Research Article

Technology-assisted psychotherapy for complex trauma

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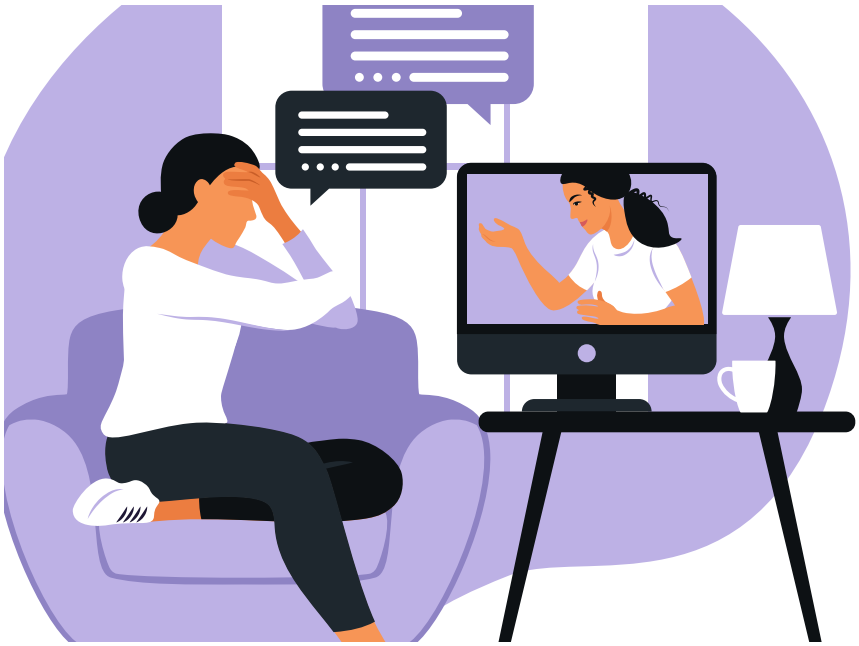

Technological advances aimed at increasing accessibility to therapy have resulted in the wide acceptance and normalisation of telehealth offerings. For clients who have experienced child sexual abuse, balancing convenience with factors including safety, the whole body in trauma work, and the potential impact of interruptions and intrusions is vital

Introduction

One in Four is a non-government organisation that provides psychotherapy and advocacy support services to adults and their families who have survived childhood sexual abuse. The organisation also delivers a prevention intervention programme to people who have committed a sexual offence against a child. This article outlines a small, mixed-methods study that explored clients' and therapists' experiences of the sudden and, for a time, total transition to technology-assisted therapy for complex trauma, necessitated by the Covid-19 pandemic. In particular, the study was interested in:

- Understanding the ways technology may influence the therapeutic relationship;
- Informing decisions in relation to programme delivery; and
- Providing a perspective on technology-assisted therapy with complex trauma.

The term technology-assisted therapy is used to refer to real-time client/therapist interaction using telephone or video-conferencing. Findings indicated that comments on convenience and the lifeline offered by technology-assisted therapy aside, the majority of participants preferred to return to the in-office setting. Despite the cyber security of online telemedicine platforms, the office setting's containment, safety, and privacy are not easily replicated for those accessing therapy via technology. The 'whole body' presence in the room is felt to be crucial for a majority of clients who have experienced sexual abuse.

Telehealth offerings

Notably, the literature on telehealth/telepsychology and eHealth comprises studies ranging from apps amd asynchronous e-mail communications to real-time therapist-engagement that most closely mirrors the traditional in-office setting (O'Connor et al., 2018; Sierra et al., 2018). The proliferation of telehealth offerings is propelled by imperatives aimed at improving access, cost-effectiveness and reducing other barriers, such as

stigma associated with attending therapy (Bennett et al., 2020; Morland et al., 2017).

Findings of studies on telehealth and eHealth often include self-guided treatments. Two meta-analyses studies that explored PTSD (post-traumatic stress disorder) based on CBT (cognitive behavioural therapy) and IBI (Internet-based intervention) models found some improvement in PTSD symptoms compared to wait-list control groups (Kuester et al., 2016; Sijbrandij et al., 2016).

Irrespective of the modality, most offerings utilise the principles of empirically-guided interventions. However, they do not address the therapeutic relationship itself (de Bitencourt Machado et al., 2016). This is curious given the general acceptance within the psychotherapy literature that the relationship itself is not only core to treatment outcomes, but arguably more important than any specific technique or modality (Carr, 2007; Horvath et al., 2011; Messer & Wampold, 2002; O'Connor et al., 2018; Wampold & Imel, 2015). While what constitutes therapy or treatment under the eHealth definition is broad and far-reaching, our study was interested in 'depth psychotherapy' – that is, moving beyond the focus on symptoms to the relationally-based exploration of all aspects, conscious and unconscious, of the client's experience – across therapeutic modalities.

Mixed-methods approach

For this article, a narrow and targeted literature review was undertaken to support analyses and provide context to findings. A mixed-methods approach was adopted, comprising a survey of 41 statements and seven qualitative questions, which was circulated to the organisation's clients and therapists. Using a five-point Likert scale, participants were asked their level of agreement ('Strongly agree' to 'Strongly disagree') for 18 statements for clients and 11 statements for psychotherapists. A thematic analysis (Clarke & Braun, 2014) on the qualitative replies was conducted in conjunction with statistical analysis using the Statistical Package for Social Sciences (SPSS). Data was analysed using descriptive and frequency analysis and comparison of means data and screened and coded for gender, age and participant type.

A small number of respondents linked being in their home environment to increased comfort and ease

A total of 64 responded and 57 completed the survey in full (psychotherapists 11%, survivors 71%, prevention/offenders 13% and family group 5%). Three themes emerged: therapeutic space and trauma; connections and disconnections; and therapeutic relationship and depth of work. While all clients who responded were grateful for the accessibility and lifeline offered by technology-assisted therapy, the vast majority wanted to return to the in-house setting.

The quantitative findings proved important, offering challenge, difference and context to responses to the qualitative questions, particularly in relation to safety, boundaries and the therapeutic relationship.

Therapeutic space and trauma

This theme refers to the concept of therapeutic space and its constituents, external and internal, influenced by trauma and shaped by the imposed restrictions of the Covid-19 pandemic. Comments on the convenience and practical advantages of not having to leave home for sessions, saving time and money and, in one case, reducing anxiety for the respondent as they did not have to request time off work were common and in keeping with the literature on accessibility (Maheu et al., 2012). One respondent commented: "The fact that I live so far away, it is helpful as I don't have to pay for public transport and I can get some work done."

A small number of respondents linked being in their home environment to increased comfort and ease, which may, for them, have created a sense of safety and relative ease. The physical therapeutic environment is accepted as important for trauma survivors (Smith & Watkins, 2008): "I was able [to] surround myself with my own objects – tea, comfortable seating, being able to stare out a window while speaking. It felt super familiar and peaceful at all times."

Results showed that over 60% of respondents felt comfortable using technology. This reflects the increased familiarity with, and reliance on, technology for day-to-day needs, such as shopping and online banking (Morland et al., 2017). Regarding the therapeutic experience itself, 46% agreed that they felt more tired after their online session than they would in person.

The quantitative findings posed questions and offered a challenge to the apparent advantages of this ease of accessibility. For example, figures showed that 34% did not feel connected to their therapist and 32% found it difficult to see their therapist in a different environment. In addition, nearly 40% of clients stated they found it difficult to talk about painful issues online.

There was a significant difference between men and women's level of comfort in talking about suicide and self-harm online, with men more likely to talk about it than women. This is at odds with a meta-analysis by Breslin and Schoenleber (2015), which found that women were more likely to report a history of self-harm

than men. It was also found that there was a more significant gender difference in the clinical settings than in the community settings. This difference might be accounted for by our small sample size, the fact that all female client participants were survivors of child sexual abuse, and that Breslin and Scoenleber's (2015) meta-analysis was not exploring reports in online therapy settings specifically. The Irish context might also be significant.

Figures varied across the sample in response to access to a private space for their therapy, with 17% of survivor clients saying they did not have access to a private space and 33% of prevention/offender clients reporting they did not have access to a private space. One respondent noted that "being in the home environment made it more difficult for me to speak openly and freely for fear of someone else overhearing". This respondent mirrored others in attempting what could be termed a compromise, engaging in the session but in a self-conscious and constrained manner.

Approximately 18% reported experiencing someone from their home entering the room during their session. These findings represent a challenge to the concept of a therapeutic space, not solely on the external or practical level but in relation to the internal – the importance of boundaries, the impact of intrusion, and the safety experience for abuse survivors.

Connections and disconnections

This theme explored connections and disconnections virtually as well as inter and intra-relationally. The continued facilitation of therapy during lockdown was a frequent, almost unanimous response:

> I think the most helpful thing about technology-assisted therapy was the ability to continue therapy from where we left off. It would have been much harder to just stop therapy or to keep putting off sessions until we could return to face-to-face.

"I found it strange trying to disconnect from my therapy – when I brought it into my home I didn't feel as safe"

Several commented on the screen itself. For some, the screen seemed to hinder connection and lead to a self-conscious engagement:

> I think in general with video calls … it's the same in a work setting … that you feel much more observed/constantly visible than you might in an in-person setting. It can make you feel a bit more self-conscious in moments when you're very upset.

Conversely, a couple of respondents felt the screen allowed a deeper engagement, increasing their confidence and ease: "Better sometimes in the separateness of online, giving confidence to say things that might not have been said if face-to-face."

Group clients, in particular, commented on the importance of initial in-house meetings as vital to fostering feelings of connection with the group:

> I personally would have found it extremely difficult to engage in the program online from the start. Having met face-to-face with the therapists and other members of the group before helped me feel comfortable enough to engage online.

Client respondents made important points about connecting or transitioning into and, just as importantly, transitioning out of, or disconnecting from, the therapy experience. Half of our respondents reported they had time to prepare and reflect before and after the session:

> I use the hour or so that it takes me to get into Holles St to mentally prepare for my session and the same to decompress on the way home. Now, I go from therapy right back into normal life, and it's a head wreck.

Another respondent revealed: "I found it strange trying to disconnect from my therapy – when I brought it into my home I didn't feel as safe."

Forty-three per cent of respondents referenced technical difficulties, and therapists particularly linked this with concerns for the therapeutic relationship. One therapist responded: "The Wi-Fi in my area is not great and I find that during sessions it is very distressing when the PC freezes and you have to ask the client to say it again." Another therapist noted that: "The pace of therapy is also skewed online, where the time gap due to the Internet often results in therapist and client speaking over each other."

Therapeutic relationship and depth of work

With few exceptions, therapists and clients missed the in-person therapy experience. Comments in Table 1 give examples of both the general view, but also note alternative experiences. Therapeutic modality seemed to influence the experience where those practising bodywork in particular felt the absence of the in-person contact most acutely. These quotes, taken from the qualitative responses, capture subtly and subjectivity in relation to the experience of the therapeutic relationship.

Discussion

At the time of writing this article in September 2021, the Rape

Crisis Network Ireland's (RCNI's) Clinical Innovation Project (Taylor & Walsh, 2021) had conducted a large survey with 645 survivors of sexual violence. The findings of our small survey largely cohere with the findings of that larger study, particularly concerning: the core importance of the body in work with trauma and implications on the impact of its distance in technology-assisted therapy; issues relating to safety, privacy and confidentiality, and importantly, the need to balance convenience with safety; ubiquitous technical challenges; and, with the exception of a minority, the preference to return to in-person therapy.

Literature on trauma highlights that the therapeutic relationship is paramount in recovery. According to (Herman, 2015) "the core experiences of psychological trauma are disempowerment and disconnection from others" (p. 133). Wallin (2007) describes the importance of a secure attachment within the therapeutic relationship, as it strengthens the capacity for affect-regulation. The importance of the body in trauma therapy is the capacity to assimilate the traumatic experience.

Odgen et al., (2006) argue that traumatic memories are encoded subcortically and that recurring activations of the traumatic memory continues to create a sense of threat: "Traumatised clients are haunted by the return of trauma-related sensorimotor reactions in such forms as intrusive images, sounds, smells, body sensations, physical pain, constriction, numbing, and the inability to modulate arousal" (p. xxix).

The fact that 15 out of 51 respondents engaged in therapy in the absence of any private space raises important safety questions. It also suggests that therapists should not assume that the physical frame provided through the private, uninterrupted, in-house setting has been internalised or can be replicated at home by clients. Reasons may relate to limitations in the environment and, perhaps, to normalisation of intrusion for abuse survivors:

> Traumatic events … shatter the construction of the self that is formed and sustained in relations to others … [it] destroys the victims' fundamental assumptions about the safety of the world, the positive value of the self, and the meaningful order of creation. (Herman, 2015, p.51)

It appears that people connect very differently in an online environment and there is much that therapists may need to consider. Contracting for the arguably inevitable technical difficulties and interruptions is vital to support safety and containment. Exploring the client's associations to and experience of the screen(s) directly may provide insights and guidance to both parties that might assist in a deeper connection moving forward. It may also be important to attend to the healthy disconnection from the session that facilitates clients in getting on with their day. Finally, in-person contact for some is vital to establish the connection necessary to engage in therapeutic work.

Conclusion

The connection in relationship is core to creating safety, however, sadly this is an elusive experience for many trauma survivors. The respondents for this study unanimously named the ability to continue with therapy during lockdown – a time that increased strain on the already over-burdened nervous systems of trauma survivors – as the main advantage of technology-assisted therapy.

While a small number of respondents named feeling safer

Table 1: Therapist and client experiences of working online

Therapists	Clients
For me, personally, there is something that takes place within the therapeutic space that just cannot happen online. It is all the small nuances, the movement, pace and rhythm of therapy that is missed online.	Some sessions I would not be fully engaged or present, but when in a room I would be calmer face-to-face.
I feel that in-person, misinterpretations are easier to avoid – you don't have to concentrate so much and because of this, you are more presence both mentally and physically.	One-on-one therapy allows me to leave everything else outside the room – I find that difficult in technology-assisted therapy.
The in-depth connection you get when in the room with the clients, missing the feeling of the client, missing those non-verbal cues, missing helping the client regulate, missing doing bodywork.	The fact I haven't met my therapist face-to- face. It feels weird that I have disclosed so much of my life to her, yet have never met her face-to-face.
One advantage when working with deeply traumatised clients is the disinhibition effect, and I have found that clients have been able to say more as the PC/ phone has allowed a space to create a gap that they feel more comfortable in and able to speak more freely.	Sessions were no different in any way, full support at all times. I have felt able to talk, be validated and helpfully challenged in a therapeutic space.

in their home environment, for the majority, this coincided with increased interruptions and disconnections of differing types. Feeling less connected to their therapist and struggling to talk about difficult issues were named by respondents as challenges that could reasonably be assumed to be interconnected.

It is important to note that this survey related to home environments during a lockdown situation, which may differ significantly from a home environment at other times. Therapists and clients with a preference for body work seemed to struggle most, feeling the absence of the body in the shared therapeutic space most acutely.

While grateful for the offering, the vast majority of One in Four clients indicated the wish to return to in-person therapy when possible. A minority named a preference to continue working via technology for reasons surpassing convenience and accessibility, so it is important to continue this offering. In addition, offering therapy online has increased accessibility to our Dublin-based service for those in other parts of Ireland.

Following the literature, there may be scope to use technology to augment psychotherapy for those on the waiting list or as a step down in the transition to ending therapy. However, the depth of therapeutic work, at least in the experience of One in Four, is not easily achieved via technology.

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Julie Brown is a psychoanalytic psychotherapist and clinical supervisor working mainly from an object relations perspective. She has worked in the area of complex trauma and sexual abuse for 18 years and is Clinical Director of One in Four. Julie is a training analyst with the Irish Institute of Psychoanalytic Psychotherapy and a past Chairperson of the Irish Forum for Psychoanalytic Psychotherapy. Julie is in her final year of a Doctorate in Psychotherapy at Dublin City University where her area of research is a psychoanalytic exploration of online child sex offending.

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