoretical framework of the study.

This researcher is a practicing AEDP clinician who actively worked to maintain the boundary between the role of the researcher and the role of a therapist when interviewing each of the fifteen clinicians. It is possible that, at times, those boundaries were blurred, which may have possibly and, in some ways, affected the findings. This researcher knew many of the AEDP research subjects prior to interviewing them for this study and considered a few of them as close colleagues and friends. Some of the clinicians asked me about the responses and viewpoints of the other clinicians while they were reflecting on their own responses. They were also curious about some of my clinical experiences in moving through the pandemic and working on the Zoom platform. In efforts to support some dialogic sharing, this researcher may have offered some limited biased responses of her experience.

APPENDIX I (RESEARCH QUESTIONS)

Background information & demographics (to be given prior to start of interview):

How many years ago did you finish your graduate degree and what type of program was it?

How many years have you worked in the field post-graduate degree?

Tell me about your practice (i.e., private solo/group practice or agency? Clinical areas of focus/specialty? Do you work primarily with individuals/groups/families/couples? Geographic location?)

How long have you been certified as an AEDP therapist?

What technology do you typically use to see clients virtually?

Did you practice virtually prior to the start of the pandemic in March 2020?

Have you returned to the office to see any patients in-person?

Do you plan to return to the office? If so, what is your plan?

Can you share your race/cultural background?

Warm-up:

Thank you for agreeing to participate in this qualitative research study addressing the questions: ***What has been the clinical experience of the AEDP therapist since the onset of the COVID-19 global pandemic and the accompanying shift towards telehealth? How has the therapeutic relationship been impacted, if at all?***

Tell me about how you came to be an AEDP practitioner?

What have you found to be the most meaningful aspects of practicing AEDP?

What do you consider your strengths to be as an AEDP clinician?

Can you share more about your current level of satisfaction and fulfillment in your clinical work?

Can you share what you consider to be your attachment style?

What is your personal preference, to provide telehealth or work in-person? How come?

_____

Transition to telehealth:

Can you share what the transition and shift to telehealth after COVID-19 was like for you?

Did you experience technical problems?

What technology issues have you and/or your patients struggled with the most?

How do you feel that technical problems have affected the therapeutic relationship?

What has it been like working from home?

In what ways do you feel that telehealth has affected intimacy in the therapeutic relationship?

What feedback have patients given to you about their experience working through telehealth?

Do you think some of your patients do better with telehealth than others?

What was it like to start with a new patient by way of telehealth?

_____

COVID-19 and Shared Trauma:

What was it like to go through a very difficult, if not traumatic experience, at the same time as your patients?

Did you feel like your self-care changed or that you needed to implement any self-care?

_____

AEDP and the therapeutic relationship:

Has working remotely during the pandemic altered the way you practice as an AEDP clinician,

for example: using judicious self-disclosure, therapeutic presence, moment-to-moment

tracking/micro attuning, dyadic affect regulation, metaprocessing

Wrapping up:

Is there anything else that you might want to share about the transition to telehealth during COVID-19 and any changes, if at all, on the therapeutic relationship?

_____

APPENDIX II (Consent Form):

Consent Form

Dear Colleague:

I am a licensed clinical social worker and a current doctoral candidate at the University of Pennsylvania School of Social Policy and Practice. I would like to invite and welcome you to participate in my dissertation research study. The purpose of this qualitative study is to explore the clinical experience and impact of the COVID-19 global pandemic and the accompanying shift towards telehealth on the AEDP clinician and the therapeutic alliance. Findings will be used to enhance and support mental health professionals and AEDP clinicians in their ongoing therapeutic work and clinical training in both telehealth and in-person settings.

This study will consist of a semi-structured interview that will take place on a HIPAA compliant telehealth zoom platform for up to two hours in length. With your written consent and permission, the interview will be video-recorded, and notes may be taken. All your responses will be de-identified, and your participation in this study will be fully anonymous and your responses completely confidential. I will transcribe the entire interview myself into software on my computer. Once it is entered into my software, the recording will be erased.

Participants will be compensated with a thirty-dollar gift certificate for participation in the interview. There are no known risks of participating in this study. I am hoping that sharing and metaprocessing your own lived experience of being a clinician during this unprecedented time can be an interesting and useful experience for you. I will also ask your permission to contact you by email in the following two weeks after your interview to determine if there is more that you might want to add, or for this researcher to ask any clarifying questions.

If you are interested in participating in this research and you are a certified AEDP clinician who shifted to a telehealth platform during the COVID-19 pandemic, please contact me at the contact information provided below. I welcome your interest and encourage you to ask any questions that you might have about this study and potential interview questions. Thank you in advance for your consideration. Your engagement in advancing the clinical psychotherapy knowledge base is greatly appreciated.

Sincerely,

Karen

Karen Tantillo, LCSW

karenta@upenn.edu (770) 296-4842

Signature: _____

Date: _____

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