

**Emotion-focused and Video-technology Considerations in the COVID-19 Crisis**

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## Emotion-focused and Video-technology Considerations in the COVID-19 Crisis

### Abstract

The Coronavirus or COVID-19 crisis has forced counsellors and therapists around the globe to use online videoconference programs to provide psychotherapy treatment, teaching, and supervision. Some varieties of psychotherapy have historically used video technology for these purposes. Intensive short-term dynamic psychotherapy (ISTDP), one such method, is built on activating intrapsychic crises that lead to emotional experiencing and change. In the current context, external or extrapsychic crises can also be a launchpad for personal growth. The treatment method relies on detailed examination of verbal and nonverbal cues as markers of unconscious avoidance processes and unconscious emotional experiences. Adopting video technology and online treatment present some unique challenges and benefits. At the same time, the current COVID-19 crisis results in common treatment themes that therapists will encounter. In this review we will examine common crisis response patterns, some client characteristics based on attachment trauma, and common themes emerging due to this crisis and the related social changes it brings. We will also review some technical issues and tips for those now pressed into using video technology, often for the first time.

*Keywords:* Crisis, stress, anxiety, quarantine, emotion, intensive short-term dynamic psychotherapy

### Introduction

Videoconference technology is crucial to maintain counselling and psychotherapy services amid the isolating effects of the COVID-19 pandemic. Closed-circuit television and video link technologies for diagnostic and treatment efforts date as far as the 1960's, but, widespread clinical use of these has been ushered in by more recent technological, financial and other advances. (LeRouge & Garfield, 2013). The recent COVID-19 context is certainly pushing many clinicians out of their comfort zones to engage with clients online and incorporate this technology into routine clinical practice. Pros, cons other issues related to using this technology have been reviewed previously (e.g., Abbass, 2004, Elliott, Abbass, & Cooper, 2015; Elliott, Abbass, & Rousmaniere, 2018; Rousmaniere, 2014; Rousmaniere & Renfro-Michel, 2016). We provide a practical overview of videoconference technology and session recordings within the clinical context of a specific therapy approach—Intensive short-term dynamic psychotherapy (ISTDP; Davanloo, 2001, Abbass, 2015).

ISTDP has a metapsychology that many common psychological problems are driven by unprocessed feelings from early attachment adversity that get reactivated in current relationships. The model incorporates video recording of sessions in training and routine practice for quality improvement and ongoing professional development. Given the limitations of memory and bias, a major advantage of using this technology is the opportunity for careful examination of verbal and nonverbal responses of both therapist and client through self-study, peer-consultation, and supervision.

When original reviews were written almost 20 years ago, videoconferencing and review of session recordings were not as common as they are today. Some initial challenges of using this technology include clinician and client discomfort with the technology. However, now,

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3 given the widespread use of social media and the fact that almost everyone has a camera in the  
4 form of a cell phone, people are generally more accustomed to being recorded. Thus, it is  
5 relatively easier to transition to recording and videoconferencing treatment sessions now than it  
6 was before the turn-of-the-century. Nonetheless, we recommend you take some extra time while  
7 orienting clients to the quality control rationale of using video recordings and the value of being  
8 able to see each other while connecting with videoconferencing technology.  
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10  
11 If you have not been recording your counselling sessions or using videoconferencing, you  
12 may find this technology to be a challenge. Among other issues, you may for example, have  
13 discomfort or worry about how you will appear and perform on video or how others will  
14 perceive you while using recordings for peer review or supervision. These things may take some  
15 getting used to. However, once the initial discomfort passes, you will benefit from consultation  
16 and support from peers that this technology allows.  
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### 33 **Videoconferencing Issues**

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35 Secure videoconference applications are now more commonly used in clinical settings.  
36 However, there are certain issues that may arise while transitioning to this technology. Beyond  
37 ethical issues that we review in the above papers, some of the other emerging issues are as  
38 follows.  
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#### 44 ***A Change in the Frame***

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46 Beginning to have online treatment sessions changes the treatment frame. First, you may  
47 be in your own home and you are seeing clients in their own homes while providing treatment.  
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49 At the time of this writing, the vast majority of counselors in the Western world are housebound  
50 and not using their offices for clinical care because of the risk of spreading infection inside small  
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## EMOTIONS IN COVID-19

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3 offices. Now you are working from your house and your dog might be pawing at your door  
4  
5 seeking food. You are only a few feet from post-work activity you will be doing later. You may  
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7 be one room away from your children or partner. The context is a bit different and something to  
8  
9 get used to. In the same way your client maybe in a living room having shuffled both spouse and  
10  
11 children out of the room for that hour. Otherwise your client may be in a car, bedroom, or even a  
12  
13 closet trying to find privacy. Another change in the context may include using a different  
14  
15 administrative contact to arrange appointments and provide some orientation to the  
16  
17 videoconference technology. We recommend being patient with yourself and clients while  
18  
19 navigating this unusual situation. If there are feelings or other responses that come up about the  
20  
21 change in frame or the technology, then we recommend examining these feelings as a part of the  
22  
23 therapeutic process so they do not become a treatment obstacle.  
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***Comfort with Technology***

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31 Although many videoconferencing applications are relatively simple to use, it is  
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33 important for the therapist to be comfortable with the use of a computer and application while  
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35 maintaining backup phone access to clients. It is not uncommon for therapists who finished their  
36  
37 training in the 80s or 90s even to have some discomfort with these types of technologies. It is a  
38  
39 good opportunity to speak to your younger relatives or friends who will be more than happy to  
40  
41 give you an update on how current computers and these software programs work. It is also  
42  
43 advisable to consult with your professional organization and current online application tutorials  
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45 while conducting some trial runs.  
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***Security and Confidentiality***

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51 Both you and the client need to be comfortable with the security of the technology you  
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53 use while negotiating the limits to confidentiality. For this reason, you require related  
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3 professional procedures and secure videoconferencing applications that are encrypted and  
4 recommended by your professional licensing bodies for these purposes. It is important to  
5 recognize that sessions could be recorded by the client without your consent. While this is  
6 possible, it would be highly unlikely for this to happen inside of a trusting therapeutic  
7 relationship. It is important that there is an adequate level of trust both ways to have such an  
8 exposed process. Both of you need to be willing to work together to establish a reasonable level  
9 of comfort within this format in order to have a therapeutic impact rather than becoming  
10 distracted by related worries.

***New Client at a Distance***

11  
12 Because you're not in the same location as your client, be prepared for unforeseen  
13 difficulties. If your client is new to you, then be sure to get personal phone numbers and a  
14 backup phone number (e.g., name and phone number of emergency contact, physician, or local  
15 urgent services). If you are seeing a new person, then you may not know what type of  
16 psychological or psychiatric difficulties are present in advance so these backups are important.  
17 Having the phone numbers is also important in case the technology breaks down and the session  
18 must be continued on the telephone.

***Looking into a Computer***

19  
20 With most videoconferencing applications you are typically looking at a computer screen  
21 at a person who is doing the same on the other end. Collaborate with your client to ensure  
22 adequate lighting and sound for a therapy session. Headphones are advisable along with  
23 adjusting your typical speech and turn-taking rates to the available Internet speed at the time of  
24 your videoconference. Even under the best conditions, the sound and appearance of the client  
25 will obviously differ from an in-person session. Getting used to these differences is important

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3 and it can help to imagine or think of the client in three dimensions while attempting to connect  
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5 via a two-dimensional image. It can also be helpful to normalize the context and to begin  
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7 referring to the videoconference space as “here with me” or “here together” while attempting to  
8  
9 reach through any technological barriers to connect with your client.  
10

### 11 ***Where is the Eye Contact?***

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15 If you're used to working in a therapy model where eye contact is encouraged and  
16  
17 expected, such as ISTDP, it can be a challenge to maintain eye contact or even to know whether  
18  
19 or not the client is looking at your eyes on their screen. Using a computer, it is useful to position  
20  
21 the image of your client in the videoconference application just below your computer webcam  
22  
23 so that you are looking in the general direction of the camera while viewing your client's image.  
24  
25 Also, positioning your computer so that the webcam is at your eye level and sitting back from  
26  
27 your computer slightly can enable good approximation of direct eye contact so you can detect  
28  
29 breaks in eye contact and other nonverbal distancing maneuvers. We recommend coaching your  
30  
31 client to set up a similar arrangement.  
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### 35 ***Seeing the Upper Body and Gestures***

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38 Ideally, it is best to have your client sit far enough back from the computer webcam so  
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40 that you can see them from the waist up or at least the gestures of their arms and upper body.  
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42 This arrangement allows you to detect changes in muscle tension (e.g., hand clenching, sighing  
43  
44 respirations) and other markers of emotional activation. Similarly, it is best for you to back up  
45  
46 enough so that the client can see your emotional responses, arm gestures, and other nonverbal  
47  
48 responses. Therapists also have a unique opportunity for increased self-reflection during sessions  
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50 by periodically noticing their own emotional and nonverbal responses on the screen.  
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### **Recording Sessions**

After obtaining written consent to video record sessions, it will be a good opportunity to begin to record sessions if you have not been doing so before. This may be the first time that you record sessions and are able to review them for the benefit of yourself and your client. This may be one of the big advantages of this online treatment wave on future clinical practice. In order to get a more usable recording it is best to set up a side-by-side image of you and your client for review purposes. Split screen is superior to having a smaller picture-in-picture configuration where the therapist is barely visible--making it difficult to examine your own responses to the therapy work under way. Some videoconferencing applications allow for secure and straightforward session recording whereas others require you to record from your computer screen, often with larger video file sizes.

### ***Self Review of Video Sessions***

Different treatment methodologies emphasize different psychological processes. However, common themes across therapy models include the establishment of a conscious therapeutic alliance, emotional attunement, collaboration, shared goals and tasks, and an alive, engaged process bolstering various cognitive, interpersonal, and emotional capacities. While doing self-review from video recordings, you can self-reflect on areas of the interview that seemed challenging or where the process seemed to get stuck. You can then try to put yourself in the position of your client or see if you can detect any emotional or psychological responses in yourself that gives insight into what you may do differently the next time you meet together. You can also use the same technology for deliberate practice in targeted areas of your clinical work over time (Elliott, Abbass, & Rousmaniere, 2018). The advantages of this type of review are immense.



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***Peer Review of Video Sessions***

Peer review of video sessions offers an opportunity to have another pair of eyes and another person's emotional structure to provide an independent look at your treatment processes. This can be invaluable on so many different levels. First of all, it can assist you to feel more confident about what you are doing. It reduces the isolation that you may feel in private practice with often challenging clinical situations. It allows validation of various experiences that you may be having in your treatment sessions. Thus, in many ways, peer review contributes to your ongoing professional development. Beyond this, there are some client populations (e.g. severe personality disorder) and clinical situations (e.g. psychiatric inpatients) where none of us should be working entirely on our own without the support of a colleague.

Indeed, many peer review groups are already conducted online through videoconferencing applications and some include consultation and learning based on review of actual therapy session video recordings rather than discussion without any video. So, you will be sitting together, online, watching each other watch videos that were recorded online. All of these are things to get used to compared to in-person meetings and case conferences. We have also used this technology to review the process of video-based supervision online, adding another layer to it all (Abbass et al., 2011; Elliott, Abbass, & Rousmaniere, 2018). A few advantages to think of include easier access to peers and supervisors from abroad as well as savings on parking costs, gas, and travel time.

**Responses to the COVID-19 Crisis**

The responses that your client will have to a major crisis like the COVID-19 crisis will depend on various factors such as the nature of her individual experience (e.g., duration, severity,

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3 and predictability of external stressor, degree of social isolation) combined with her  
4  
5 psychological makeup, attachment history, early adversity, anxiety tolerance, and personality  
6  
7 structure (e.g., Ford, Grasso, Elhai, & Courtois, 2015). Using an ISTDP framework (Abbass,  
8  
9 2015), we can categorize response patterns to external stressors such as COVID-19 in several  
10  
11 ways: tense and busy, weak and depleted, and frightened and guarded response patterns (Table  
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15 1).

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17 In the tense and busy response pattern, the person is fairly well-adapted, keeping up on  
18  
19 news, staying busy, mentally focused, and ready to respond to the environment. She may lose  
20  
21 some sleep and complain of being tense. She is reaching out for information and supports. She  
22  
23 aims to lend support to others and has energy to do so. She may tend to worry and obsess  
24  
25 resulting in distraction.  
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29 In the weak and depleted response pattern, the person will be fatigued and note weak  
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31 muscles. He may want to stay in bed. He may have stomach upset, headaches, and other somatic  
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33 symptoms. He may be pessimistic and very depressed. He feels overwhelmed and defeated by  
34  
35 the stressor, akin to a state of learned helplessness. In the extreme, he may have suicidal ideation.  
36  
37 He is quite prone to substance use at this time.  
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41 In the frightened and guarded response pattern, the person is acutely preoccupied with the  
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43 threat from the stressor. He may be obsessed with the risks of infection and be extremely vigilant  
44  
45 to prevent it. He will have a lot of difficulty sleeping due to fear. He will have difficulty trusting  
46  
47 others not to contaminate him so will likely avoid people and become more socially isolated. He  
48  
49 may become overtly irritable and hostile toward perceived threats. His senses are all on high  
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51 alert, noting sounds smells and even tastes he would not otherwise detect. He may be too afraid  
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53 to use a substance or medications to calm down.  
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Note that these response patterns can all be considered adaptations to external stressors and threats. All of these patterns have certain advantages and disadvantages. A person may move between these patterns as the nature or intensity of the threat changes. However, some of these patterns may reflect a serious mental illness reactivated by the stressors. For example, a person with schizophrenia may have a psychotic episode with delusions and other psychotic features. In this context we should be monitoring and staying in supportive contact with more vulnerable individuals in such difficult times.

### TABLE 1 ABOUT HERE

#### **Intensive Short-term Dynamic Psychotherapy**

Intensive short-term dynamic psychotherapy (ISTDP) is a relatively brief treatment approach that was developed by Dr. Habib Davanloo at McGill University (Davanloo, 1990; 2001; 2001). He developed the approach and related metapsychology from detailed case studies of hundreds of recorded therapy sessions beginning in the 1970's and continuing into the 2000's. The method has been taught and researched using of video technology for over 40 years. ISTDP and treatment methods derived from it called Experiential Dynamic Therapies (WWW.IEDTA.NET) have empirical support from 50 randomized controlled trials and a large number of case series for the full spectrum of common mental disorders, including personality disorders, anxiety, depression, and somatic symptoms disorders. There is also evidence ISTDP can be helpful with clients with more severe mental disorders, including treatment resistant depression, bipolar disorder, psychotic disorders and substance addiction (Abbass, 2016; Abbass et al., 2015; Town, Abbass, Stride, & Bernier, 2017, Frederickson et al., 2019).

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3 The ISTDP model has a dynamic, emotion-focused framework emphasizing the close  
4 study of nonverbal and verbal communication as well as unconscious anxiety and emotional  
5 pathways in the body. The ultimate objective of the treatment is handling unconscious defensive  
6 patterns or resistances that prevent emotional closeness with the therapist and the subsequent  
7 experience of unprocessed complex feelings related to the client's early attachment disruptions  
8 or adversities. In this framework, symptoms and behavior problems related to current and past  
9 attachments and attachment disruptions are the central focus (Malan, 1995; Figure 1).

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19 Davanloo was influenced by the work of Erich Lindemann (1944), an early grief  
20 researcher who worked with clients from the Cocoanut Grove fire tragedy in which almost 500  
21 people perished. One of Lindemann's findings was that the psychological impact of the fire crisis  
22 appeared to create a window of opportunity in which some clients' past trauma-related feelings  
23 were activated and more accessible. It was partly from this work that Davanloo recognized a  
24 therapeutic opportunity could be achieved for clients who were not currently in a crisis by  
25 facilitating a type of internal or intrapsychic crisis. Specifically, this crisis involved more  
26 resistant clients being put face-to-face with the current destructiveness of their defensive  
27 response patterns that had been developed to cope with their attachment difficulties in childhood.  
28 Through developing treatment interventions specifically timed and geared to help the client  
29 recognize and rise above the defeating defensive patterns, Davanloo (1990) and his clients  
30 described a process of "unlocking the unconscious" wherein emotions, memories, and images  
31 related to previous attachment trauma were mobilized in the treatment relationship and then  
32 processed in a healing manner.

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54 **FIGURE 1 ABOUT HERE**  
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6 A major emphasis of the ISTDP model is on evaluating attachment patterns as identified  
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8 by defensive response patterns to the clinical interview (Neborsky & Bundy, 2013). Clients are  
9  
10 categorized along two major spectra in the ISTDP metapsychology (Figure 2). First, the  
11  
12 psychoneurotic spectrum, includes clients who have somatic anxiety mediated primarily through  
13  
14 voluntary muscle tension along with capacity to isolate affect and use formal defenses to  
15  
16 distance and detach from the therapist. On one end of the psychoneurotic spectrum are low  
17  
18 resistant clients who have had a loss with grief that is not resolved. They do not have any  
19  
20 unprocessed rage or guilt about rage towards attachment figures and they have a secure  
21  
22 attachment style. On the other end of the spectrum are highly resistant clients who have had  
23  
24 major disruption of attachments inside the first five years of life (e.g., loss, parental divorce or  
25  
26 depression). These clients have rigid defensive patterns that prevent closeness with the others,  
27  
28 including the therapist, resulting in self-sabotaging behaviors and that prevent access to their  
29  
30 own feelings. These defenses are so fixed and automatic that the client himself cannot see them  
31  
32 anymore. These clients have intense painful feelings, rage, and guilt about the rage toward  
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34 attachment figures. In the middle of the spectrum are moderately resistant clients who have had  
35  
36 later attachment trauma, typically from age 5 to 7. They have a moderate level of intensely held  
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38 defenses to prevent the experience of mixed painful feelings, rage, and guilt about rage related to  
39  
40 these attachment interruptions (Figure 2).  
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47 The second major spectrum, fragile character structure, includes clients with limitations  
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49 in anxiety tolerance and reflective capacity, resulting in cognitive perceptual disruption and  
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51 primitive defenses at some level of rise in anxiety. Mildly fragile clients experience cognitive  
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53 perceptual disruption and use primitive defenses at a high rise in anxiety while severely fragile  
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3 clients have the same experiences at a low rise in anxiety. These clients have insecure attachment  
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5 or disorganized attachment styles. The more severe fragile clients have dissociative disorders and  
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borderline personality features (Figure 2).

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11 In between these two spectra of clients are those who have resistance involving  
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13 repression. These clients have also had major trauma in the first four years of life and the main  
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15 manifestations of this are chronic repression of the emotions into the body. The result is fatigue,  
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17 irritable bowel syndrome and migraine headaches, major depressive disorder, and motor  
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conversion disorder with episodic weakness and paralysis (Figure 2).

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**FIGURE 2 ABOUT HERE**

### *Interventions to Match Response Patterns*

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The treatment process for these different categories of clients varies according to client capacity to reflect and tolerate anxiety and related underlying attachment feelings. Low resistant clients and moderate resistant clients have good anxiety tolerance and reflective capacity, and generally only need encouragement to be emotionally present and to identify and feel their emerging complex feelings. The treatments with these clients are relatively short, ranging from one to 10 meetings. More highly resistant clients have robust defensive patterns that function as a barrier to emotional closeness with the therapist and their own underlying complex attachment feelings. These clients require considerable work to help them consciously recognize, evaluate and then turn against these defensive patterns in order to be emotionally present while identifying and experiencing their emerging attachment-related feelings. Treatment with these clients is longer, ranging from 20 to 40 meetings. Clients who have significant repression require

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3 a graded treatment process to build anxiety tolerance first before they are able to effectively  
4 tolerate their underlying mixed feelings. Treatment for clients with significant repression is  
5 typically longer, requiring 20 to 40 meetings. Fragile clients also require a gradual process of  
6 capacity building prior to being able to self-reflect, tolerate anxiety, and feel their underlying  
7 attachment related feelings. Treatment with fragile clients can range from 20 sessions for  
8 symptom reduction to as much as two to three years in the case of severe fragility.  
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**TABLE 2 ABOUT HERE**

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24 The Coronavirus crisis and the multiple resulting stressors involving quarantine, extended  
25 isolation, financial loss, inadequate communication, and stigma (Brooks et al., 2020) will  
26 interface and produce different responses with these different categories of clients. Some types  
27 of responses that an individual will have were described above. Your client's attachment history  
28 and his psychological makeup will have some impact on where he will land in terms of acute and  
29 longer-term response to a crisis. A person can fluctuate between these different response patterns  
30 as well. As a therapist, our first objective is to help stabilize the client, if needed, and hopefully  
31 help him make some gains or growth from the crisis so that he emerges stronger than he was  
32 before the crisis.  
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**Common Themes Emerging Around the Coronavirus Crisis**

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47 The following are some common clinical themes seen with cases since the emergence of  
48 the COVID-19 crisis and the social, emotional, economic and behavioral impacts it has had on  
49 people (Brooks et al., 2020).  
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***Loss***

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Ultimately, the most salient threat of the Coronavirus is illness and death of the self or others. Such a threat of loss will mobilize any unresolved grief about lost loved ones or lost relationships in the past. This may manifest as a preoccupation with death accounts, media of people who have died and the responses of their loved ones, or simply a preoccupation with one's own death. Depending on the characteristics of the client, a loss preoccupation may take the form of a high degree of somatic symptoms, exhaustion and depressive symptoms, tension and irritability, or emotional detachment (See Table 2).

### ***Forced Confinement***

Quarantining and pressure from governments to stay at home is a type of externally imposed confinement. Clients report strong mixed feelings about the system trying to take care of people by confining them. In one recent case a person describing extreme irritability and rage coming up about government-imposed restrictions. When focusing on these feelings, the client was able to experience intense rage and also remorse for having such an intense rage towards the regional leadership. After experiencing these complex mixed feelings, the client was immediately reminded of times of control and physical brutality by a parent. The client was then able to experience intense rage in the body, sadness, and guilt about the rage related to this 'confinement' by his parents. The end result of this session was a marked relief and reduction of defensive responses and symptoms. The client had moved from more 'frightened and guarded' to more 'tense and busy' as a result of this session.

### ***Control by Others***

Similar to confinement, the experience of being controlled by others commonly mobilizes feelings about power use in previous relationships. One client described a great deal of rising tension and power struggle taking place in the home in relationship to being controlled by



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3 the spouse who was now at home full-time. With the focus on these feelings, the client was able  
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5 to experience strong complex feelings, including sadness, rage and guilt about the spouse. This  
6  
7 immediately linked to memories of times of intense parental mental control and manipulation  
8  
9 during the client's childhood. The client was then able to experience these strong complex  
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11 feelings from the past and make a therapeutic gain out of it.  
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***Stuck with the Family***

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17 Another emerging theme is that of being 'stuck' with family members in homes in a  
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19 much more intense way than prior to the COVID-19 crisis and government restrictions. For all  
20  
21 the upside of being present in the home with family members, clients describe the emergence of  
22  
23 a lot of emotions tied to relentless interactions where they are forced to maintain their role in the  
24  
25 family structure without any breaks. For example, a parent who was used to having days to  
26  
27 herself while the children were in school is now confronted with constant parental duties, 24  
28  
29 hours a day, without any let up. This situation mobilized unprocessed complex feelings around  
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31 having to assume a caretaking role for her parents when she was a child.  
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***Economic Losses***

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38 There is already a great deal of fear about what people are going to do financially as time  
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40 goes on in this crisis. Will they lose their jobs, their house, their pension, their family savings?  
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42 People are clambering to secure unemployment assistance or government assistance. Inevitably  
43  
44 the loss of income and loss of role are major stressors for individuals and family members. Long-  
45  
46 term economic downturn is linked to a range of adverse health effects and increased rates of  
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48 suicide. The emotional impact of economic loss will inevitably become a focus for clients over  
49  
50 six months to two years after a crisis.  
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***Uncertain Future***

## EMOTIONS IN COVID-19

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3 The unpredictability of the COVID-19 situation in terms of what is going to happen to  
4 society, jobs, roles, school, and other facets of life raises many elements of insecurity within the  
5 person. Any clients who have experienced nonsecure attachment will be reminded of childhood  
6 times when there has been chronic family instability. One client with severe fragile character  
7 structure described an increase in concentration difficulties and a sense of desperation. It was as  
8 if he was grasping for a piece of wood to hold onto while adrift in the ocean. A focused,  
9 reflective process aimed at reducing his anxiety and the security of the therapeutic relationship  
10 had a marked effect on him during these treatment sessions.  
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***More Closeness***

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24 The impact of social isolation and people having more time together in the home gives  
25 the opportunity for more emotional and physical closeness. This, on its own, is a positive thing  
26 so long as the person does not have a major history of trauma by close relationships in the past.  
27 If there is such a history and related attached feelings are stirred up, then there may be increased  
28 anxiety, somatic symptoms, depression or irritability, and defensiveness activated by this  
29 increased potential for closeness and intimacy. One client described with a great deal of muscle  
30 tension that she now has more time with her husband of 25 years. She described that she was  
31 more tense and was having sleep disruption even while in some ways she was enjoying having  
32 more time with her husband. When focusing on her responses there were a lot of underlying  
33 feelings related to accumulated emotions in that relationship and her childhood that had not yet  
34 been processed.  
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***Less Closeness***

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51 The impact of social isolation has meant disruption for some family members where they  
52 cannot even visit other family members. This is a painful process that can mobilize feelings  
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3 about relational disruption in the past. The manifestation of this as with the other type of themes,  
4  
5 will depend on the characteristics of the individual client and the stress response they are having  
6  
7 (Table 2).  
8

### 9 10 ***Calm and Indifferent***

11  
12 Some clients who have a tendency toward self-destructiveness, may respond to these  
13  
14 stressors with a paradoxical calmness, somewhat akin to “la belle indifference” seen with some  
15  
16 conversion patients. They feel relaxed under what they see as ‘abusive’ threats from the virus  
17  
18 and controls by others. One patient, for example, noted that she no longer felt the urge to cut  
19  
20 herself and felt oddly relaxed. In these cases, it is important to help the person turn against the  
21  
22 pattern of passive submission and avoidance of emotions being mobilized in a difficult situation,  
23  
24 in order to make further therapeutic gains.  
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27

### 28 **Conclusion**

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30  
31 There are a range of response patterns that all people can have under such a stressful  
32  
33 period of time and with the unique features of this crisis. As we are also pressed into using  
34  
35 videoconferencing to work with clients, it is best for us to be armed with information so that our  
36  
37 efforts do not become an added stressor for our clients or ourselves. Certain themes related to  
38  
39 attachments and risks of loss appear central in activating a range of somatic anxiety responses  
40  
41 and defensive patterns to handle old feelings about attachment disruptions. There are notable  
42  
43 advantages and disadvantages to transitioning to online treatment and we have described these  
44  
45 above. Our experience is that most challenges of videoconferencing and video recording use  
46  
47 diminish over time and you gradually feel as if you’re sitting together in the same room with  
48  
49 your clients once again. Until such time as we can meet back with our clients in person, we wish  
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EMOTIONS IN COVID-19

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3 you the best in your clinical care and in your own adjustment to this crisis and any future crises  
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5 that you may experience during your career.  
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Table 1  
*General Stress Response Patterns*

|                      | <b>Tense–busy</b>                                                | <b>Weak-depleted</b>                                                              | <b>Frightened-guarded</b>                           |
|----------------------|------------------------------------------------------------------|-----------------------------------------------------------------------------------|-----------------------------------------------------|
| <b>Cognitive</b>     | Realistic view on the crisis or obsessions about the crisis      | Depressive view of the crisis, suicidal ideation                                  | Paranoid ideas, preoccupied with threats, risks     |
| <b>Behavior</b>      | Staying educated, active, engaged, some compulsive behaviour     | Low activity, avoidant due to low energy and drive                                | Hypervigilance, monitoring excessively              |
| <b>Interpersonal</b> | Connect to others to help and get help, but tend to over-control | Avoiding support from others due to pessimism or become overly passive-dependant. | Avoiding others due to suspicion and mistrust       |
| <b>Emotional</b>     | Nervous, irritable, but able to grieve losses that arise         | Weepiness, helplessness, hopelessness                                             | Irritability, fearfulness                           |
| <b>Physical</b>      | Tension in muscles. May have muscle aches. Some sleep loss       | Stomach upset, migraines, fatigue, hypersomnia or insomnia                        | Tend toward mental clouding and confusion, insomnia |

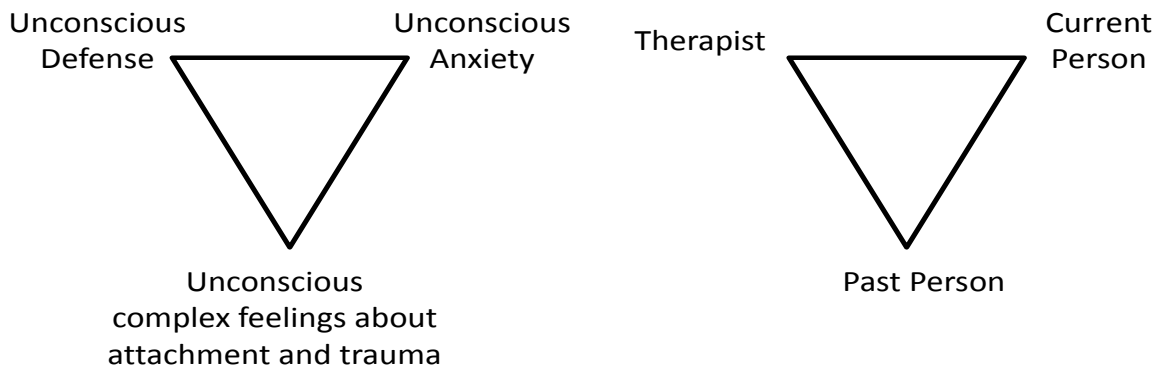
Table 2

*Client Categories Using ISTDP Meta-psychology*

| <b>Category</b>                    | <b>Treatment Duration</b> | <b>Common Symptoms</b>                                                                                    | <b>Common Themes</b>                                                                                                 | <b>Process</b>                                                                    |
|------------------------------------|---------------------------|-----------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|
| <b>Low Resistant</b>               | 1-2                       | Worry and mild tension                                                                                    | Loss                                                                                                                 | Experience grief about recent and past losses                                     |
| <b>Moderate Resistant</b>          | 2-10                      | Tension and anxiety, sleep loss                                                                           | Loss of control, fear of death of self or loved ones                                                                 | Override detachment and feel underlying complex feelings                          |
| <b>Highly Resistant</b>            | 20-40                     | Irritability and defensiveness, isolating self, sleep loss                                                | Loss of control, control by others, fear of death of self or loved ones                                              | Turn against firmly held defences then experience and process underlying feelings |
| <b>Resistant with Repression</b>   | 20-40                     | Diarrhea, migraines, fatigue, muscle weakness and depression                                              | Helplessness, hopelessness, resigned to death or welcome death                                                       | Build anxiety tolerance, then process underlying complex feelings                 |
| <b>Fragile Character Structure</b> | 20-150                    | Confusion, fearfulness to paranoia, functional neurological symptoms or paradoxical calmness/dissociation | Rage about abandonment, fear, preoccupation with conspiracies or calm resignation to possible death, Rotating themes | Build anxiety tolerance then process underlying complex feelings                  |

Figure 1

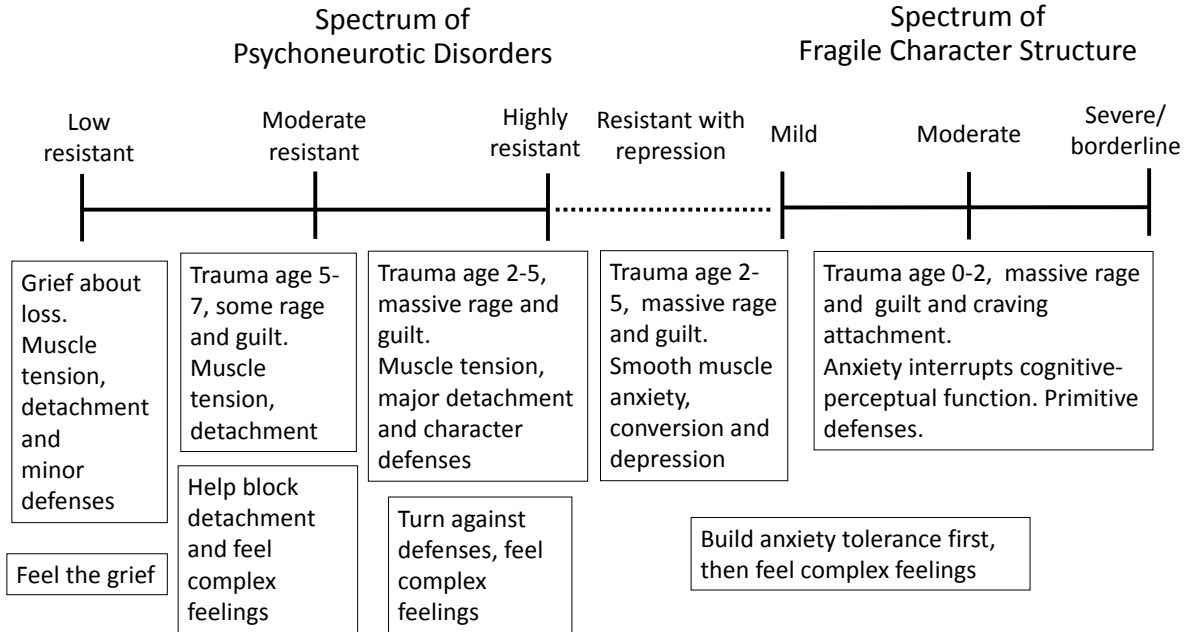
*The Two Triangles*



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Figure 2

*Spectra of Clients Suitable for ISTDP*



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