

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

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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 dates go as far as the 1960's, but, widespread clinical use of these has been ushered in by more recent technological, financial. (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 and cons of 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 somatic, psychological, and interpersonal 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.

Some initial challenges of using this technology include clinician and client discomfort with the technology. When original reviews were written almost 20 years ago, videoconferencing and review of session recordings were not as common as they are today. Now people are more comfortable being recorded and some clients come to expect or even insist that they will be recorded for quality improvement. Given the widespread use of social media and the fact that almost everyone has a camera in the form of a cell phone, people are generally more accustomed to being recorded. Thus, it is relatively easier to transition to recording and videoconferencing treatment sessions now than it was before the turn-of-the-century. Certainly, taking some extra time while orienting clients to the quality control rationale of using video recordings and the value of being able to see each other while connecting with videoconferencing technology can be helpful.

If you have not been recording your counselling sessions or using videoconferencing, the concept of beginning to use this technology may be a challenge. Among other issues, this can result in discomfort or worry about how you will appear and perform on video or how others will perceive you while using recordings for peer review or supervision. These things may take some getting used to. However, once the initial discomfort passes, you will benefit from consultation and support from peers that this technology allows.

Videoconferencing Issues

Secure videoconference applications are now more commonly used in clinical settings. However, there are certain issues that may arise while transitioning to this technology. Some of these issues are as follows.

A Change in the Frame

Beginning to have online treatment sessions changes the treatment frame. First, you may be in your own home and you are seeing the client in his or her own home while you are

providing treatment. At the time of this writing, the vast majority of counselors in the Western world are housebound and not using their offices for clinical care because of the risk of spreading infection inside small offices. Now you are working from your house and your dog might be outside your door barking. You are only a few feet from post-work activity you will be doing later. You may be one room away from your children or partner. The context is a bit different and something to get used to. It is the same for your client who is possibly going to be sitting in his living room having shuffled his spouse and children out of the room for that hour. Otherwise she may be in a car, bedroom, or even a closet trying to find a private space. Another change in the context may include using a different administrative contact to arrange appointments and provide some orientation to the videoconference technology. We recommend being patient with yourself and clients while navigating this unusual situation. If there are feelings or other responses that come up about the change in frame or the technology, then we recommend examining these feelings as a part of the therapeutic process so they do not become a treatment obstacle.

Comfort with Technology

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

Security and Confidentiality

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

New Client at a Distance

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

Looking into a Computer

With most videoconferencing applications you are typically looking at a computer screen at a person who is doing the same on the other end. Collaborate with your client to ensure adequate lighting and sound for a therapy session. Headphones are advisable along with

adjusting your typical speech and turn-taking rates to the available Internet speed at the time of your videoconference. Even under the best conditions, the sound and appearance of the client will obviously differ from an in-person session. Getting used to these differences is important and it can help to imagine or think of the client in three dimensions while attempting to connect via a two-dimensional image. It can also be helpful to normalize the context and to begin referring to the videoconference space as “here with me” or “here together” while attempting to reach through any related barriers to connect with your client.

Where is the Eye Contact?

If you’re used to working in a therapy model where eye contact is encouraged and expected, such as ISTDP, it can be a challenge to maintain eye contact or even to know whether or not the client is looking at your eyes on their screen. Using a computer, it is useful to position the image of your client in the videoconference application just below your computer webcam so that you are looking in the general direction of the camera while viewing your client’s image. Also, positioning your computer so that the webcam is at your eye level and sitting back from your computer slightly can enable good approximation of direct eye contact so you can detect breaks in eye contact and other nonverbal distancing maneuvers. We recommend coaching your client to set up a similar arrangement.

Seeing the Upper Body and Gestures

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

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 notice and study 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-supervision from video recording review, 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.

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

In the tense and busy response pattern, the person is fairly well-adapted, keeping up on news, staying busy, mentally focused, and ready to respond to the environment. He may lose some sleep and complain of being tense. He is reaching out for information and supports. He aims to lend support to others and has energy to do so.

In the weak and depleted response pattern, the person will be fatigued and note weak muscles. He may want to stay in bed. He may have stomach upset, headaches, and other somatic symptoms. He may be pessimistic and very depressed. He feels overwhelmed and defeated by the stressor, akin to a state of learned helplessness. In the extreme, he may have suicidal ideation. He is quite prone to substance use at this time.

In the frightened and guarded response pattern, the person is acutely preoccupied with the threat from the stressor. He may be obsessed with the risks of infection and be extremely vigilant to prevent it. He will have a lot of difficulty sleeping due to fear. He will have difficulty trusting others not to contaminate him so will likely avoid people and become more socially isolated. He may become overtly irritable and hostile toward perceived threats. His senses are all on high

alert, noting sounds smells and even tastes he would not otherwise detect. He may be too afraid to use a substance or medications to calm down.

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 an exacerbation of 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
General Stress Response Patterns

	Tense–busy	Weak-depleted	Frightened-guarded
Cognitive	Realistic view on the crisis or obsessions about the crisis	Depressive view of the crisis, suicidal ideation	Paranoid ideas, preoccupied with threats, risks
Behavior	Staying educated, active, engaged, some compulsive behaviour	Low activity, avoidant due to low energy and drive	Hypervigilance, monitoring excessively
Interpersonal	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
Emotional	Nervous, irritable, but able to grieve losses that arise	Weepiness, helplessness, hopelessness	Irritability, fearfulness
Physical	Tension in muscles. May have muscle aches. Some sleep loss	Stomach upset, migraines, fatigue, hypersomnia or insomnia	Tend toward mental clouding and confusion, insomnia

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).

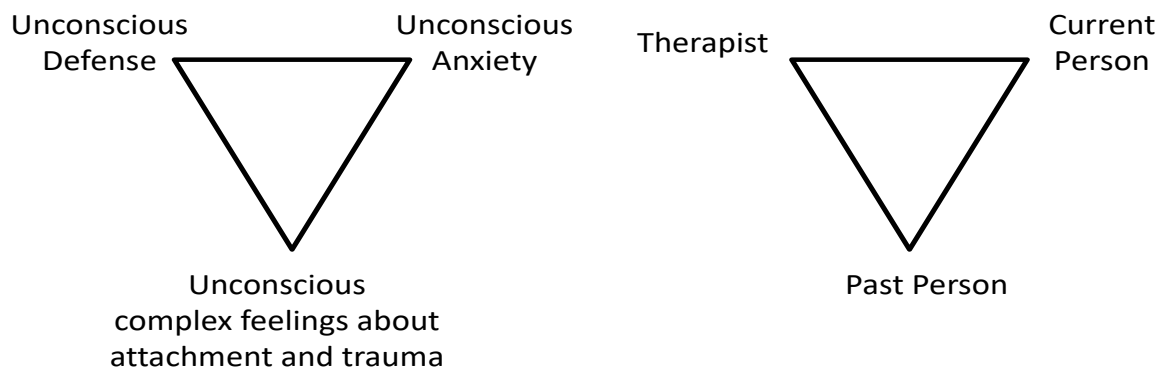
The ISTDP model has a dynamic emotion-focused framework emphasizing the close study of nonverbal and verbal communication as well as unconscious anxiety and emotional pathways in the body. The ultimate objective of the treatment is handling unconscious defensive patterns or resistances that prevent emotional closeness with the therapist and the subsequent experience of unprocessed complex feelings related to the client's early attachment disruptions

or adversities. In this framework, symptoms and behavior problems related to current and past attachments and attachment disruptions are the central focus (Malan, 1995; Figure 1).

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

Figure 1

The Two Triangles



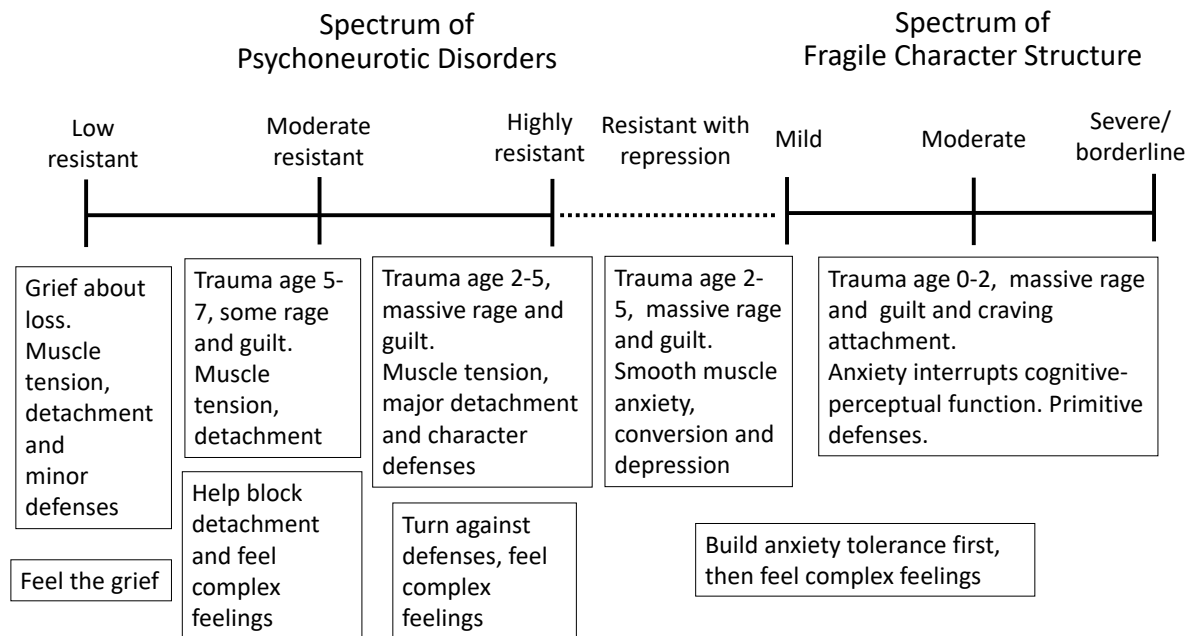
A major emphasis of the ISTDP model is on evaluating attachment patterns as identified by defensive response patterns to the clinical interview (Neborsky & Bundy, 2013). Clients are categorized along two major spectra in the ISTDP metapsychology (Figure 2). First, the psychoneurotic spectrum, includes clients who have somatic anxiety mediated primarily through voluntary muscle tension along with capacity to isolate affect and use formal defenses to distance and detach from the therapist. On one end of the psychoneurotic spectrum are low resistant clients who have had a loss with grief that is not resolved. They do not have any unprocessed rage or guilt about rage towards attachment figures and they have a secure attachment style. On the other end of the spectrum are highly resistant clients who have had major disruption of attachments inside the first five years of life (e.g., loss, parental divorce or depression). These clients have rigid defensive patterns that prevent closeness with the others, including the therapist, resulting in self-sabotaging behaviors and that prevent access to their own feelings. These defenses are so fixed and automatic that the client himself cannot see them anymore. These clients have intense painful feelings, rage, and guilt about the rage toward attachment figures. In the middle of the spectrum are moderately resistant clients who have had later attachment trauma, typically from age 5 to 7. They have a moderate level of intensely held defenses to prevent the experience of mixed painful feelings, rage, and guilt about rage related to these attachment interruptions (Figure 2).

The second major spectrum, fragile character structure, includes clients with limitations in anxiety tolerance and reflective capacity, resulting in cognitive perceptual disruption and primitive defenses at some level of rise in anxiety. Mildly fragile clients experience cognitive perceptual disruption and use primitive defenses at a high rise in anxiety while severely fragile clients have the same experiences at a low rise in anxiety. These clients have insecure attachment or disorganized attachment styles. The more severe fragile clients have dissociative disorders and borderline personality features (Figure 2).

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

Figure 2

Spectra of Clients Suitable for ISTDP



Interventions to Match Response Patterns

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

Table 2

Client Categories Using ISTDP Meta-psychology

Category	Treatment Duration	Common Symptoms	Common Themes	Process
Low Resistant	1-2	Worry and mild tension	Loss	Experience grief about recent and past losses
Moderate Resistant	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
Highly Resistant	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
Resistant with Repression	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
Fragile Character Structure	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

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

Common Themes Emerging Around the Coronavirus Crisis

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

Loss

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

Stuck with the Family

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

Economic Losses

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

Uncertain Future

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

More Closeness

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

Less Closeness

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

Calm and Indifferent

Some clients you have more tendency toward self-destructive to these stressors with a paradoxical calmness, somewhat akin to “la belle indifférence” seen with some conversion patients. They feel relaxed under what they see as ‘abusive’ threats from the virus and controls by others. One patient, for example, noted that she no longer felt the urge to cut herself and felt oddly relaxed. In these cases, it is important to help the person turn against the pattern of passive submission and avoidance of emotions being mobilized in a difficult situation, in order to make further therapeutic gains.

Conclusion

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

you the best in your clinical care and in your own adjustment to this crisis and any future crises that you may experience during your career.

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