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Eliciting emotional expressions in psychodynamic psychotherapies using telehealth: a clinical review and single case study using emotional awareness and expression therapy

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Abstract

The COVID-19 pandemic and ensuing social distancing requirements resulted in an abrupt transition in the provision of most mental healthcare to telehealth; yet it was, at first, unclear whether patients' emotional expressions – of great import to the success of many psychodynamic therapies – could be facilitated using teletherapy. This article first presents a targeted literature review focused on emotional expressions in psychotherapy and implementing psychodynamic therapy over telehealth and then describes our clinical experience transitioning a psychodynamically-informed, evidence-based, and experiential group treatment for chronic pain, emotional awareness and expression therapy (EAET), to video telehealth at VA Greater Los Angeles Healthcare System. We discuss barriers we encountered in our implementation of EAET over video telehealth but also illustrate the ultimate success of the approach using verbatim excerpts from our therapeutic work, which aim to demonstrate the potential to facilitate powerful emotional expressions over video telehealth when conducting a psychodynamically-informed treatment. We examine the possible applications for video telehealth to maintain emotionally focused, psychodynamic psychotherapy administration and enhance its teaching and training. Although we describe limitations of our specific approach, ultimately, our experience supports the potential efficacy of experiential, emotion-focused psychodynamic therapies in a telehealth setting.

Keywords

group psychotherapy; psychodynamic; emotions; emotional expression; telehealth

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Introduction

In response to the COVID-19 pandemic, most mental healthcare was abruptly moved to a telehealth platform. Despite many challenges of this transition, positive developments came about from the novel clinical experiences and research studies that resulted from this time. The current paper seeks to characterize the effects that performing a psychodynamically-informed therapeutic modality via telehealth had on one key ingredient of psychodynamic psychotherapy, emotional expression. Through a targeted literature review and verbatim excerpts from our work at VA Greater Los Angeles Healthcare System, we will explore the nature of emotion in psychodynamic psychotherapy and the ways in which patients' emotional expressions may be impacted by engaging in psychodynamic psychotherapy in a telehealth modality.

First, we present theory and research on the relevance of facilitating emotional expressions during psychodynamic and other psychotherapies for optimal therapy outcomes. Next, we present literature describing the effects of different telehealth formats (e.g., video telehealth with synchronous, or same-time, therapist contact versus internet-delivered asynchronous therapy that is self-guided with only occasional phone or email contact with the therapist) on the ability to facilitate emotional expressions in psychotherapy, with a particular emphasis on psychodynamic therapies. We then describe our clinical experience transitioning an evidence-based, psychodynamically-oriented group treatment for chronic pain, emotional awareness and expression therapy (EAET), to synchronous video telehealth during the pandemic and present verbatim excerpts from our work. We finally examine the potential applications for video telehealth to maintain emotionally focused, psychodynamic psychotherapy administration during the pandemic and beyond.

The role of emotion in psychodynamic and other psychotherapies: background and theory

Therapeutic focus on disavowed affect is one distinguishing characteristic of psychodynamic therapies (Jones et al., 1992; Keefe et al., 2019). Indeed, a key technique of psychodynamic therapy is focusing on the expression of emotions in session, especially conflicting, conflictual, or unconscious emotions (Shedler, 2010). While behavior therapy is based in habituation and exposure to new information, experiential and dynamic therapies aim to make direct contact with emotional experiences and follow them with a deeper exploration to make sense of the material (Greenberg & Pascual-Leone, 2006). This emotional insight, unlike intellectual or cognitive insight alone, is thought to lead to deep and lasting changes in patients' lives. Psychodynamic therapies also focus on the patient-therapist relationship to access emotionally charged material in real-time. This relationship is utilized to explore patients' emotional reactions, which inevitably connect to early relational themes and experiences. In sum, expressing and reflecting on primary, adaptive, or 'core' emotions (e.g., sadness at loss, healthy anger at injustice) in an environment of safety and trust aim to support patients in meaning-making and to develop a cohesive life narrative.

When painful emotions are experienced, individuals commonly employ numerous defenses or unhelpful emotion regulation strategies, such as emotional suppression and avoidance. This notion is based upon Freud's Second Theory of Anxiety, which posits that symptoms derive from psychological conflicts, and, particularly, conflictual emotions that must be

faced rather than avoided to provide symptomatic relief (Freud, 1926/1959). Research shows that over time, a chronic disposition to avoid internal experiences can lead to decreased wellbeing and increased emotional pain (Greco et al., 2008), as well as more depressive symptoms and less satisfaction with life (Gross & John, 2003). On the other hand, Stanton et al. (2000) found that emotional expression served as an adaptive process for women diagnosed with breast cancer. Emotional approach coping is also associated with better outcomes in chronic pain (Lumley et al., 2021; Ziadni et al., 2020). Thus, how people understand and interact with their emotions matters, and these findings inform the ways in which psychodynamic psychotherapy seeks to work with patients' emotional experiences.

The role of emotion in psychodynamic psychotherapies: outcomes research

Emotion has long been considered instrumental to effective psychotherapy, but only recently has research begun to operationalize and study how emotional expression is related to treatment outcomes. Exploring emotions collaboratively with the therapist is common across multiple types of therapy (e.g., interpersonal therapy, cognitive-behavioral therapy [CBT]) and has been correlated with positive outcomes (Coombs et al., 2002). Research has shown that working with patients to overcome their avoidance of primary, core emotions (e.g., sadness at loss, healthy anger at injustice) by approaching them in therapy is a central process of therapeutic change (Greenberg, 2016). It is not just cognitively discussing these emotions that has been shown to be beneficial, but rather eliciting and expressing emotion within the therapy itself (Greenberg & Pascual-Leone, 2006; Jones et al., 1992; Lilliengren et al., 2017; Malan & Della Selva, 2018). A recent meta-analysis (Peluso & Freund, 2018) demonstrated a significant, medium-to-large effect size correlation between patient emotional expression and positive psychotherapy outcomes, regardless of psychotherapy modality.

The importance of facilitating deep in-session emotional experiences in psychodynamic therapies has been supported by clinical research studies in recent years (Greenberg, 2002; Greenberg & Pascual-Leone, 2006; Samoilov & Goldfried, 2000). Intensive short-term dynamic psychotherapy (ISTDP; Davanloo, 2000) is one psychodynamically-oriented treatment with a strong emphasis on in-session emotional experience and expression that has been studied in several clinical trials, many of which evaluated the importance of emotional expressions to outcomes. Lilliengren et al. (2017) found that greater patient emotional experiencing while engaging in ISTDP predicted reduced psychiatric symptoms, interpersonal problems, and healthcare costs for individuals with generalized anxiety disorder. Other empirical studies of ISTDP and related treatments also demonstrate a positive association between treatment outcome and achieving a level of emotional expression that leads to new self-understanding in session (Abbass et al., 2017; Fisher et al., 2016; Johansson et al., 2014; Kramer et al., 2015; Town et al., 2017). In another short-term psychodynamic therapy model, panic-focused psychodynamic psychotherapy (PFPP), Keefe et al. (2019) found that when patients engaged in greater emotional expression during early sessions, they experienced better treatment outcomes. Facets of emotional expression, and how these relate to clinical outcomes, have also recently been studied in patients who complete EAET. An increased capacity for emotional processing (i.e., the ability to make contact with emotions and not become overwhelmed by intrusive emotions) has been

linked to reductions in physical symptoms among patients with centralized symptoms who completed asynchronous, internet-delivered EAET (Maroti, Ljótsson et al., 2021). These findings converge to suggest that making meaningful in-the-moment emotional contact within the therapeutic context has the potential to lead to lasting change in the intrapsychic and interpersonal worlds of patients.

Psychodynamic psychotherapies via telehealth

It has been well established that many psychotherapy modalities may be delivered via telehealth with similar clinical outcomes to those conducted in person (e.g., Boykin et al., 2019; Fleuty & Almond, 2020; Gros et al., 2013; Varker et al., 2019). Moreover, growing evidence suggests that many psychodynamic psychotherapies specifically may be effective via telehealth, whether conducted in formats with synchronous or asynchronous therapist contact. For instance, promising but underpowered results on the efficacy of dynamic interpersonal therapy (DIT) with synchronous therapist contact have been shown (Lemma & Fonagy, 2013; Turcu & Minulescu, 2019). Similarly, several studies have also shown positive results for internet-delivered, emotion-focused psychodynamic therapies with little to no synchronous therapist contact. One randomized controlled trial of an online psychodynamic treatment for depression conducted as guided self-help for 10 weeks revealed that patients who received the psychodynamic treatment improved more than the active control group (Johansson et al., 2012). Positive results (i.e., reduced somatic symptoms and levels of anxiety, depression, and functional disability) have also recently been found in the first trial of internet delivered EAET for adults with somatic symptom disorder with centralized symptoms, which was also delivered in a guided self-help format with email contact only with a therapist (Maroti, Ek et al., 2021).

Conversely, Chavooshi et al. (2017) found that for patients who received treatment for medically unexplained pain using ISTDP delivered over Skype, the in-person group had better outcomes than the video-telehealth group. The authors of this study concluded that the poorer outcomes among the telehealth group were the result of greater difficulty in achieving deep, meaningful emotional expressions with this modality compared to in-person provision of ISTDP.

When conducting telehealth treatments that use synchronous therapist contact, we found that one important factor to consider is whether the therapeutic alliance can be effectively established via telehealth, given that a strong working alliance is positively related to the depth of emotional experiencing in session (Kaiser et al., 2021; Malan & Della Selva, 2018). The working alliance via telehealth may be affected by the unique kinds of treatment resistance that arise and are harder to detect via screen-based modalities. Examples of these kinds of resistance include patients more frequently using substances prior to a session (Roesler, 2017; Swales, 2017). Or, in one reported extreme case, one patient was reportedly able to view pornography off to the side on a second monitor which was out of the therapist's line of sight during teletherapy sessions (Swales, 2017). Concerns around recognizing and interpreting subtle non-verbal communications (e.g., vocal prosody, tone, gestures, mannerism, subtle facial expressions of emotions) have also been expressed (Brahnam, 2017; Chavooshi et al., 2017).

Introduction to emotional awareness and expression therapy (EAET)

While its developers cite numerous theoretical models as inspiration for EAET (see, Lumley & Schubiner, 2019), EAET may be viewed largely as a time-limited experiential, psychodynamic psychotherapy. This is because the rationale and conceptual model for EAET are based upon Freud's Second Theory of Anxiety, and many of the therapist's interventions are guided by Menninger's Triangle of Conflict (1958), which operationalizes this theory. Patients are provided psychoeducation on Menninger's Triangle to learn how to monitor their own defenses, anxiety, and conflicts (Lumley & Schubiner, 2012; Menninger, 1958). Another psychodynamic principle used in EAET is its integration of current symptoms with life-long patterns of behavior, using worksheets and handouts to encourage patients to examine how the onset of their symptoms correlates with early attachment relationships, adverse experiences, and core conflicts (Lumley & Schubiner, 2012). EAET also occasionally employs the use of the transference. For instance, the manual includes instructions to 'support [the patient's] experience of being mad at [the therapist],' if the therapist needs to interrupt a patient to stay on schedule (Lumley & Schubiner, 2012, p. 8).

The key intervention in EAET is called 'experiencing, expressing, and releasing emotions,' which derives from ISTDP (Lumley & Schubiner, 2012; Yarns et al., 2020). Patients are guided to recall a recent stressful event in a current relationship and experience all the previously avoided, anxiety-laden, and conflictual adaptive emotions (e.g., healthy anger, healthy guilt, longing, and compassion) about this relationship in the safe relational context of the therapy. The therapist addresses defenses against experiencing these feelings as they arise, and the therapist and patient monitor the patient's level of pain and other symptoms as emotions are experienced. The desired outcome from this technique is Alexander and French's (1946) notion of a 'corrective emotional experience,' in which longstanding patterns are thought to be modifiable by engaging in new, emotionally-evocative relational experiences (Lumley & Schubiner, 2012, p. 3).

EAET is a manualized treatment that may be delivered as individual or group 1-, 3-, 8-, and 9-session formats, with recent research also supporting an adaptation to internet-delivered asynchronous treatment (Maroti, Ek et al., 2021). EAET was developed in the early 2010s by Mark Lumley & Howard Schubiner to address medically unexplained or 'centralized' symptoms (Lumley & Schubiner, 2019). Centralized symptoms include conditions such as fibromyalgia, irritable bowel syndrome (IBS), chronic fatigue syndrome, chronic pelvic pain, temporomandibular joint pain, tension headaches, and many regional musculoskeletal pain conditions (e.g., low back pain), all thought to be maintained, amplified, or even generated by the central nervous system and especially the brain (Lumley & Schubiner, 2019; Yunus, 2007). These conditions are highly comorbid with PTSD (Fishbain et al., 2017), and patients often have psychological conflicts and relationship problems deriving from adverse childhood experiences and trauma (Lumley & Schubiner, 2019). EAET posits centralized symptoms can be addressed by treating these psychological conflicts, with these changes believed to act on regions of the brain that are involved in the experience of both physical pain and emotion (Yarns et al., 2020). Clinical trials have demonstrated the efficacy of EAET for fibromyalgia, IBS, chronic pelvic pain, and chronic musculoskeletal pain (Carty et al., 2019; Lumley et al., 2017; Thakur et al., 2017; Yarns et al., 2020; Ziadni et

al., 2018), including some advantages over CBT in two of these trials in different research groups and populations (Lumley et al., 2017; Yarns et al., 2020).

Materials and methods

Our clinical and research group has conducted in-person EAET groups since 2017 in older veterans in Los Angeles. At the beginning of the COVID-19 pandemic, we began implementing EAET over video telehealth as part of a new research study funded by VA. This study was approved by the Institutional Review Board (IRB) at VA Greater Los Angeles. Research methods and quantitative outcomes from this pilot study will be described in a separate paper which is in preparation. The purpose of this article is to describe our clinical experience with EAET over video and, particularly, our ability to facilitate powerful emotional experiences despite the numerous technical and logistical challenges inherent to video telehealth psychotherapy. To that end, we will present our clinical experience and then present verbatim excerpts from work with one participant during a group session. In addition to IRB approval for the study, we obtained written informed consent from this participant to publish the details of his case, including verbatim transcripts.

Implementation of EAET over video telehealth

Our implementation of EAET over video telehealth had synchronous therapist contact in that patients and therapists logged into a weekly Zoom (San Jose, CA) therapy room at the same time each week. All our patients were age 60 years and older, consistent with the focus of our research program on the ability of older adults to respond to EAET. Because our patients were older, we provided each patient with a tablet computer mailed to their homes along with all EAET worksheets that were reviewed and referenced during sessions. Patients were also mailed a technology training manual with written and pictorial instructions for how to connect to their home Wi-Fi and log onto Zoom to access the group. A research coordinator performed technical consultation with patients by phone. All patients joined the Zoom conference and participated entirely from their homes without ever making a trip to our medical center. The EAET we provided included one 60-minute individual therapy session followed by eight 90-minute group therapy sessions. Further detail on the contents of each session may be found in Yarns et al. (2020).

Results

Technical challenges

At the outset, we had substantial skepticism about our ability to elicit powerful change-promoting emotional experiences using video telehealth, and indeed, we experienced numerous technical challenges conducting EAET over video with our older patients. These included: difficulty establishing and maintaining eye contact, difficulty hearing patients and seeing patients' full bodily emotional expressions, patients dropping off and on the Zoom chat, interruptions due to phones ringing or other noises in the homes of the patients, and even patients getting up and walking away from the camera during the session. This all occurred despite numerous occasions in which we educated patients about the importance of

having technical difficulties worked out prior to the start of sessions (along with the support of a research assistant available 30 minutes prior to the start of each session to help patients connect to Zoom) and repeated admonitions to have phones silenced. Nonetheless, on the whole we were able to achieve a tremendous amount of emotional expressions from our patients that led to substantial clinical improvements.

Verbatim excerpts from work with one group member

Below, we have verbatim excerpts from the first group session with a 75-year-old African American man with over 40 years of chronic low back pain, Mr. B, that demonstrate our ability to elicit powerful emotional expressions despite numerous technical difficulties. It should be noted that upon reviewing the therapy video, we observed that the therapist (B.C.Y.) maintained very poor eye contact with the camera and had a roaming gaze throughout this interchange, although he was totally unaware of this during the session since he was new to communicating into a webcam.

In our EAET protocol, we adhered to the 8-session EAET manual developed by Lumley and Schubiner (2012), with some minor modifications due to (1) the addition of an individual session with each patient prior to the start of the 8-session group and (2) the elimination of some exercises to tailor to our older population, which are described in Yarns et al. (2020). During the individual session, we included psychoeducation and experiential activities from the EAET manual's group session 1 and 2, and so we were able to do a brief check-in and then begin the 'experiencing, expressing, and releasing' exercises in group session 1. In these exercises, one patient works 1:1 with the therapist for several minutes while other patients observe. Then, the therapist moves to the next patient until all patients have gotten a turn.

The following transcript shows Mr. B experiencing, expressing, and releasing his feelings about a 'key, stressful relationship' (Lumley & Schubiner, 2012), which was his relationship with the nuns at his Catholic school. According to the EAET manual (Lumley & Schubiner, 2012), in this exercise, the patient is guided to: 'Step 1: Experience anger in the mind and body; Step 2: Express anger with words and muscles; Step 3: Inquire about guilt; Step 4: Inquire about sadness and loss; and Step 5: Talking to 3 important people, to yourself in the past, to the person who offended/hurt you, and to yourself in the present.' As demonstrated below, in practice, these steps often occur spontaneously with minimal encouragement from the therapist when the patient is highly emotionally involved in the process:

Pt: (With a raised voice) I feel what's significant right now is the Catholic school feelings came up. I'm talking to you, but it was very much about the Catholic school feelings. And I think that I, they twisted me or formed who I was to become. I was put into a rigid model, and it's like ... I was no longer me. I was who they wanted, or said I was supposed to be, and I've lived like this my whole life. And um, it didn't help being a black man in America. Those two. Catholic school and race has twisted who I really am. And if I'm angry about anything, I'm angry about that. Because at this point when Black Lives Matter came up, it made me look at all of the compromises I've made just to LIVE in this world. (He pauses.) And THAT (tears starting – slams fist down on table) is why I'm fucking pissed off! (slams fist down again harder)! God damn it! (shakes head)

Th: Mhm, yea, don't, don't hit your [hands]

Pt: I haven't lived my life! I've lived to survive.

Th: Good, yeah, let it come up.

Pt: (deeply sighs) That's where my anger is. (He slams his fists down more gently. Face clenching up, contorted, furrowed brows. Another deep breath. Takes glasses off, and rubs his face with hands.)

Th: So, there's been so much pain, so much anger inside you for so long, all the way back to Catholic school.

Pt: (Takes a deep breath)

Th: All the way back to things that happened when you're growing up

Pt: (Wipes tears off face)

Th: That pressure for conformity, and the facts that it's so painful that in many ways you did conform, and didn't really live the life you wanted to live.

Pt: (Takes a deep breath) Yes.

Th: And that's what the anger's really about, and the pain.

Pt: (Nods). Yes, yes, yes. And I had no support. If the nuns said I did it, my mother said then you must have did it. No one gave me the benefit of the doubt and said well maybe they were wrong. No, I was always the wrong. As my mother said, 'you're black hearted.' So, it was like I never had a defender.

This exploration of mixed feelings was met with a major interruption from another patient trying to connect to the Zoom session with the help of the research assistant. After this interruption, we explored Mr. B's feelings about several painful traumas the patient had experienced in his relationship with his mother. This included a similar exploration of anger, guilt, sadness, and loss in his relationship with her. We then concluded by asking Mr. B what he would say to himself as a younger person:

Th: I'm wondering, how are you feeling right now? Are you in touch with any feelings about your mother? Or not? Or about the nuns?

Pt: I feel when you say in touch with my mother, rather than anger at her, I feel the hurt of a little boy. I feel what was done to me (hands touching his chest) so I'm not angry at myself, but I'm feeling, you know, um.

Th: Do you have an image of that little boy in your mind?

Pt: Yes.

Th: How old?

Pt: Probably 7 or 8.

Th: What did you go by then? What were you called?

Pt: (States childhood name)

Th: If you look at his eyes (patient closing eyes, taking audible breath), what do you see?

Pt: (Grimacing) Fear.

Th: And how do you feel?

Pt: Scared.

Th: But I'm wondering –

Pt: I used to be scared that one of those two people that I lived in a house with would kill me.

Th: Mm. So I'm wondering though as an adult, as Mr. B today, can you go back there? To that little boy? Can you imagine yourself going and what would you do, what would you say to him?

Pt: That he's gonna live. He'll get away from them.

Th: Do you want to do anything?

Pt: (Wipes face with tissue, shaking head)

Th: Give him some comfort?

Another group member's cell phone begins to loudly ring

Pt: (Tears flowing, looking down)

Th: Another wave of pain.

Pt: (Clenching tissue in hand. Taking deep breath.) I would hug him.

Th: Uh-huh, you would hug him, uh huh, and how would you go?

Pt: I would just hug him to my chest, and I feel like I would just hold his hand to let him know that he's not walking through this by himself.

This discussion led to a 'corrective emotional experience,' in which the patient experienced several minutes of painful sobbing, ultimately resulting in a newfound sense of compassion and love toward himself which also led to a reduction in his pain from 7 at the outset to 3 at the end (on a 0–10 scale). Mr. B continued to work exploring more feelings about his past in subsequent sessions. At the end of EAET treatment, Mr. B exhibited a 33% reduction in his pain score, which improved further at 2-month follow-up to a 55% reduction

in pain. The fact that Mr. B was highly engaged in the emotional awareness, process, and expression work and received a clinically-significant outcome provides evidence for a powerful relationship between emotions and chronic pain.

In total, we treated 16 older U.S. military veterans in three EAET groups over Zoom: the first group included 4 veterans, and the second and third each included 6 veterans. There were no dropouts in any of the groups. Mr. B was a participant in the second EAET group, which had all male participants including 5 Black participants and 1 White participant. Mr. B's work described above demonstrates many of the key aspects of EAET that were typical of our experience conducting these online therapy groups. First, the patient and therapist were able to remain connected and focused on the emotionally rich content despite the interruptions brought about by technology. Second, Mr. B was not unusual in these groups. Like many of the patients in these groups, Mr. B was also able to experience multiple, complex feelings and gain new insights into how his life experiences have impacted his present. Third, we believe Mr. B's work in this early session had a major impact on the other patients in this group. Once others saw Mr. B benefit from bravely approaching his traumas and all of the associated painful and conflictual feelings, others in the group were more eager to face their traumas as well.

Discussion

In presenting the application of EAET over video telehealth, this paper first reviewed the importance of eliciting and expressing emotion in psychotherapy, particularly in psychodynamic and experiential therapies. Some voices have raised reluctance in transitioning these therapies to telehealth (e.g., Essig & Russell, 2017) due to potential pitfalls such as the anticipated inability for patient and therapist to connect emotionally and the harmful effects of technological interruptions. Yet, growing evidence shows psychodynamic and experiential therapies via telehealth, both in synchronous and asynchronous formats, can facilitate therapeutic emotional expressions and lead to clinical improvements (e.g., Johansson et al., 2013; Lemma & Fonagy, 2013; Maroti, Ek et al., 2021). As demonstrated in the above transcript, this has also been our experience with EAET over video telehealth.

An unexpected lesson

One of the key surprising takeaways from this work has been that the typical recommendations for effective telehealth implementation of psychodynamic psychotherapy (e.g., closely maintaining the therapeutic frame) may not be required to achieve positive outcomes. The space of our virtual therapy groups often was filled with interruptions such as phones ringing, patients getting up and wandering on and off the video frame, poor lighting, and difficulty seeing the entirety of patients' faces. However, even without ideal teletherapy conditions, significant gains were able to be made by the patients, as demonstrated by the experience of Mr. B. Furthermore, therapist factors such as difficulty maintaining good eye contact were not always achieved during these groups, and yet did not preclude patients from feeling connected the process. This was surprising to us, given the saturation of literature (e.g., Geller, 2021; Gros et al., 2013) on best practices for telehealth in terms

of factors such as audio and video connection. What our group suggested is that perhaps these factors are not as primary as they may initially appear. In the end, the 55% pain reduction Mr. B experienced at follow-up is consistent with outcomes from older U.S. military veterans in our prior work who had participated in EAET groups in person. Our in-person EAET results demonstrated at 3-month follow-up that 42% of patients experienced clinically-significant (at least 30%) pain reduction from baseline, 26% of patients had moderate (at least 50%) pain reduction, and 21% of patients had large (at least 70% pain reduction; Yarns et al., 2020).

Recommendations for future implementation

Several interventions did prove helpful in facilitating the emotional expressions of patients in our video telehealth group. At a basic level, our experience has compelled us to recommend trying psychodynamic therapy over telehealth, especially when transitioning to this modality may be crucial to ensuring patient and therapist safety. In addition, this experience has clearly demonstrated to us the importance of not ‘giving up’ on a session despite technological barriers such as poor audio, video, or connectivity because we are still able to achieve the emotional expressions and insights with patients. Our work in these groups suggests that it is less the responsibility of therapists to directly facilitate emotional expression in the patients, but that patients can do this despite technological barriers. Many patients have a much greater capacity for powerful transformational experiences than we give them credit for, and so our study suggests that simply holding the space in teletherapy regardless of interruptions is invaluable for patients’ emotional processes.

An additional tool to encourage patients in this process includes building an alliance around the importance of emotional experience to meet the patient’s specific goals and relieve symptoms, which serves to enhance the patient’s motivation to engage in emotional experiences. In addition to the emotional partnership between therapist and patient, a key component of the therapeutic alliance also includes an agreement about how therapy will work to achieve patients’ goals (i.e., focusing on the ‘tasks’ of therapy; ten Have-De Labije & Neborsky, 2012). In EAET’s model, this included spending a significant amount of time in psychoeducation and drawing connections for patients between how their emotional experiences have related to their chronic pain. As Peluso and Freund (2018) describe, ‘orienting [patients] towards affect’ (p. 469) serves to encourage emotional expressions and deepen the therapeutic work, in both in-person and video telehealth modalities. Clinicians may also be trained to pick up on bodily cues of emotional expression, such as facial displays, tone of voice, body posture, hand movements, etc., and use these as sources of communication to guide the therapeutic work.

Limitations

While our experience suggests efficacy of emotion-focused psychotherapy conducted via video telehealth, it is important also to acknowledge certain limitations of the applicability of our model to others’ clinical practice. First, because this was a funded research study, we had the resources available to provide our patients with tablet computers. In clinical practice, patients would most likely have to acquire their own video-capable devices to join sessions. However, it is increasingly likely in the future that more patients will have

appropriate devices due to necessity arising from the COVID-19 pandemic. Secondly, we had the support of a research coordinator to train patients how to use their tablets to join the Zoom sessions and help patients in real-time who had technical difficulties. This burden would likely fall on the treating therapist in most practice settings, which would pose greater obstacles. Finally, although the patient treated here was interrupted by others' technical difficulties, he did not drop from the call or have other technical difficulties. Therefore, our advice may only be applicable to patients with a certain baseline technological capability to join video telehealth appointments and troubleshoot problems on their own, or practice settings where this is part of the service.

Conclusion

Having 'backed into' teletherapy because of the COVID-19 pandemic, we were admittedly skeptical about how effective an emotion-focused, experiential psychodynamically-informed group therapy would be via video telehealth. However, as exemplified in the transcript segments presented in this article, these negative expectations were largely disconfirmed. Albeit more challenging to implement than typical in-person sessions, teletherapy proved quite effective in facilitating corrective emotional experiences that resulted in noticeable shifts in patients' symptoms, such as level of reported physical pain. What this experience has taught us is at the very least, there need not be fear in trying telehealth even for complex experiential and psychodynamic modalities. Our pilot groups have further questioned the concerns about teletherapy for older adults (e.g., Myers et al., 2010), in that even our geriatric population was able to navigate this new frontier when provided with appropriate guidance and support, through telephone assistance and written materials. While more is yet to be discovered and studied, this clinical review demonstrates the potential efficacy of experiential, emotion-focused psychodynamic therapies in a telehealth space. Based on our experience in these pilot groups, it is our hope that capitalizing on the power of telehealth, with its wide-ranging applications, has the power to grow the field and expand the reach of psychodynamically-informed experiential therapies. We foresee that teletherapy has the potential to make psychodynamic therapies more accessible in terms of both training (e.g., easier to train therapists in different geographic locations using remote, live supervision) and patient care (e.g., the possibility to treat patients in more diverse locations), both of which can be evaluated in future research.

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