

Reflections on online psychotherapy in the age of COVID-19

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Introduction

The context of this article (and indeed, this issue of this journal) is the current COVID-19 pandemic—which, as at December 2020, has led to populations in nearly half of all countries in the world experiencing some form of self-isolation and/or social alert levels or “lockdown”. One of the implications of this is that psychotherapists have had to transition from working face-to-face in person in their consulting rooms to working face-to-face online, mediated by a screen. This shift, in addition to the necessary speed of what for many therapists is a radical change in the delivery of our practice, has already thrown up a number of responses and issues, some of which have been identified in early research studies (Békés & Aafjes-van Doorn, 2020). This includes concerns around the technology supporting online practice and the practicalities of such practice, as well as number of clinical considerations (Silver et al., 2020). Despite this, a number of initial studies have reported on positive attitudes of psychotherapists towards online psychotherapy (e.g., Békés & Aafjes-van Doorn, 2020; McBeath et al., 2020), and, for instance, a decrease in missed appointments (Silver et al., 2020). In this article, we focus on our experiences of changing clinical practice in the age of COVID-19, how we understand that, and what themes arise from that. Drawing on a wide range of psychotherapeutic literature, we offer a framework that integrates our thinking about psychotherapeutic practice in the context of the current crisis.

The article begins by offering some background to the authors' interest in this subject, and acknowledging the immediate, local, and global context of the coronavirus pandemic. It then discusses each of the five themes identified, i.e., transition, the dynamics of administration, therapeutic space(s), working with unconscious dynamics and processes, and uncertainty. Throughout the article, we use italicised text to indicate our separate voices and vignettes about clients.

Background

Although we have come together to write, discuss, and ultimately co-author this article, we have done so from slightly different perspectives.

Gina writes: *My interest in writing about this comes from a sociocultural Indigenous perspective. I have facilitated counselling training and student supervision online for the last seven years and, more recently, received online supervision due to geographical*

distance, but have not worked this way in my psychotherapy practice. My gestalt training as a psychotherapist was conducted in person and focused on the presence and “aliveness” of the relationship *kanohi ki te kanohi* (face-to-face). The ground of my work being in the relationship has called me to commit to translating this through the online space and, being Māori, working online has, to date, attracted Indigenous clients to me with whom I would not have had the option to work previously. Socio-politically, my alignment is with the Black Lives Matter movement, which calls for public conversations about painful histories and demands a liberated future with as much ferocity as COVID-19. Notwithstanding this, psychotherapy practice is presented with the opportunity of a new frontier for decolonising our practice and including the authority of Indigenous knowledge as part of these new field conditions.

Keith writes: My interest in writing about this subject came from a number of experiences and perspectives. While I have been offering online supervision for over 10 years, as far as working with clients has been concerned, apart from the occasional telephone session (usually in the context of an emergency) I have tended not to work with clients online. I have always preferred (and perhaps privileged) the live, “in-person” relationship. Secondly, and relatedly, I have been provoked by the challenge of a colleague to think more about the nature of reality—or, more accurately, realities—and extending this to include virtual realities and relationships and, therefore, working in and with different media to accommodate different ways of working. I am also interested in how this might change the scope and range of psychotherapy. As someone who is interested in the politics of psychotherapy, I am (almost) excited by the prospect that we could be on the verge of a paradigm shift in how psychotherapy is or can be delivered, and therefore accessed—especially by people who may not have been able to access it before.

Louise writes: Despite working as a psychotherapist for over 30 years, and enjoying the benefits of technology, with which I lack any natural affinity, until the beginning of April 2020, I had never conducted a therapeutic meeting or supervision online. I had used the phone with clients rarely in emergency situations, and perhaps half a dozen times to talk to clients who were dealing with challenging situations but who were unable to attend sessions through family illness, or because they were working away from home. I had experienced the usefulness of such contact in those situations, but was convinced that what Allan Schore (1994) referred to as the “psychobiological regulation” and the right-brain-to-right-brain communication necessary for psychological contact was impossible if I was not with the client in the same room. Like Margot (see below), I had concerns about my capacity to sense the states and the worlds of clients and supervisees if I were relying solely on information derived from seeing and hearing them. However, in the short time I have been working online as a result of shifting my practice due to the current Alert Level 4 in New Zealand, I have been astonished and excited by my clients’ feedback, as well as my own sense that our meetings have been as helpful as ever. I have also been interested in the opportunities the online medium presents, and by the feelings and thoughts arising in me during recent events as I come to terms with how much less control I have over therapeutic boundaries and the provision of the therapeutic environment.

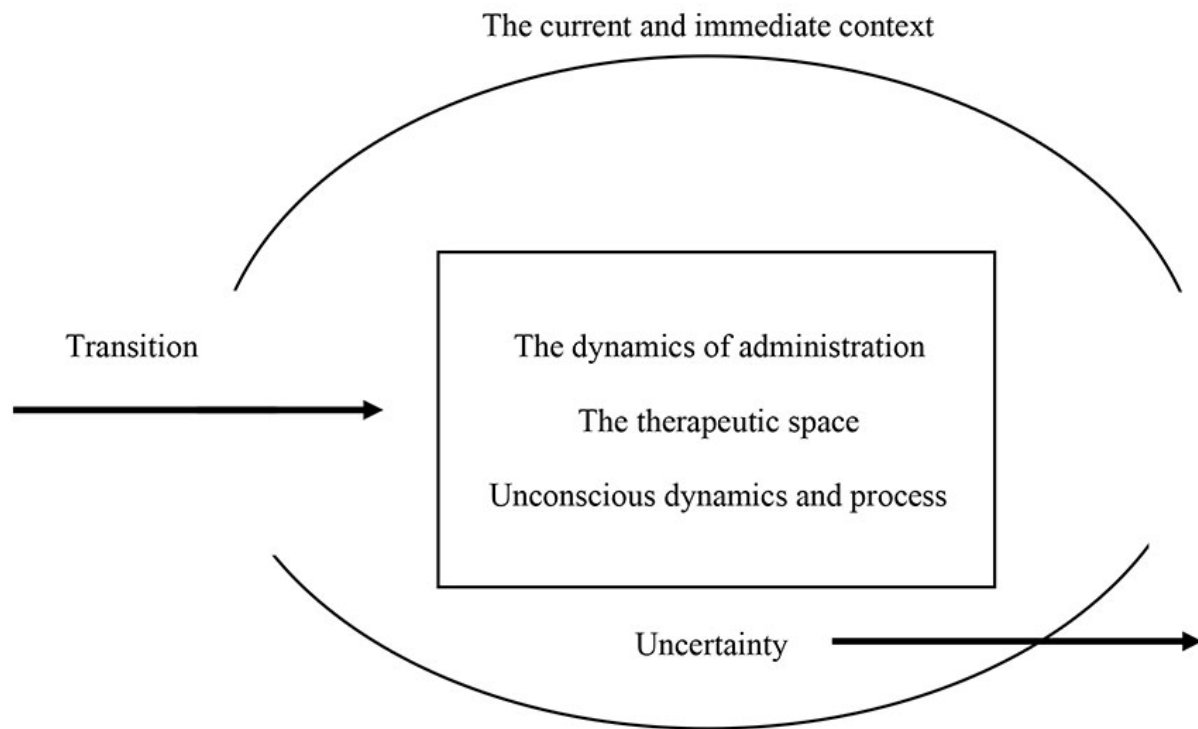
Margot writes: *I have worked online for 10 years, as a teacher and a supervisor, but hardly ever as a psychotherapist. It is not my preferred way of working, but something I have done for expediency. My main concern about working online is what happens to the felt sense (Gendlin, 1981) when the other is seen on a screen and not experienced in the room. Felt sense incorporates my experience of myself, the other, and the context in the moment. It is for me primarily a bodily experience. I have grappled with what working online does to the relationship. I know from talking to colleagues that some therapists prefer the phone to Skype or Zoom; they say they can get a sense of their clients better through the sound of their voices. I prefer to have the visual alongside the auditory. What this means in the face of COVID-19 is a question I wish to explore. The big change now in the current crisis is that I am running groups online. I have been surprised at my experience in the online group—it does seem to work. However, I hold a concern that the therapist loses control of dynamic administration in the online setting. Is that my issue? I want to understand more about this, too.*

Given these interests, and in response to the call for papers for this special issue, we four came together, inevitably and appropriately enough online, to offer some reflections on what we are seeing in our practices (vignettes from which appear in italicised type throughout the article), what we are thinking about it, and how we are conceptualising the issues we are seeing in the microcosm of therapy in relation to (and in the context of) the macrocosm of the world. Our methodological approach was a heuristic self-study (Moustakas, 1990; Sela-Smith, 2002). The word “heuristic” means “serving to discover or find out, originally from Greek *heuriskein* to find; find out, discover” (Harper, 2020). As a research tool, heurism embraces the researcher’s everyday experience of a particular phenomenon as the focus of study. In this context, this entailed each of us reflecting on and writing about our experience of conducting psychotherapy online. Following our individual reflections we responded to each other’s experiences. Typical of the heuristic method, we wrote our way into the themes, which emerged through each of us writing in a shared document and then responding to each other. The writing of this article has a quality akin to working online generally, i.e., each is sitting in their own personal space, and communication is through the online medium. The heuristic method is enhanced by the shared intersubjective enquiry by the co-researchers (Key & Kerr, 2011). The heuristic methodology is well suited to exploring new experiences from multiple perspectives.

We represent our conceptualisation of what we are seeing (and the structure of this article) in Figure 1, in which the overarching context is on top, acknowledging the fact that the COVID-19 virus is airborne. The transition between therapeutic practice before COVID-19 and the present is marked by the first horizontal arrow representing linear time. The therapeutic space is represented by a square or *temenos* (see Tudor, 2001; Tudor & Embleton Tudor, 1999), in which we pay attention to the dynamics of administration, the space itself, and the unconscious. The final element, uncertainty (which is, as it were, underneath all of this, and which we anticipate will continue) is represented by a second horizontal indicating a movement forward. We view this as an integrative framework, not only because it is informed by theoretical perspectives from different traditions of psychotherapy—our own education/training(s) and influences encompass person-

centred, psychoanalytic, neo-Reichian, integrative, gestalt, transactional analysis, group analysis, relational, and pluralistic—but also because it acknowledges the interface and interplay between the social, cultural (and political) context and clinical work and concerns. As such, it offers a working framework across settings, theoretical orientations and therapeutic modalities as well as—we hope—space and time.

Figure 1. A conceptual map of elements of online therapeutic practice in the age of COVID-19



The Immediate Context

In the context of the COVID-19 pandemic and the associated healthcare responses, changing the form or delivery of practice has meant (or will mean) rapid adaptation to the use of online technology and applications for many psychotherapists (e.g., Feijt et al, 2020; McBeath et al., 2020). This may be relatively easy for those who have studied or trained more recently in university programs, as many universities are already providing some of their lectures and classes online. Those who were already practicing different forms of online therapy may also manage the transition without too much difficulty. Conversely, it will be harder for practitioners who have little or no experience of working online, and especially challenging for those who may have been sceptical or even antagonistic towards this form of therapy. Those who studied or trained at private psychotherapy education/training institutes may also struggle, as the majority of these programs have not prepared their students/trainees for online practice. Many therapists are having to learn not only about a new medium (and its technology) but also about a new culture—that is, the culture of online technology, systems, platforms, and communication in a professional (rather than social) context (see Ioane et al., 2021).

Practitioners who are used to working face-to-face and in person with clients, and especially those used to working long-term, may find such rapid change not only challenging but anxiety-provoking—for both therapist and client. Moreover, while more traditional talking therapy may be more easily transferable from the consulting room or outdoors in nature to the screen or phone, such a dramatic change of form may have a greater effect on those who work with children and young people, as well as those who specialise in group work or creative, expressive, and somatic therapies. Whilst such transitions are challenging, especially in a time of crisis, they also offer opportunities for creative and, we suggest, more integrative responses (see DeLuca et al., 2020; Wade et al., 2020).

For some colleagues, creating a private and secure space (and frame) at home is challenging. For at least one colleague we know, this involves the rest of her family staying off the internet while she is working online with clients—a truly systemic response. In the current context, colleagues all over the world are dealing not only with their clients' issues and responses to the pandemic and its consequences, but also their own anxieties, which include transferring and maintaining their practice.

In addition to questions regarding the safety and security of different forms of online communication platforms (see Ioane et al., 2021), using online media can be challenging. This is especially true for those who are not used to them, those who are hard of hearing, and those who have sight impairments. This is because the technology and commercially-based platforms that are currently being used for the purposes of online therapy have not been designed for use by people with disabilities. In addition, communication can be challenging when trying to use a medium with someone who finds technology uncomfortable, confusing, and/or frightening (see, for instance, Vincent et al., 2017).

Moreover, therapists are making these changes in the context of a pandemic in which we—clients and therapists alike—are involved. We are critical of the notion that this pandemic (or any other pandemic or epidemic) is a great leveller, as clearly COVID-19 strikes different populations and communities differently (Thomsen, 2020). This is also true historically: for instance, New Zealand's death rates in the 1918 influenza pandemic were eight times higher for Māori than for *Pākehā* (non-Māori) (New Zealand History, 2020). This is a historical and social fact that had a huge impact on the history of New Zealand, with resonances that still echo today. Nevertheless, the sense in which “We're all in this together” (a phrase/slogan used by the current New Zealand government) does acknowledge that clients and therapists are both sharing the phenomena around COVID-19. Each have experiences of (and responses to) restrictions around movement and travel, self-isolation, lockdown, increased government regulations, and so on—experiences which, we suggest, are common and shared, not identical and levelling.

This is the current, immediate, and changing context in which many psychotherapists have had to make a radical shift in our practice. The rest of this article considers this shift in relation to five identified themes.

Transition

While psychotherapists acknowledge the importance of attachment and loss (and, therefore, of transition), many therapists as well as clients are not so comfortable with the transitions that accompany change (and especially enforced change). In the current context, perhaps the first and most obvious of these is managing technology.

In shifting from face-to-face, in person therapy to face-to-face, online therapy, therapists and clients are having to establish and deal with some form of technology (such as the phone, Skype, or Zoom), all of which require some negotiation in terms of setup and an invitation to the meeting, as well as some maintenance (especially when things go wrong or the communication is interrupted), and raise a number of issues of clinical interest.

The political and socio-cultural determinants of health do not favour First Nations people around the world (Yashadhana et al., 2020). This acknowledges that in shifting from *kanohi ki te kanohi* (face-to-face) to the online space for First Nations clients, one real challenge is socioeconomic (for instance, loss of employment as a result of COVID-19), which makes the use of technology challenging (Carrington et al., 2020). The cost of electronic devices suitable for therapy, as well as of WiFi and data: all impact on the therapeutic relationship.

One client sent a text message, saying that they could use their phone data for the session until it ran out because they lost their job and had to cancel the internet account to save money. The therapist saw this as a threat to the safe container of the therapy and, specifically, the well-being of a First Nations client in a system that does not recognise the benefits of psychotherapy. After a brief yarn about what would support the client for access to the entire session time, the session was conducted by phoning through to the mobile device. During the session, therapist and client uncovered the importance of acknowledging the systemic racism felt by the client of being othered, a process that clarified their desire to manage their closeness to their vulnerability and choice to control things in their life.

Communication about how to join a meeting can be a challenge, and may involve a flurry of emails or text messages back and forth between client and therapist, some of which may be instructing the client, but some of which may be instructing the therapist—which, of course, has an impact on the therapeutic relationship.

One client sent a text to their therapist, saying that they (the client) would invite the therapist to a Zoom meeting. The therapist viewed this as a challenge to their ability to hold the therapeutic space and frame. In the event, the client did not send an invitation; the therapist did, but the client was unable to access the meeting. After 20 minutes of emails and text messages, therapist and client established a connection by phone. Some time into what remained of the session, the therapist was able to help the client make a connection between their need to control the process of connection with their sense of a lack of control in their life at this time. One colleague working with couples reported that when couples were in the throes of full blown conflict, he really missed being face-to-face

and in person, as he felt more in control of the environment and able to assert boundaries around the therapy more directly and effectively. Another colleague had the opposite experience with individuals, and noticed that she was more active and even directive when some of her student clients were in difficulty online—as if she felt that she had to really reach into their space in order to get alongside them.

More generally in our practices, we have noticed that the focus of the beginning of the session has moved from meeting, greeting, and seating, with the usual “Hello” or “Welcome,” and a handshake (or not), to, as it were, “adjusting the set” and thus “Can you hear me?” “I can’t see you,” “Wait a minute; I’ll see if I can adjust the volume,” etc. We think that this represents a subtle but significant shift: in effect, from “How are you?” to “How is it?”

Also, when the first few minutes are taken up with establishing the connection and/or dealing with any technical hitches, the therapist or the client can end up offering the other some advice (for instance, about which button on the keyboard to press), and, thereby, take on the role of being a technical helpline advisor. While this is helpful, it does change the relationship, and, we suggest, needs some reflection and thought, and, for instance, linking to the client’s presentation and history. For the therapist, such beginnings and hitches may cause some anxiety.

Gina: From a First Nations therapist perspective, a holistic view of practice is not new. Te whare tapa wha (Durie, 2004) and social and emotional wellbeing (Gee et al., 2010/2014) are two multidimensional and Indigenous models of health for First Nations groups, which emphasise connection between culture and land. This whole-of-lifespace view includes the switching of roles from therapist to mentor when responding to a dilemma in the session about a cultural matter in the community, such as government services being suspended since the last session. For a First Nations therapist, becoming a part-time technician momentarily is not a stretch: it’s part of the practice.

Louise: I noticed how, at the beginning of working online, when the internet connection was weak, resulting in temporary interference or distortion on the line, my anxiety and sense of responsibility increased. It was as if I had failed to provide a good enough environment, even though I believe that what I am offering over this time is good enough and that, for some clients whose anxiety or isolation is particularly hard to bear, it is more than good enough.

Gina: I was interested that I was calm at the start of sessions when the internet was “unstable” and the screen was frozen, intermittently interrupting our connection. My sense of connectedness became my figure against this interrupted context/contact. I found myself thinking on my feet about other ways to connect in that moment in order to stay in contact with the client until the technological issue was resolved. Using the chat facility of Zoom and texting, “I am here, we will resolve this and be back in contact shortly” was a resource for me to be able to communicate my commitment and the importance of our

relationship to endure these teething issues, possible therapeutic ruptures as a result of feeling othered or abandoned, as well as the larger field situation of COVID-19, which also affects me as a therapist.

The transition to online therapy also has an impact on the therapists use of different senses.

Margot: When I have tried phone therapy, I always found it hard to stay engaged, which represents a personal, idiosyncratic preference for visual feedback. Some years ago I had the occasion to understand this further when I lost my vision for about six weeks due to a detached retina in one eye and a cataract on the other. My visual register is critically important to my felt sense of the other. I found that while I have strong physical resonance with people I am with, it is the visual register that helps me make sense of that. I was not confident that this would transform to the online setting. However, it has. In all my online experiences, while I was more tired from the increase in effort required to attend so vigilantly to what I could see and hear, I was able to use my felt sense as usual. I am beginning to understand a little of how it might work, a process that Stern (1985) describes as representations of interactions that have been generalised (and, in 1998, as “ways-of-being-with”). All my current psychotherapy relationships are ongoing, and so I can hypothesise that each person (including myself) has already generalised the experience they have in the therapy space at a core level of functioning. This creates a base from which we can work with the difficulties inherent in the current situation.

All transition involves loss and, therefore, grief. We suggest that acknowledging and understanding grief can help with processes of transition and change, both personal and social (Marris, 1974). Thinking about this in terms of Kübler-Ross' (1970) seminal work on death and dying, we can understand psychotherapists' various and changing responses to the need to shift their practices thus:

- disbelief about the seriousness of the pandemic—as denial; the discounting of the difference of online practice—as denial;
- the lack of preparation for online meetings—as (displaced) anger;
- continuing face-to-face in person practice, and justifying it as psychotherapy is classified as an essential service—as bargaining;
- closing their practice—as a form of depression; and
- viewing the current situation as “the new normal” —as acceptance.

While these stages are identifiable and useful, Kübler-Ross' work has been supplemented and somewhat superceded by perspectives that acknowledge continuing bonds with the deceased (Klass et al., 1996), and with another wave of models that acknowledge and emphasise loss and grief as multi-factoral and multi-dimensional. One of these is Wanganeen's (2010/2014, 2011) seven phase model, which is based on what she has referred to as “seven humanities,” i.e, mental, emotional, physical, spiritual, sexual, social, and cultural. Drawing on Western systems but, more significantly, her

experience of the health challenges experienced within Aboriginal communities, Wanganeen identifies seven phases across three time frames: past, present, and future (see Table 1).

Table 1: Seven Phase Model of Grief (Wanganeen, 2010/2014)

The Present	Phase One	Contemporary adult major grief reaction
The Past	Phase Two	Identifying childhood and adolescent multiple losses and suppressed unresolved grief
	Phase Three	Ancestral losses and suppressed unresolved grief being “converted” into intergenerational suppressed unresolved grief
	Phase Four	Identifying ancient Aboriginal and European grieving ceremonies/activities using the physical body for its expression (i.e., what they lost)
	Phase Five	Identifying ancient Aboriginal and European grieving ceremonies/activities creating and maintaining Intuitive Intelligence in the highest degree (i.e., what they had)
The Future	Phase Six	Recreating Aboriginal grieving ceremonies/activities using the physical body for its expression
	Phase Seven	Maintaining Aboriginal grieving ceremonies/activities to maintain Intuitive Intelligence in the highest degree.

Gina: *For me, as a First Nations psychotherapist shifting practice, and drawing on Wanganeen’s (2010/2014) model, my thinking and work is as follows:*

- *The present (Phase One): for example, questioning about the sudden shock of how the change to practice happened so quickly and why it needs to happen? (I do not want to be told what I can and cannot do!).*
- *The past (Phases Two to Five): addressing my own history with loss, naming systemic oppression and trauma as a result of colonisation that I carry, being aware of my own feelings of anger about this, being less organised for sessions due to other community and professional meetings/commitments and negotiation for the home office space, choosing to go online to support community fears and risking being othered because lockdown laws do not restrict in-person psychotherapy in Australia (“Why is she not meeting us in person?”). At times this was too much. How do I stay true to cultural protocols of being in person and work safely to protect my own physical health and that of my family by going online? Mostly, I was deeply connecting to the concept of hau ora (wellbeing) that I am supported by: wellbeing that links all of our experience together, that is, connection to people, land, body, mind, and spirit. I connect to that wellbeing online as best as I can. Once I was able to connect myself and the person, even despite the frustration of technology, and find an object or piece of country or whenua to support us, we could connect deeply. Indigenous cultural healing practices that have existed for millenia support me to be open and, in turn, to support clients and the wider community during COVID-19, via the online space.*
- *The future (Phases Six and Seven): accepting the current situation and continuing with creative ways of applying Indigenous healing concepts in this online space; creating story lines about the impacts of COVID-19 on Country, communities, and our bodies, and how past ancestral knowledge can shape what the future looks like; acknowledging collective grief and loss experiences of colonisation and capitalism, rather than individualising client issues—this is not a choice for me, as I see it as part of my role to decolonise and make visible to my clients that our shared sociopolitical history is the context in which we experience our lifespace; acknowledging collective grief and loss as part of the COVID-19 situation, which provides a shared context and unburdening of internalised colonised experiences, while also advocating for “individual, family and community mental health and social and emotional wellbeing” (Wanganeen, 2010/2014, p. 491).*

The Dynamics of Administration

In group analysis, the term “dynamic administration” (Barnes et al., 1999) is used to connect the practical with the dynamic. This means that the therapist considers the underlying possible meaning of anything that occurs in a group that has an impact on the frame. COVID-19 has had a huge impact on the frame of the group. All of us have increased anxiety, and our awareness of this varies from person to person. The way each person expresses their anxiety reveals the structure of their own subjectivity.

Margot: *I was amazed to see that the person whose voice kept fading out in the online meeting was the one who often moved his chair slightly out of the group when we were in the room in person together. The group wondered about that with him. Of course, the complexity of thinking about events like this dynamically includes the consideration that the issue is purely technical. When we are anxious and unused to technically-oriented equipment, what better way to manage the discomfort than to righteously blame technology: "The line drawn around a group, creating a boundary, makes creativity possible... A good enough external holding environment becomes an internalised holding environment" (Barnes et al., 1999, p. 29).*

In an online group, the line around the group (or frame) is to some extent lost. When the group meet face-to-face and in person, the group conductor holds the space. When a group is online, each group member has to take full responsibility for creating and holding their own space. This is also true for individual meetings. This can be a useful learning for the client, but also poses problems. For some, finding a safe space in the context of the current lockdown can be difficult, when many people live together and especially with children.

Margot: *I noticed one individual client who struggles with boundaries was constantly interrupted by her young children.*

One of the assumptions about effective therapy, whether individual or group, is that the client feels safe: safe enough to be vulnerable, and safe enough to explore emotions and memories that may be extremely uncomfortable.

Margot: *Some of my supervisees have reported that there are people in their practice that seem to flourish in the online space, as if the greater physical distance gives them confidence. Another theme that has emerged is when the therapist feels an emptiness in the online session, as if the client is not really there.*

Two Examples of a Feeling of Emptiness

Margot: *In two separate individual sessions on Zoom, I felt an emptiness, a lack of connection with each of these two clients. It is only afterwards that I linked them together as possibly having a similar issue, one that in face-to-face therapy I was intuitively working with them on. One client where I felt this feeling of emptiness was a female, who I had always experienced as barely physically present. The male client approached therapy in an intellectual way, and is not connected to his physical self. The online sessions with each of them was very different from face-to-face sessions, where a connection had been made. There was something that had been happening face-to-face that was no longer there in the online session. I thought that, when they came into the physical therapy space, there was an embodied holding that I did, a non-verbal, unconscious, empathic connection to an aspect of these clients. In the sudden move to meeting by Zoom, I noticed the absence of a sense of connection. I think that when I was in the physical room with my client, I unconsciously cross-modally matched (Stern, 1985) my client. I can only use my imagination about how that was. It may have been a*

movement of the head of the client, inclining themselves towards me and I may have made a sound in my throat. There were probably a whole range of these cross-modal matchings that settled the client and enabled them to be connected to me. Online this was less intuitive. This kind of holding is an essential part of working with traumatised clients.

The Therapeutic Space

Generally, it is the therapist who provides and creates the space, usually a room, in which the therapy takes place. For Indigenous therapists, this may involve sitting on Country or the *whenua*, literally, outside. Most therapists, especially in private practice, pay significant attention to the management of external intrusions (such as noise and interruption) and how the room is decorated and set up (including what objects or pictures are in the room). Typically, this is informed by their theoretical orientation or therapeutic modality. For therapists working in the public sector, the nature and state of the room is often much less negotiable. Nevertheless, in both contexts, the therapist often sits in the same chair and asks (or requires) their clients to sit in another, specific chair. Most therapists provide water for the client to drink during the session, and therapists have views about whether or not this should extend to the provision of tea or coffee. In some cultures, therapists provide some food (a sweet or light refreshment) which is reflective of their views and obligations regarding hospitality. With online therapy, all of this changes. The client is in their own space and surroundings. However, in the current situation in which clients may be in isolation with their families, they may have less control over their environment.

One of us has had sessions with a client sitting in her clothes' closet, and with another sitting on the deck outside her house, and has also supervised and done therapy with clients sitting in their cars outside their homes or places of work. A female supervisee reported realising some way into the session that her autistic male client had been speaking to her from under his bedcovers (see Russell, 2018)—although, as he emerged, he was fully clothed. This was understood as the client having chosen the safest and most private space available, and also as a mark of trust in the therapist. It was not something to process with the client—at least not this point, as attempts to do so would likely not be comprehended and could evoke shame. The chat facility on Zoom has been utilised spontaneously by clients experiencing intrusion into the space, intentional or otherwise, or fear of being overheard.

Louise: In this new frame, my client shares their space with me as much as I share mine. Symmetry and equality are gained as power is shared. My clients can offer to show their beloved and emotionally-regulating pets. They can show precious and meaningful objects, which can thus be imbued with the sense of a soothing and benevolent therapist, thereby enhancing their power. This kind of sharing and expansion of the frame can provide the therapist with therapeutically-useful information and foci in a more immediate way. For me, though less so for some of my colleagues, this has been exceptional. Mostly, I have been surprised and amazed by how quickly people got down to talking

about what they wanted to discuss, without preamble, and with the scantest acknowledgment of our changed circumstances, or attention to any different opportunities it affords.

Time is one of the ways of organising space, holding space, and taking responsibility for the space. We notice that time flows differently in the online medium. Organisation takes longer, meetings seem longer, and everything has to be more consciously mediated, which, in turn, makes doing therapy in this medium more tiring (Feijt et al., 2020; McBeath et al., 2020), due largely to the fact that our brains are having to work harder to reconstitute the compression of video and sound inherent to online communication (Richardson, 2010). We know a number of therapists who are working in shorter sessions.

Margot: One client who in face-to-face, in person therapy constantly watches the clock and usually begins to leave before the end of the session, has apparently been unaware of time during online therapy. Usually she is about to rush somewhere; under lockdown, that is not happening. I think there is another factor: this client wants to keep control. Online therapy gives her a greater sense of control over her environment.

We have all found ourselves being more active than usual, that silences are not occurring in the same way as usual. The silences have a quality about them that is different to being in the room together. It is harder to see tears and changes in skin colour. It is as if the therapist has to check more often that they are resonating with what the client is feeling and saying. This could be because it is early days, and clients are full of immediate concerns which need expression and attention, or could it be that either therapist or client (or both) lack the same level of trust in the new medium. It could also be because the difference between an online medium and in-person work is akin to the difference between non-verbal and verbal communication. When a child learns to speak, they are often frustrated by the limits of language. Perhaps in the same way, therapists have to make significant adjustments to our ways of listening, of taking in the client, and making sense of the experience of being with the client.

Space is both external and internal. Each person has their own sense of personal space. We have discussed space as an externally-moderated part of being with another and, indeed, an important aspect of therapy is the creation and maintenance of an internal space: like a room inside where dreaming, reverie, and reflection occur. Many people do not have the capacity to use this internal space, and psychotherapy offers the possibility of developing it. In the move from entering the space of the therapist to having to provide one's own physical space, we wonder whether this aspect of the therapeutic process becomes compromised. Creating internal space in psychotherapy is borne out of the process of sitting with, and of bearing—and baring—what the client brings, of creating within the physical space a potential space; a space, as Winnicott (1971) acknowledged, “between reality and fantasy,” and a space for emotional connection.

Gina: *Prior to beginning a session, I acknowledge the tribal lands and Indigenous nation whose land it is and pay respects to Elders in the usual way. I then introduce myself by way of my pepeha in te reo Māori (the Māori language) and state that, as a fellow Indigenous person, not of this land referred to as Australia, I stand in solidarity with my Indigenous brothers and sisters on this Country. My Indigenous clients respond with which mob makes them up, where they are from, and how we are linked. There is usually a person known to both of us, whether or not the referring person is a relative, or they may have connected with me after a community training session. This multifaceted connection to country, people, and spirit, holds our work steady. Using the Aboriginal and Torres Strait Islander acknowledgement of country and the Māori pepeha allows for the inclusion of extrapersonal (Fleming, 2016) connections that reduce barriers and provide a bridge embracing a rich therapeutic exchange “across the pae (threshold)” (Salmond, 2017, p. 286) of the online space.*

Margot: *At this stage, I am aware of being less likely to go into reverie: that is, connecting consciously and unconsciously simultaneously with my clients’ material. As we say above, the situation needs more conscious mediation. I need to focus more intentionally on the client, because I cannot take for granted our shared presence in the room. The contrast in the room together is that because of the taken-for-granted presence, I can relax into reverie.*

Louise: *In this new medium, I have not yet found that stillness and groundedness in me from where I can reverie or zoom the lens of my attention closer and further away, wider and narrower, with the same range as I am used to. As I become more familiar with working this way, will my anxiety about it diminish and will I regain my full capacity? Or, maybe the medium requires me and/or my client to be more vigilant about maintaining the connection, and maybe we cannot allow the same amount of space to develop between us as in the consulting room? It never feels good (even if I might know that it is or could be helpful) if a client leaves the consulting room in the unmediated throes of a negative transference or with something seriously conflictual totally unresolved between us, but how would it feel if we ended a Zoom meeting that way? There are non-verbal ways in which I try to let my clients know that I remain solidly available and that I care about their wellbeing at the end of such a meeting, and I would not have the same opportunity when the meeting ends with a click of the keyboard as when I stand up with the client at the end of the session and we move towards the same door at the same time.*

Unconscious Dynamics and Processes

Damasio (2010) shed light on the systems in the brain which are involved in unconscious processes, on how conscious and unconscious phenomena constantly influence each other, and on many of the reasons for the unconscious often prevailing. Damasio and others (e.g., Cozolino, 2006; Ginot, 2015) have elaborated on how psychotherapy, through the therapist nurturing an environment in which the client feels cared for, resonating empathically, and engaging in reflective process in relation to transferential phenomena, can change the brain. This requires the therapist to shift their focus between internal states in which she has access to information and sensing which is easily known

and consciously available, and states of availability and attunement that are harder to sense and understand. They need to be able to transition, sometimes rapidly, utilising many systems in their brain and traversing many areas of the brain, in order to help the client to learn to do the same. We address ourselves here to a preliminary exploration of whether or how this is possible online.

Although as described in some of the vignettes above, we have been pleasantly surprised at how easily many clients appear to be settling into the new medium and framework, we cannot help wondering what we might be missing and where we might fail to appreciate and to connect with something important to our clients in the absence of the experience of being physically together in the room. So much information is derived effortlessly and unconsciously (such as smell, which strikes the amygdala directly, unlike information derived from our eyes and ears). Changes in skin colour are harder to perceive on screen, as are subtle changes in voice (tone and pitch). We cannot see changes in breathing or know when a breath is being held, although we might guess. Often we can only see our clients' head and shoulders, not whether, for example, their feet are jiggling, whether they are wringing their hands, or whether their body appears braced or relaxed. We realise that we are relying greatly on prior knowledge of each person, derived from face-to-face meetings, which, so far, generally seems to be leading to making correct assumptions and, similarly, accurate attunement to what occurs in person.

So what is happening? What is the nature of the psychobiological attunement about which Schore (1994) and others speak, and on which so many of us base our practice? How does it work and how much do we need to be in the same room? The fact that we are relying a lot on our previous experiences of our clients to sense and to "read" them accurately suggests that, whilst online therapy "works," it is not a direct substitute for being physically in the room; and we (along with many others) are working toward an understanding of those differences. We seek clearer understanding of what is gained and what is lost in each setting.

A Dialogue

Margot: *I do not tend to close my eyes when sitting in the room with a client, though I do often look away from them. I find this harder to do when online, because the looking is much more direct.*

Louise: *Yes, me too. Is that part of why doing therapy online is so tiring: that we do not get to down-regulate as much? We are looking and trying to see, and we are being looked at and possibly being seen all of the time. I have to ask some people to repeat what they have said a little more than usual and all that makes it more tiring too.*

Margot: *Yes, I think so. Like I say above, there is a vigilance of looking that I notice myself doing, which I have understood as a compensation for the lack of physical presence. I think I have relaxed more over time and I have become accustomed to the online medium. I have one client who usually lies down when in the room, and in our second online session I suggested she might like to try lying down. She did it immediately and it*

was noticeable how she also moved from thinking to feeling, she became more reflective. We know, from developmental theory, that the gaze is considered an important aspect of the infant internalising a sense of core self and self-with-other (Winnicott, 1971; Stern, 1998), and I think that, while some clients are hungry for the visual connection, others prefer to have control of where they look. I have noticed some babies are the same. Therefore I am careful when using the screen to create enough space for clients to look where they want to. One way we can do this is by sitting back from the screen so the client can see more of us. If you think about it, the personal space is much less when you consider the distance from the face that the other is sitting in the virtual environment.

Louise: Yes, I never thought of sitting further away from the screen. I have been more aware of sitting so that the client can clearly see my face and my expression. Maybe the position and distance between us is something to raise with clients, as it could be a very meaningful conversation. This reminds me that we have varying capacities to attend to our inner worlds at the same time as attending to another and to the space between us, although this is something we work hard to develop as therapists. I have a client who puts her feet up on the sofa in my room, and who, in order to remain in touch with herself and to avoid dissociating, closes her eyes to take a rest from the task of relating to herself and to me at the same time for between two and 15 minutes at least once or twice during each of our meetings. During these interludes, she often shuffles down the sofa and gets into a sleep position and I experience myself as an attuning mother. She has chosen to stay online but to close her eyes and rest her head in her hands at such times. She reports that she “feels me there,” and that it is important for her to know that I am still there.

We have found that the more we understand about the ways in which our brains tend to interpret our internal and external experiences and the unconscious patterns which result, from reading neuroscientists such as Cozolino (2002, 2006), Damasio (1999), Schore (1994), and others, the more aware and purposeful we are in choosing how and when to be active or inactive in the therapeutic relationship. Different levels of therapist activity involved in psychoeducation—as suggested, for instance, by Adern (2019) and by the practice of emotion-focused therapy (EFT) and eye movement desensitisation and reprocessing (EMDR) therapy can be viewed as (only) “techniques,” or they can be seen as part of a brain-based approach, and incorporated mindfully into practice in order to target particular difficulties and unconscious processes which have their origins in deeply-rooted and entrenched brain processes (Ginot, 2015). Some of these more active ways of being with clients seem to lend themselves better to the online medium than reverie-oriented ways of being. In our experience, it is harder to access the latter way of working when we are working online, as we find ourselves needing consciously to monitor so much of the interpersonal interaction, and, in doing so, we find that we can less easily divide our attention. Thus, it seems to us that therapists can address unconscious processes online—albeit in more active ways than in the consulting room, in which we have (or had) the luxury of being able to switch into a more reverie-based or reflective way of being from time to time.

Having offered some reflections on the implications for the therapeutic space, its dynamic administration, and working with unconscious dynamics and processes in the transition to online therapy, by way of acknowledging what is both in this space and in the outside world, we turn to the issue of uncertainty.

Uncertainty

For many of us, therapists and clients alike, uncertainty may be the hardest aspect of the current situation. As demonstrated in a 2016 study (de Berker et al.) the greater the uncertainty, the higher the stress, including when a negative outcome is the certain one. In other words, losing your job takes a lower toll on your health than fearing job loss. The study also demonstrated that people are calmer when anticipating inevitable pain than if they are told that they might experience pain. When we know what we are dealing with, we are more able to take action to prepare ourselves and to manage our stress. Activity in anticipation of the fall of the sword feels better than waiting to see whether it will fall (to which, no doubt, Damocles could have attested). Our natural and protective negative bias, whereby we assume the worst until we know for certain (Anderson et al., 2019), is designed to enable us to prepare for danger. If we cannot do so because we lack information, we are stuck in stressful, unregulated states, unable to engage the sympathetic nervous system to mediate the flood of neurochemicals in our systems, with all of the negative consequences to our wellbeing such as changes in energy, mood, appetite, and sleep. Add to this the lack of quiet or privacy in living in a crowded home 24/7 when you are not used to it; or, at the other extreme, the potential unalleviated loneliness of isolation for those living alone; and new, practical challenges: shopping for food, parenting 24/7, juggling work online, with childcare, and the expectation to home-educate, especially for home-workers and essential workers; being in isolation in unhappy relationships; being separated from new partners; worry about the well-being of loved ones; and so on, and there is a perfect storm for the exacerbation or creation of mental ill-health and physical dis-ease.

The experience of a sense of control and certainty in our lives leads to increased happiness and therefore to increased health (Mirowsky & Ross, 1998), through our sense of competence and mastery, or self-agency (Knox, 2011; Stern, 1985, 1998), and as a result of a diminished sense of threat and uncertainty. In the current context, we are all experiencing, to a greater or lesser degree, a range of threats to our way of life before COVID-19, our expectations of the future, our security, and our very existence. It is no wonder that the theme of control emerges in the therapeutic space.

In traditional, face-to-face, in-person psychotherapy, the therapist generally controls and frames the therapeutic environment (in terms of the location, nature, decor, and furnishing of the consulting room), and their clinical hospitality in the clinical space. In online psychotherapy, the therapist retains control of the therapeutic environment through hosting the meeting (choosing the online platform, arranging a waiting room, holding the time-frame, and terminating the meeting) but does not have any control over the client's environment.

Keith: *Five minutes into a first telephone session since the lockdown with a regular client, with whom I had previously been working face-to-face, in person, I realised that he was walking while we were talking. I had quite a strong reaction to this—mainly, on reflection, due to the fact that he had not told me. Another client, a young man with whom I have just started to work with online, dialled into the session from his phone, sitting in his bedroom in a shared flat. It was first thing in the morning, and he was wearing a dressing gown. We talked about this as representing him feeling relaxed—and the advantages and disadvantages of this.*

Whilst we acknowledge that certainty and control are desirable, we also acknowledge the importance of uncertainty. In a rare article on subject of uncertainty, Gordon (2003) wrote that: “Authenticity and anxiety, anxiety and creativity, creativity and uncertainty—it is the complexity of these co-creative relationships that provides the ground of tension from which existence continuously emerges” (p. 108). Uncertainty acknowledges the impermanence of being, and is seen by some as a principle of relational practice (International Association of Relational Transactional Analysis, 2009/2020). Early on when we in Aotearoa New Zealand we are Alert Level 4, some of the authors were shocked to see an email in which a major decision taken in a particular institution had been reversed because a group of people had expressed some anxiety about how the proposed changes (due to COVID-19) would affect them, citing concern about the uncertainty created by the changes. We live in an uncertain changing world—in which people, including clients (and therapists) need to be able to deal with uncertainty. In this context, uncertainty is the “new normal,” and should not be seen as a problem. Indeed, in the face of uncertainty, we have seen some clients shift their perceptions and thinking.

Indigenous knowledge allows for sitting with uncertainty. First Nations thinking is and has always been distinctive in that it is grounded in the concept of unity and reciprocity with both the natural and human world around us (Durie, 2004; Salmond, 2017) transmitted and recorded through strong ancestral narratives, song, weaving, and many other methods. We and our ancestors are “part of” the field (Lewin, 1951). This is different to most Western concepts (of the individual), and it is suggested that by integrating ancestral creation stories into practice, uncertainty is held with connection to cultural identity.

Louise: *I have had two clients disclose important experiences, and then spontaneously reflect on how they probably would not have wanted to “go there” face-to-face (in person). One said: “I know you don’t judge me, but I would’ve felt ashamed to mention that. I’m really stoked that I could, as it doesn’t feel so bad now”. Another client said: “I thought this [being online] would never work for me. I thought I really needed you to be in the room right there” (and this from someone who, prior to the session, had tried to argue for a fee reduction on the basis that “It [meeting online] won’t work for me, although I’ll give it a try”). This client observed, with evident pleasure, that the change to online meeting had not made a difference after all. Clearly, this needs further exploration with the client, but my observation was that during the online meeting there was a deeper connection than usual, with the revealing of a childhood trauma that had previously only been alluded to,*

despite my having shown that I had noticed it. One speculation is that he experienced enough empathy and security in the session to “go there,” at the same time as feeling a greater sense of control, or, perhaps, a greater capacity for self-regulation, because of the physical separation. Going it alone has been a more familiar experience for him than being in the presence of a responsive and co-regulating other.

For some, it appears that the online medium diminishes the intensity of being with the other just sufficiently to enable processing at a deeper level.

Louise: This client worries about my wellbeing and about burdening me with all of his trauma and worries. So I wonder if, on the computer screen, I become either more of an object or, somehow, more myself and—in either case—less like the mother who needed to be protected and placated.

Conclusion

The COVID-19 virus has brought about a health crisis of pandemic proportions, and with it an existential crisis. The virus itself is totally invisible, and none of us know if we will catch it and whether we will survive it if we do.

Margot: One of my clients was trying very hard to convince herself and me that she did not care if she died, and that she did not care about all the people that died. As we unpacked her feelings, it became clear that this response was a practised defence against the pain and fear of loss and abandonment which had already happened (Winnicott, 1974).

There are, of course, many ways of understanding these experiences which, for therapists, will be informed by their backgrounds, previous experience, and thinking, as well as their theoretical orientation or therapeutic modality (influences acknowledged by Békés & Aafjes-van Doorn, 2020). For some clients, their distress in response to being in self-isolation or lockdown will be evocative of earlier experiences, and others will be retraumatised by aspects of what they are experiencing and facing. Some couples whose relationships rely on having some time, space, and/or distance away from each other (for example during their usual working days) will find being together 24/7 hugely stressful. For others, creating and being in their own “bubble” offers a time and opportunity to reconnect and to change aspects of their daily routines.

While it is important to acknowledge and focus on the loss, fear, anxiety, and uncertainty which clients—and colleagues—are presenting, it is also important to acknowledge the possibilities and the creativity that is emerging in the crisis. We are, for instance, aware of the resilience of many clients. Each of us has been surprised at the resilience of some people who we might have predicted to be among the most traumatised by the lockdown. For several clients, this has been an opportunity to summon or to connect with their strengths in surprising ways.

One person who is living alone, not by choice, reported that not much had changed for her during this time, and that she was sustained by her continuing faith-based practices in a way she had not expected to be. Another whose early childhood trauma was evoked by lockdown immediately felt relief when we made the connection between specific aspects of his experiences then and now, and over the lockdown period has made great progress in self-regulation and in addressing a pattern of self-sabotaging procrastination.

We acknowledge existing research that already produced findings about psychotherapists' experiences with telepsychotherapy (e.g., MacMullin et al., 2020; Watts et al., 2020), and useful recommendations for the provision of high-quality e-mental health to clients (Van Daele et al., 2020). We hope that the process-oriented focus of this present contribution offers some consideration of how clients' own issues (conflicts, confusions, and deficits) continue to manifest in the online medium. We also hope that, given the particular importance placed by many psychotherapists on the therapeutic frame, our reflections are useful and reassuring as well challenging.

Authors

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Gina O'Neill (she/her) is a descendant of Ngāti Kahungunu, Rangitāne, Ireland, and Germany, living and working currently on Eora and Bundjalung lands in Australia. Gina is an experienced psychotherapist and ecotherapist in private practice, an educator, and a supervising consultant (MasterGestalt Therapy, GradDipCouns, and BAppSocSci). She has 20 years of clinical experience supporting individuals, families, and groups presenting with addictions, mental health, relationship issues, and trauma-related experiences. Gina has worked in private psychiatric clinical settings, non-government organisations, and in the public health sector. She is a member of the Psychotherapy and Counselling Federation of Australia's (PACFA) College of Aboriginal and Torres Strait Islander Healing Practices and the PACFA Research Committee. As a New Zealand Māori woman, her interest is in growing her Indigenous healing practice informed by te Ao Māori in reciprocity with the natural world, and the intersection with gestalt psychotherapy to support healing relationships with people and our environment.

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