Review

Telepsychotherapy and the Therapeutic Relationship: Principles, Advantages, and Case Examples

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Abstract

Objective: *As the use of technology continues to expand within our mental healthcare system, there has been an increasing interest in conducting psychotherapy online using videoconferencing. Literature pertaining to telepsychotherapy has explored possible drawbacks of this modality on the therapeutic relationship, although several studies have shown that the efficacy of online psychotherapy is equivalent to in-person approaches. Little is written about the potential advantages to the psychotherapeutic relationship when psychotherapy is carried out over videoconferencing.*

Methods: *The available literature was reviewed, as were the general principles of telepsychotherapy and the therapeutic relationship, followed by a more in-depth consideration of patient populations for whom telepsychotherapy may offer distinct advantages.*

Results: *The current literature, as well as our own clinical experience, suggests that telepsychotherapy may be effective for a broad range of patients, and it may offer distinct advantages in the building of a trusting psychotherapeutic relationship.*

Conclusion: *Telepsychotherapy offers a novel way to reach and form strong psychotherapeutic relationships with many different types of patients, and it may foster therapeutic intimacy in ways that in-person psychotherapy cannot. More research is needed to further explore this unique modality.*

Keywords: *telepsychotherapy, telepsychiatry, online psychotherapy, psychotherapeutic relationship*

Introduction

Much has been written about the potential pitfalls of conducting psychotherapy online using videoconferencing, including ways in which this modality may limit the ability of a patient-therapist dyad to build a therapeutic relationship. The published literature in this area has detailed concerns about issues of boundaries, technical impediments to communication, confidentiality and privacy, legal liability, and other ethical snares.[1–4] Literature describing the advantages of an online approach has not focused much on aspects of the therapeutic relationship, and instead it has tended to center on concrete benefits, such as reducing costs, improving access to underserved patient populations, or allowing for continuity of a psychotherapeutic relationship after one of the participants has relocated.[4,5] Significant effort has been put forth by the psychotherapy research community to demonstrate that online variants of cognitive behavioral therapeutic (CBT)[6] and, more recently, psychodynamic psychotherapy[7–9] are noninferior as a whole in comparison to treatments delivered in person.

Very little has been written, however, about the potential distinct advantages of using an online approach for the building of a working therapeutic relationship itself. This important and under-researched area warrants attention, especially given the ever-increasing role of technology and the Internet in our global healthcare system. We intend to explore how Internet-based psychotherapy may have some specific advantages in the building of a productive psychotherapeutic relationship, and we suggest areas for further research. We will discuss some basic principles, followed by a more in-depth exploration of patient populations for whom telepsychotherapy may offer specific advantages.

Reduction in Patient Anxiety and A Shift Toward Egalitarian Power Dynamics

There are a number of broad aspects that make the process of telepsychotherapy more egalitarian than traditional in-person therapy, and may lead to a reduction in patient anxiety. These include:

(1) The place where therapy occurs.
Traveling to see a therapist in their office can be stressful and anxiety-provoking, and patients are always at somewhat of a disadvantage psychologically by having to be seen on the therapist's "ground." For most patients, this anxiety decreases after the first few

sessions; whereas for others, stress and anxiety around psychotherapy visits is an ongoing struggle that can lead to poor treatment adherence and outcomes. With the advent of telepsychotherapy, patients have the option to be "seen" from their homes or other familiar settings. The environment of the patient's home, work, or primary care clinic, by virtue of its familiarity, likely has a containing effect for the patient, which may help the patient feel more at ease both in initiating therapy and in being honest and forthcoming with the therapist. Similarly, the therapist has the option to see the patient from a setting that is more containing for him or her—such as the comfort of the therapist's own "desk space" at their office, which is not typically a portion of the office shared with the patient, or even from the therapist's home. This geographical relocation may help both parties to feel more relaxed or "settled," and it could foster the development of psychotherapeutic intimacy.

A number of psychoanalysts in the authors' local community have commented that they conduct sessions with some patients (typically those who have moved away but wish to continue psychoanalysis) over HIPAA-compliant videoconferencing platforms, and that they were surprised by the "naturalness" of the encounter, as well as by how "at ease" both parties seemed to feel (unpublished correspondence, 2016). Our patients frequently comment that they would rather communicate with us online than see a local provider in person. Some who live in small rural communities say that seeing us is preferable, as they know they are not going to inadvertently run into us outside the office in a local community setting. However, it should be noted that patient privacy still warrants careful attention even in home settings, as many patients live in space shared with others, and ensuring availability of a quiet, secluded space in the patient's home is essential.[4]

(2) The virtual space in which the consultation occurs.
In some in-depth psychotherapies such as psychoanalysis, increased eye contact is expressly avoided (for example, by use of the psychoanalytic couch) to help reduce patient feelings of shame or pressure to attend to the perceived needs of the therapist. The traditional analytic couch also offers the therapist some distance and freedom from the necessity to tightly regulate visible expressions of the therapist's affect stimulated in the therapy. Interestingly, telepsychotherapy tends to result in more eye contact compared with in-person psychotherapy, perhaps as a means for "making up for" the physical distance and "remoteness" of the two parties in the therapeutic dyad. However, this literal distance between patient and therapist may also create a type of psychological distance similar to that experienced through the use of an analytic couch. Yellowlees has discussed the concept of a "virtual space" in telepsychotherapy, which he described as a combination of the increased physical and psychological distance, both of which arise by virtue of the teleconferencing medium, and which between them provide more safety to allow an increased sharing of intimacy.[10] In telepsychotherapy, the patient may be able to be more honest, and to describe important material more candidly due to the "protection" afforded by the virtual space, all the while still maintaining intimacy-fostering eye contact. We have noted that telepsychotherapy patients regularly comment that they feel more relaxed using this modality, and that they have a sense of greater comfort with being honest. The authors have further experienced that it seems "easier" both for them to ask patients about difficult or stigmatized subjects (such as sexual abuse or drug use), and for patients to respond to these inquiries in a forthcoming way. However, it should be noted that some psychoanalysts conducting therapy online still have the patient lie down in their home, and the patient hears audio only—this remains an option for patients with significant issues around shame.[9]

(3) The patient's sense of control.
In telepsychotherapy, the patient experiences a greater sense of physical and psychological control of the session; simultaneously, the therapist is less likely to be successful with a paternalistic approach. The combination means that in general, treatment styles are more likely to be "patient centered." As discussed earlier, traditional in-person psychotherapy gives the therapist the "advantage" of conducting sessions from the familiarity of their office or clinic, which is an unfamiliar space for the patient. Conversely, an online modality allows for both parties to be seen from a containing space of comfort. Coupled with the increased eye contact and the use of the virtual space in telepsychotherapy, these factors combine to drive the relationship into a more egalitarian space.[10] Though the experience would likely be rare, it is also possible for the patient to literally "switch off" the therapist by turning off their computer or video device, although this has not happened to us. We have had occasional patients walk out of the videoconference, however, and have the impression that this is easier to do than it

would be when sitting in an office with the therapist physically present. The existence of these potential "exit strategies" may grant the patient an additional sense of control, perhaps similar to that of anxious patients who feel more secure having an anxiolytic tablet available in their pocket, even if it is never actually taken.

(4) Option for use of a "hybrid" model combining in-person therapy and telepsychotherapy.
There are several groups of patients, about whom we elaborate later, who struggle to access and remain engaged with psychotherapeutic care. For patients with high levels of anxiety or hypervigilance, such as phobic patients, patients on the autism spectrum, or traumatized patients, leaving the home environment to seek therapy may feel tremendously difficult. This group may more readily engage in telepsychotherapy than traditional in-person psychotherapy due to the greater sense of control afforded by this modality, including the ability to remain in settings that feel safe to the patient. Ultimately however, allowing the patient to remain shuttered at home risks perpetuating the anxious process. Thus, we propose that gradual integration of in-person sessions, after formation of an initial psychotherapeutic rapport from the "safety" of online sessions, may be a novel approach to exposure therapy. In this way, the power of the therapeutic alliance could be harnessed to help "draw out" the patient from their confines to the physical office of the therapist, as a "stepping stone" to the outside world. The ratio of in-person to online sessions could be gradually adjusted based on patient and provider needs. This hybrid approach may also be appropriate in reverse for patients who may need a greater degree of in-person care upfront, such as those suffering from personality disorders, as elaborated later.

Special Patient Populations

After years of practice by many psychiatrists and psychotherapists, the consensus of the field is clear that any type of patient may be seen using videoconferencing.[5] The only absolute contraindications to a psychiatric interview are if the patient refuses to attend, as some do, or if they are actively acting out and demonstrating dangerous behavior to themselves or others at the time of the interview. There are, however, a number of groups of patients where other specific psychotherapeutic issues apply.

PSYCHOTIC PATIENTS

Psychotic patients often feel very unsafe by virtue of their illness. Though psychotic patients commonly have paranoid thoughts about televisions and radios, interestingly we have observed that some psychotic patients do seem to feel more at ease when the provider is not in the room. In their comprehensive review of the literature, Sharp et al. found that psychiatric care through videoconferencing was well tolerated by psychotic patients, and that the increased physical and psychological distance afforded by the modality may reduce anxiety in this population.[11] For especially paranoid patients, offering to temporarily point the camera away from them (so that the provider has only audio information, but the patient can still both see and hear the provider) may provide enough distance that the patient feels safer. In addition, the therapist may feel safer with the removal of the threat of physical harm by psychotic patients who are potentially assaultive. This enables the therapist to be both more relaxed and more direct when communicating with such patients.

HIGHLY ANXIOUS PATIENTS

Psychotherapy over video may be particularly helpful for anxious patients who have difficulty with leaving the home, especially if related to agoraphobia or other phobias.[4] With a video-based modality, patients who might otherwise delay or forego treatment could access a therapeutic relationship in a way that feels safe for them. If a CBT model is used for treatment, having the patient eventually come to the therapist's office could be set as a goal for therapy, or it could specifically serve as one of the steps in a set of gradually escalating "exposures." As far as we know, this use of a "hybrid" approach of telepsychotherapy and in-person psychotherapy has not been studied, and it may have potential as a powerful tool in the treatment of highly anxious patients who might otherwise avoid psychotherapy entirely.

PATIENTS ON THE AUTISM SPECTRUM

Patients on the autism spectrum struggle with tolerating novel environments, and many have difficulty with the social norms and sensory experience of visiting the office of a doctor or therapist.[12] Many higher functioning patients on the autism spectrum enjoy using computers and find a sense of community online, such that they may feel more comfortable with this modality for receiving psychiatric/psychotherapeutic care. This population of patients may benefit from an online psychotherapy modality in which they can begin building a relationship with the therapist from the comforting and containing aspect of their own home or school, potentially eventually transitioning to in-person sessions if the pair feels

this would be helpful. A series of interesting experiments has occurred using online virtual reality systems to teach social skills to autistic children that may be a model for other groups of patients.[13]

CHILDREN AND TEENS

Younger children may be less nervous at home than in a therapist's office, and, thus, the therapist may get a more accurate picture of the child's everyday behavior from the less intrusive vantage of telepsychotherapy.[14] In addition, many teens today spend a considerable amount of time online, and they may be more comfortable using online modalities to obtain mental health services. Teens and older children may also feel that this means of obtaining care offers improved privacy; for example, they would not need their parents to drive them to a clinic for care.

TRAUMATIZED PATIENTS

Patients with significant childhood abuse histories may have an especially difficult time feeling safe around the "authority figure" of the doctor or therapist. For victims of sexual abuse or rape, the intimate setting of the therapist's office and the potential gender difference between patient and provider (e.g., female patient, male therapist) may cause considerable anxiety. It is important to note that for the patient to heal, such anxiety would ideally be worked through. However, an online approach may help to build important initial rapport and safety. For example, the authors recently saw a female patient with a history of sexual abuse over teleconference for an initial psychiatric assessment. A thorough history was gathered, including some history pertaining to the past abuse. At the close of the session, when asked for feedback about her experience, the patient remarked, "I would have felt anxiety if you were in the room with me. I like this better." She additionally commented that she felt she could be more honest about her history of sexual abuse over teleconference, and that this conversation "was easier than usual." A patient such as this may benefit from beginning psychotherapy online, gradually transitioning over to in-person sessions once some rapport has been established, and eventually perhaps undergoing therapy in a hybrid manner, with some sessions in person and some online, depending on mutual need and convenience. In a sense, such an approach would serve as a graduated "exposure" to the intimate setting of psychotherapy.

Regarding treatment of patients suffering from post-traumatic stress disorder (PTSD), which is a trauma-related condition involving problems with distressing memories or dreams, and associated disturbances in mood and arousal, Morland et al. have conducted several studies examining the use of teleconferencing for delivery of psychotherapeutic treatments in both veteran and nonveteran populations with PTSD.[15–18] Their work has shown that cognitive processing therapy (both individual and group) and CBT over videoconference are noninferior to in-person delivery of these modalities. The advantages discussed earlier, in particular the comfort provided by the physical and virtual space of telepsychotherapy, as well as the potential for increased privacy and reduction of expose to stigma, may make this modality preferable for treatment of some patients with PTSD.

PERSONALITY DISORDERED PATIENTS

More research is needed to assess the particular aspects of caring for this group of patients online. Telepsychotherapy for personality disordered patients will have many challenges, just as it does in person. However, the convenience of the online modality may allow for a greater total number of sessions, and potentially an increased sense of comfort and "therapist presence" for those patients struggling with abandonment fears. However, a hybrid approach or exclusively in-person sessions may be necessary for some patients at the beginning of treatment, as many personality disordered patients have a diminished capacity for symbolization and may struggle without the literal, concrete presence of the therapist in the room (i.e., the patient may feel the therapist is not "there" unless they are literally physically present). When caring for these patients, the therapist will have to be attentive to setting boundaries and maintaining a consistent frame just as is true in person. Morland noted that a specific discussion of boundaries remains important for the effective delivery of psychotherapy over teleconferencing, as she noted that her patients engaged in "multitasking" activities such as cooking or smoking during therapy sessions taking place in the patient's home.[4] An area of particular importance is maintenance of boundaries around access to the therapist. This population may require a firmer structure regarding times that they are permitted to contact the therapist, as the therapist may quickly become burnt out if they are "always on" and continuously responding to every patient bid for contact any time of day or night.

ILLUSTRATIVE CASES

Patient A: hybrid therapy. Ms. A was a 38 year-old Latina, divorced with three children, who had been diagnosed with a somatization disorder and treated in a conventional outpatient in-person model of care with mainly supportive and behavioral psychotherapy, as well as medication management, for about 2 years. She had a good relationship with her psychiatrist and had made gradual improvements in her life over this time, reducing her use of narcotics and her tendency to see multiple doctors for a wide range of somatic symptoms.

On the day of one of her appointments, she called her psychiatrist, said she had terrible allergies, and asked whether he could call her for a phone session instead of her attending the clinic. Her psychiatrist told her that he could securely videoconference with her to her home, and she gladly agreed. During this session, she was remarkably different from usual, and spontaneously talked about a long history of sexual abuse and prostitution that she had not previously revealed. She noted that she felt much more comfortable talking to her male psychiatrist about these issues at a distance and asked whether she could have combinations of sessions, both by video and in person, in future.

Patient B: long-term "supervisory" therapy. Ms. B, a 40 year-old separated mother of four children by three partners, has been seen two or three times per year on video for psychotherapy since 2010. Throughout this time, she was also seeing a series of local counselors in her community, most of whom she abandoned within a few months either because she lost trust in their capacity to be confidential or because she did not feel they were competent to treat her. When first seen, she gave a history of early childhood sexual and physical abuse, a dysfunctional family where methamphetamine and alcohol abuse was rife, teenage years characterized by self-mutilation and parasuicidal gestures, multiple chaotic and sometimes abusive relationships, and episodic polysubstance abuse. She was working as a trauma advocate/counselor, which she found stressful and where she tended to become over-involved with her clients. She was diagnosed as having a borderline personality disorder and gradually taken off a series of medications originally prescribed for a presumptive bipolar disorder. Seeing the telepsychiatrist gave her some psychotherapeutic continuity over several years during which she gradually learned about her personality style, its psychological and behavioral implications, and how to adopt improved coping strategies. After about 15 sessions in 6 years, she remains in occasional "supervisory therapy," has gradually developed a trusting relationship with the telepsychiatrist, takes only occasional "prn" medications, and is happier and much more stable in the community.

Patient C: trauma and intimacy. Ms. C was a 16 year-old Native American girl who was referred for telepsychiatric assessment because she had become angry and dismissive of her family, was refusing to attend school, and had stopped taking part in all tribal activities, which had previously been a source of great pride to her. She refused to talk to her family or to her primary care physician about her situation despite having previously had excellent relationships with them. She also refused to go and see a local counselor, but she reluctantly agreed to meet with a telepsychiatrist. She initially presented as sullen and angry, and was focused on making sure the call was completely confidential and that the telepsychiatrist was not physically visiting the community in the near future. After reassurances and a deliberately nonconfrontative approach from the male telepsychiatrist, she finally admitted that she had been assaulted recently. She was afraid to take part in the tribal activities because the assailant was also involved in them, but she felt unable to give an explanation for her sudden cessation. She felt completely trapped and hopeless, and she was unable to talk to anyone in the community about her situation. After a highly charged and emotional session, Ms. B finally agreed to the telepsychiatrist talking to a female community elder that she trusted to have that person quietly speak to her assailant and insist that he drop out of the tribal activities. She agreed to further sessions with the telepsychiatrist and to her primary care physician being told verbally about what had happened, as long as nothing was put in her medical record, because she had relatives who worked in the clinic. She attended several telepsychiatry sessions, becoming increasingly comfortable over time, while seeing her primary care physician and the elder regularly. She refused to charge her assailant and chose to avoid him as much as possible.

Patient D: anxiety and depression. Mrs. D was a 53 year-old Caucasian divorcee presenting with depression. Her major stressor was her only child, a 29 year-old son with a long history of alcohol dependence and several rehab admissions. He lived in a broken-down shack and kept aggressively appearing at his mother's home to invade her fridge and eat, on several occasions breaking down her door when she occasionally tried to stop him, while spending any money he had on drink. Mrs D. was challenged on her co-dependent relationship with her son, and understood that she was enabling his drinking, finally agreeing to obtain a restraining order. She started a cognitive behavioral program for her anxiety and depression that the telepsychiatrist planned in conjunction with her primary care physician, and in combination with antidepressant medication, gradually improved. Over several sessions, she developed insight into how her co-dependency was related to a series of her own failed victimized relationships and losses, and she gradually started to build a more effective egalitarian relationship with her son who finally had a successful rehab admission and maintained sobriety afterward.

Conclusion

The potential benefits of using an online modality for the psychotherapeutic relationship have been insufficiently studied.

There may be distinct advantages to the psychotherapeutic relationship when it is carried out over videoconferencing platforms, especially for certain patient populations. More research is needed to explore this important area during this time of increasing integration of technology into the wider mental healthcare system. In particular, understudied areas include elucidation of which populations would most or least benefit from a telepsychotherapeutic approach, the use of teleconferencing for long-term psychotherapies (psychodynamic, psychoanalytic, etc.), identification and exploration of boundary issues particular to the practice of telepsychotherapy (especially when settings include the home of the patient and/or the therapist), the use of "hybrid" models integrating telepsychotherapy and in-person psychotherapy, and the use of virtual space as a tool for deepening the therapy (akin to the use of a psychoanalytic couch).

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