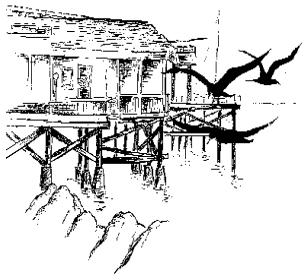
The Monterey County Chapter

California Association of Marriage and Family Therapists

January / February 2021 Newsletter



Benefits to MC-CAMFT Membership:

- Reduced fees at our events
- Invitation to our Members only annual gatherings
- Access to Members only Salons, which are intimate workshop offerings taught by fellow Members
- Periodic Newsletter with relevant CAMFT informa tion and Member created writing
- Opportunity to contribute your writing to our News letter, including things such as a column, book re view, workshop or conference review, poem, opinion piece or article
- Free advertising in our Newsletter and "Classifieds" section of our website
- Inclusion in our "Find a Therapist" website directory
- Access to Member and Announcements Forum on our website where you can seek feedback from other members and post things to the community
- Opportunity to submit a proposal to host a Salon for our Members
- Option to join us on the Board as a volunteer com mittee chair or ad hoc committee member
- Opportunity for MC-CAMFT to co-sponsor your workshop, so you can offer CEUs to your attendees
- Free Mentoring by experienced clinicians
- Invitation to suggest any member activity you find interesting, and we'll consider it!

Benefits to MC-CAMFT Website:

◊ Current Member Directory
◊ Classifieds Page for Members
◊ Chapter Board Contact
◊ Specialized Forums
◊ Online Newsletter
◊ Networking Opportunities
◊ Chapter Documents Access
◊ Sponsorship Opportunities
◊ Membership Information

MC-CAMFT CALENDAR

JANUARY : C.E. PRESENTATION

Date/Time: **January 30, 2021 / 8:30 AM -12:00 PM**
Topic: **Transforming the 'Living Legacy' of Trauma**
Presenter: **Dr. Janina Fisher**
3 CEs are included in the registration cost for this presentation
Licensed MC-CAMFT Members: $35
Licensed Non-Members and Guests: $50
Pre-licensed: $25

FEBRUARY : SAVE THE DATE!

Date/Time: **Friday, February 19th, 2021**
Topic: Local Member Salon
Presenter: **Nan Heflin, LMFT**

More info to follow! Please check the MC-CAMFT website for the most up-to-date information on events

In This Issue...

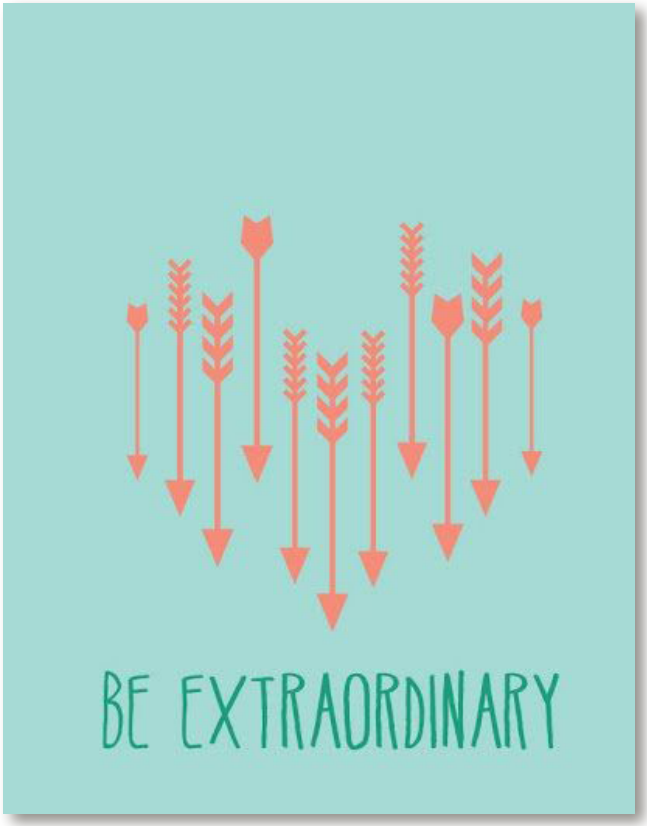
2021 MC-CAMFT Board Roster

2021
Board of Directors
- Officers -

President:
Jennifer Farley
jennifer@shamanhealingmonterey.com

Treasurer:
Susan West
831-206-7639

Secretary:
Rochelle Hall
rochellehall.consult@gmail.com



Like Us on Facebook!
Connect with your colleagues through the Monterey Chapter CAMFT Facebook page.

2021
- Committee Chairs -

Membership Chair: OPEN

Public Relations: OPEN

Programs Chair: OPEN

Pre-Licensed 3000 Hour Club Chair: OPEN

Legislative & Ethics Chair:
Michael Newman

Mentorship Chair:
Pat McDermott, LMFT
patmcdermft@comcast.net

Newsletter Editor:
Ross E. Farley III
ross@shinealight.info

Hospitality Chair:
Olivia Fae Stadler
olivia.stadler@yahoo.com

Continuing Education Chair:
Raceal McWhorter, LMFT
racealarttherapist@gmail.com

Member-At-Large:
Carmen Martin, LMFT
lovehealing@me.com

Member-At-Large:
Sarah Lauterbach, LMFT
sarahlauterbach.lmft@gmail.com

Jennifer Farley

2021 Board President

Happy New Year!! I think it is safe to say that 2020 was a very impactful year for most of us in one way or another. As I welcome in 2021, I enter this new year with great humility and respect for life's unpredictability. Yet, I am also very curious and open to seeing how things continue to evolve locally, nationally and globally in the coming year. I do trust that our healing work continues to play an important role in whatever will evolve.

With that in mind, we, the MC-CAMFT board, wanted to kick off the new year with a bang, and we found just the person to do so! We are excited to host Dr. Janina Fisher as our first CE presenter of the new year. She is a renowned researcher, teacher and clinician in the field of complex trauma. She is speaking on the topic of her new book, Transforming the Living Legacy of Trauma. If you haven't registered yet, please make sure to do so. Janina is sure to offer new information and helpful interventions to even the most seasoned of clinicians.

Also, the roster of speaker events for 2021 is still being created. If you are interested in presenting a virtual salon, please reach out! I know that we have a lot of expertise in our community, and I want to make sure our Chapter members have as much access as possible to that expertise.

Lastly, thank you to those who participated in our MC-CAMFT board nominations process. We received wonderful interest from community members. Finalization of this process is currently underway, and I look forward to introducing new board members to you all soon!

Happy Happy Happy New Year!

May You Be Well,
Jennifer Farley

January 30th, 2021 - C.E. Presentation with Dr. Janina Fisher

Transforming the 'Living Legacy' of Trauma

Despite having survived, traumatized individuals are left with only a fragmented, confusing sense of what happened. Traumatic reminders continue to keep the trauma 'alive' by repetitively re-activating the stress response system and survival defenses. Unaware that these reactions are traumatic memories held in the body, they assume that they are still in danger or somehow at fault.

Without a way to understand sensory and body memories, survivors of trauma come to either distrust themselves or distrust others. They still feel unsafe, still re-experience the same emotions of shame, fear, anger and hopelessness over and over again. Telling the story of what they remember sometimes brings relief but does not resolve the 'living legacy' of traumatic reactions that continue to torment the client day after day.

In this presentation, participants will learn how to assess and make sense of trauma-based symptoms, such as dysregulated autonomic arousal, overwhelming emotions and sensations, intrusive images, numbing and disconnection. They will discover how to use psycho-education to help clients manage these overwhelming symptoms and begin to change their relationship to the traumatic events. In addition, participants will be taught how to integrate neurobiologically-informed treatment techniques into psychotherapy that help resolve the traumatic past and finally put it to rest. Specific learning objectives include the following:

Describe the autonomic, cognitive, affective and somatic effects of traumatic events
Identify psychoeducational interventions that support stabilization or offer relief to clients
Implement mindfulness-based techniques to challenge conditioned patterns of response
Integrate somatic interventions that regulate a traumatized nervous system
Utilize worksheets to discover and address trauma-related symptoms

About Dr. Fisher:

Janina Fisher, PhD is a licensed Clinical Psychologist and Instructor at the Trauma Center, an outpatient clinic and research center founded by Bessel van der Kolk. Known for her expertise as both a therapist and consultant, she is also past president of the New England Society for the Treatment of Trauma and Dissociation, an EMDR International Association Credit Provider, a faculty member of the Sensorimotor Psychotherapy Institute, and a former Instructor, Harvard Medical School. Dr. Fisher has been an invited speaker at the Cape Cod Institute, Harvard Medical School Conference Series, the EMDR International Association Annual Conference, University of Wisconsin, University of Westminster in London, the Psychotraumatology Institute of Europe, and the Esalen Institute. Dr. Fisher lectures and teaches nationally and internationally on topics related to the integration of research and treatment and how to introduce these newer trauma treatment paradigms in traditional therapeutic approaches.

Course meets the qualifications for 3 hours of continuing education credits for LMFTs, LPCCs, LEPs, and/or LCSWs, as required by the California Board of Behavioral Sciences.

FOR GENERAL INFORMATION, SPECIAL NEEDS, ADA ACCOMMODATION OR GRIEVANCES : Please contact Jennifer Farley at jennifer@shamanhealingmonterey.com

CE CERTIFICATES : Please Note: Certificates of completion will be awarded at the completion of the workshop to those who attend the workshop in its entirety, sign in and out, and complete the course evaluation form.

MC-CAMFT is approved by the California Association of Marriage and Family Therapists to sponsor continuing education for LMFTs, LCSWs, LPCCs and LEPs and maintains responsibility for this program and its content. Provider# 050097.

Information on Continuing Education Credit for Health Professionals
CE credits for psychologists are provided by the Spiritual Competency Resource Center (SRCR) which is co-sponsoring this program. The Spiritual Competency Resource Center is approved by the American Psychological Association to sponsor continuing education for psychologists. The Spiritual Competency Resource Center maintains responsibility for this program and its content. The California Board of Behavioral Sciences accepts CE credits for LCSW, LPCC, LEP, and LMFT license renewal for programs offered by approved sponsors of CE by the American Psychological Association. LCSWs, MFTs and other mental health professionals from states other than California need to check with their state licensing board as to whether or not they accept programs offered by approved sponsors of CE by the American Psychological Association. SCRC is approved by the California Board of Registered Nursing (BRN Provider CEP16887) for licensed nurses in California. For questions about receiving your Certificate of Attendence, contact Pamela Hughes from Monterey County California Association of Marriage and Family Therapists at pam@pamhughestherapy.com. For questions about CE, visit www.spiritualcompetency.com or contact David Lukoff, PhD at CE @spiritualcompentency.com.

REFUND/CANCELLATION POLICY:
You may cancel for a full refund up to 15 days in advance of the event, or a 50% refund between 5 and 14 days in advance of the event. No refunds for cancellations within 4 days of the event or for no-shows or failure to attend due to emergencies. Unused funds cannot be applied to future workshops. All requests for refunds must be submitted to Jennifer Farley by email at jennifer@shamanhealingmonterey.com.

Member Article

Couples Corner

offered by EFT trained therapist **Amy Somers**

One of the many gifts COVID unveils during this challenging time is the dance. The human dance, spinning about under one roof most days now.

Matthew D. Lieberman's book Social states our need for connection as more elemental than even food or shelter, also why social pain is as real as physical pain. At the same time, we know our brains are wired to avoid pain to survive. As humans, then, we are driven to move between the two: connection and protection.

The couples my husband and I share time with (as well as we) are occasionally so stuck in this dance they feel locked in and uninspired, learned generational routines passed down, full of missteps and falls (triggers) that feel like potential death.

We champion the sweet spot in between as vulnerability. Dr. Sue Johnson of Emotionally Focused Therapy says empathy cannot happen without vulnerability; true connection lies outside our comfort zone. The in between, no-man's land that feels like it might just kill you. How do we stay here? How do we stand the need to run, exposed and naked?

According to Dr Johnson, each of the couple needs to answer the question A.R.E. you there for me (accessibility, responsiveness and engagement)? The combination of these three qualities outline new dance steps in uncharted territory and could orchestrate a smoother outcome for partnership, providing a balm for the nervous system. A re-wiring of primal fear into healing connection. From this healed place of secure adult attachment, couples can curiously explore the world around them and continue their own healing journeys from a stable platform. We will continue to step on each other's toes, although present in a new, more intimate way of being human with inevitable imperfection in all its glory. To be accessible, responsive and engaged with our partner when they reach out from a vulnerable place feels scary at first then shifts into a new way of living. Safety during a time of danger, connection during a time riddled with protection messages.

The COVID gifts will indefinitely continue. Families and couples will remain under one roof for most of our time, until a vaccine shifts the virus and clears our present reality. Until then we dance. I invite you to dance intentionally, to promote emotional healing before the physical cure arrives. Stretch yourself and heal with your partner, your family, your friends. Now is the time. Be your own cure.

Member Book Review

Book : *Raising White Kids* by Jennifer Harvey
Reviewer : Pat McDermott, MFT

I am suggesting this book because most of us see more white families than families of color. Helping families learn how to talk about race is important because our families set the tone for how our children learn about the world.

In her book Ms. Harvey explains how children pick up on our opinions about race from what we do not say as much as from what we say. She gives lots of examples of what is important for children to hear at different stages of development.

Ms. Harvey teaches college in the Midwest and she is working hard to help her students learn how our country was founded by white people who took the land from the indigenous people who lived here before the Europeans came to settle here. Most of our history classes do not focus on our violent beginnings.

It is a good read and it my help white families to learn how to have the hard conversations with their children no matter what their age.

Guest Article

When distance brings us closer: leveraging tele-psychotherapy to build deeper connection

Cory K. Chen, Nicole Nehrig, Lauren Wash, Jennifer A. Schneider, Sagiv Ashkenazi, Elana Cairo, Angel F. Guyton & Amy Palfrey (2020) Counselling Psychology Quarterly, DOI: 10.1080/09515070.2020.1779031

Abstract

In this paper, the authors describe how patients and therapists may, paradoxically, perceive a greater sense of closeness as a result of the physical distance inherent in conducting psychotherapy over synchronous video telehealth. Case material is used to illustrate ways in which tele-psychotherapy facilitated engagement, strengthened the alliance, and created unique therapeutic opportunities that may not be possible when therapy is conducted in person. This paper aims to challenge preconceived notions about the ability to develop a strong therapeutic relationship with patients and implement lasting change through tele-psychotherapy. Implications for future clinical work are discussed, with particular consideration of the recent COVID-19 outbreak's influence on psychotherapy.

Over the last 20 years, there has been a steady increase in the use of telemental health (TMH) technologies to provide tele-psychotherapy (Frueh et al., 2000; Gros et al., 2013; Hollis et al., 2015; Monnier, Knapp, & Frueh, 2003; Richardson, Frueh, Grubaugh, Egede, & Elhai, 2009). While data is not yet available, it is likely that with the COVID-19 pandemic, the use of remote technologies to deliver psychotherapy is skyrocketing. This has been facilitated by many state boards having relaxed requirements in order to ensure that patients receive needed care during this stressful time. At the time of writing, therapists across the world are utilizing technology to maintain connection and deliver critical mental health services in the face of a global public health crisis that forces therapists and patients to remain physically apart. For many, this represents a first exposure to TMH treatment. However, some institutions, like the Veteran's Health Administration (VHA), have been increasingly utilizing TMH for the last 15 years (Deen, Godleski, & Fortney, 2012; Godleski, Darkins, & Peters, 2012; Wallace, Weeks, Wang, Lee, & Kazis, 2006; Weeks et al., 2004). In 2016, the VHA began a TMH initiative to provide treatment for Veterans in areas that did not have access to specialty mental health services (U.S. Department of Veterans Affairs [VA], 2018).

Over time, the VHA significantly increased its use of TMH. During the 2019 fiscal year, more than 99,000 Veterans nationwide attended telehealth sessions at home using the VA Video Connect app, 200,000 of which were TMH appointments. (U.S. VA, 2019). VHA telemental health providers deliver a range of services including individual, couples, and group psychotherapy, psychological evaluations, and neuropsychological assessment (Chen et al., 2019; Shreck et al., 2020). There is strong evidence to suggest that TMH is an effective mode of treatment delivery for a variety of mental health conditions including post-traumatic stress disorder (PTSD), depression, anxiety, insomnia, alcohol abuse, and eating disorders with outcomes comparable to treatments delivered in person (Egede et al., 2015; Frueh, Henderson, & Myrick, 2005; Germain, Marchand, Bouchard, Drouin, & Guay, 2009; Holmqvist, Vincent, & Walsh, 2014; Luxton et al., 2016; Mitchell et al., 2008; Theberge-Lapointe et al., 2015; Wierwille, Pukay-Martin, Chard, & Klump, 2016; Yuen et al., 2013).

Despite its increasing utilization, there has been reluctance among therapists to deliver treatment via TMH. Many therapists have been deterred by the onerous process of navigating the complexities of licensure, state mandated telehealth training requirements, uncertain insurance reimbursement, risk management, and other logistical issues associated with TMH (Brooks, Turvey, & Augusterfer, 2013; Kruse et al., 2018). It is often considered an option of last resort with the assumption that in-person treatment is more effective, meaningful, or helpful to patients. Even the words used to describe TMH as "virtual" or "remote" can connote a falseness or coldness that understandably evokes hesitation and skepticism among therapists who pride themselves on their authenticity and warmth.

Critics of TMH have suggested that the physical distance between patient and therapist might contribute to a loss of perceived emotional safety for the patient. They worry that the lack of a stable containing environment, in the form of the therapist's office, can affect how patients are able to explore painful material during therapy (Argentieri & Mehler, 2003; Leffert, 2003; Russell, 2018; Scharff, 2012). Additionally, some worry that the ability to convey warmth and empathy through video technology might be curtailed (Germain, Marchand, Bouchard, Guay, & Drouin, 2010; Rees & Stone, 2005). Critics have also voiced concern that TMH may limit access to patients' verbal, non-verbal, and unconscious communications during therapy (Brahnam, 2017). Disruption in video and sound quality, coupled with the restricted view of the patient's body language, can make dynamic and introspective therapeutic work more difficult and may impede lasting change (Bayles, 2012; Essig & Russell, 2017; Gutiérrez, 2016). However, few systematic empirical studies have been done to study these concerns.

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While these concerns are important to address when providing tele-psychotherapy, there has been little written about the unique ways that TMH may enhance the depth, connection, and intimacy between therapist and patient (Ehrlich, 2019). The authors serve as psychotherapists at one of the VHA's Telemental Health programs and have been providing a range of psychological services from a variety of theoretical orientations to Veterans across the country for years prior to the COVID-19 pandemic. In this paper, it is argued that, not only is the characterization of TMH as a poor substitute for in-person treatment patently false, but that for some patients TMH may open new avenues for connection and exciting possibilities for treatment not available in person. Case material is presented to illustrate these ideas for patients that have engaged in TMH. Cases have been de-identified and disguised to protect patient identities and some represent amalgamations of multiple patients seen across therapists in our program.

Significant variability exists across patients' reactions to TMH. Some of that variability may even occur within the course of a single patient's treatment. Thus, some of the ideas presented in this paper may seem contradictory, but in fact reflect the reality that aspects of TMH may foster closeness for some and create distance for others. While other papers have described the potential pitfalls of "virtual treatment," the authors focus on ways that tele-psychotherapy has deepened clinical work, broadened the range of areas explored, and facilitated the intimacy of the therapeutic relationship.

Meeting patients where they are

Tele-psychotherapy has the potential to reach patients by reducing barriers to treatment engagement. The issues that bring some patients to treatment may also interfere with their capacity to obtain the help they need. For example, a patient who has agoraphobia may be unable to leave their home to reach the therapist's office. A severely depressed patient may be overwhelmed by the effort to prepare for and travel to sessions but have the capacity to engage in a session that does not require them to leave their home. TMH may help these isolated patients ease into engaging more fully with their lives and potentially gain the skills to transition into in-person treatment, if indicated. TMH allows therapists to reach and be present for patients at moments when they feel most alone, both literally and figuratively – to "meet" patients where they are.

"Brian," a 55-year-old, Asian American, male was seen in short-term psychodynamic treatment for severe depression that made it difficult to leave him home and regularly attend therapy. At the start of treatment, Brian tearfully expressed ambivalence about fully opening up to others, describing a fear of rejection, despite a deep longing for connection. The therapist noted the contrast between this statement and the vulnerability that the patient displayed with this disclosure. Upon reflection, Brian described being unable to imagine being as vulnerable had the treatment been in-person. As therapist and patient explored this feeling, Brian articulated fears that true closeness would expose his imagined defects and ultimately lead to rejection. Thus, for Brian, connection represented both hope and danger. The therapist's physical absence buffered that threat while maintaining the potential for new possibilities of connection. As treatment progressed, Brian experienced telehealth as a way to titrate his fears of failing to meet others' expectations. He was able to increase his ability to tolerate fears of disappointing others in the service of greater connection. He also began to translate these changes into deeper and fuller relationships outside of treatment. As termination approached, Brian reported pride in his growing ability to desire, rather than fear, closeness. As the treatment ended, he was able to describe and enjoy fantasies of meeting the therapist in person.

Similarly, some patients with severe PTSD may be triggered by travelling to the therapist's office. The intensity of their avoidance interferes with their ability to obtain the help they need. While careful not to collude with this avoidance, TMH therapists may have unique opportunities to scaffold exposures or provide skills training in ways that can help the patient better tolerate treatment. In addition to helping therapists meet patients where they are, TMH offers the opportunity for patients to take their therapists where they need to go.

"Jen" was a 40-year-old, African American, female Veteran who presented with severe PTSD following Military Sexual Trauma (MST), as well as depression, anxiety and chronic pain. She had been socially isolated for a number of years and felt extremely triggered when travelling to the VA for appointments. Jen reported that she would never have engaged in treatment if not for telehealth. The treatment began with in-vivo exposures to decrease her social isolation. Using a tablet, Jen's therapist was able to travel with her as she engaged in these exposures to different areas of her neighborhood. Jen's confidence and sense of self-efficacy increased such that she reported being willing to begin trauma-focused psychotherapy and a course of Cognitive Processing Therapy was initiated.

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Finally, travel time, inflexible work schedules, travel costs, caregiving responsibilities, health issues, and physical disabilities may represent significant barriers to obtaining treatment, particularly for patients with fewer resources. TMH, while associated with an initial cost for the technology necessary (e.g. smart phone, computer, tablet, stable high-speed wifi, etc.), may lessen sociocultural barriers to accessing treatment as patients do not incur the repeated costs associated with traveling for in-person treatment sessions or have to navigate environments that are not accessible or perceived to be unwelcoming due to aspects of the patient's identity (e.g. gender identity, sexual orientation, race/ethnicity, etc.). These features of TMH may present both exciting opportunities and new challenges associated with engaging a population of patients that had not previously sought treatment and are underrepresented in our research literature.

Safe distances

The freedom patients experience in speaking to a therapist can be facilitated by the relative anonymity of both parties. Embarrassment, shame, and anxiety around disclosing sensitive material can be eased by the patient's trust that their words will be safely contained within the therapy space. Knowing that what they disclose will not intrude into their daily life can, for some patients, be a prerequisite for engagement. However, for patients who reside in small communities, that sense of anonymity can be severely compromised.

The stigma associated with seeing a therapist and the possibility that they may be observed entering the therapist's office by someone they know may deter some individuals from seeking help. For some patients, acquaintances, friends, or even family may work in the clinics where the patient would receive psychotherapy. Patients themselves may be medical providers or mental health professionals. The fantasy (or sometimes real possibility) that their sessions could be overheard by others serves as a significant inhibitor of the safety and trust necessary to fully engage in treatment. In these small communities, the likelihood of social circles overlapping and creating complicated dual relationships serves as an additional barrier to treatment; it may be uncomfortable for a patient to know that they will see their therapist later that day at their child's soccer game or religious services. Even those who do seek treatment in these situations may be inhibited from fully disclosing more sensitive aspects of their feelings or lives. This process can occur unconsciously as the patient's mind closes off access to these more threatening aspects of themselves. The embarrassing thought, shameful memory, or conflicted impulse never reaches the patient's awareness, thus foreclosing its exploration in the therapy room.

TMH provides access to a pool of therapists that may be hundreds of miles away thus providing a sense of anonymity and safety that would not otherwise be available. In some communities, where most people know one another, TMH may offer a relatively novel experience to feel free of the fear that what is spoken to one person will be shared with the broader community. That sense of the therapist being an "outsider" may allow patients to play with new ways of being in the treatment that would be too threatening with someone "inside" the community.

> "Andrew," a 35-year-old, White, male who worked as a lawyer in a small rural community presented with a vague sense of dissatisfaction in his relationships. He had been reluctant to seek treatment as he noted that the size of his community would make it impossible to maintain a sense of confidentiality as many of his family, friends, co-workers, and even his own clients, used the same firm for a range of services. Andrew was concerned about the stigma associated with seeing a therapist and concerned about the negative impact it might have on his reputation and livelihood.
>
> TMH to his home allowed Andrew to maintain the confidentiality he needed to engage in treatment. Once therapy began, Andrew described the impossibility of sharing all of his feelings, particularly the parts of himself that he viewed as vulnerable and weak, with his colleagues, friends, or family because of a need to maintain a professional image. Andrew's rigid investment in this image left him feeling inauthentic and alienated. His ability to be open and vulnerable with the therapist came, in part, because the therapist was viewed as distinctly outside of his world. This separation made Andrew feel safer, as the therapist could hold parts of him that did not conform to the image he presented to those around him. Having the therapist accept and hold these parts of him helped Andrew to explore and begin to integrate them into a fuller and more complete sense of self. This became a launching point from which to experiment with sharing those parts of himself with others.

Dangers of proximity

The co-location of therapist and patient in the same physical space can evoke or inhibit a range of reactions and can vary across patient and moment. As previously mentioned, one critique of tele-psychotherapy is that the absence of two physical bodies in the same space can result in a sense of alienation within the therapeutic relationship (Germain et al., 2010). For some patients, however, the proximity of another's physical body may evoke anxieties that inhibit a patient's capacities to make contact with aspects of their internal experience.

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Patients who have suffered trauma may perceive themselves to be tainted or toxic in ways they worry will infect others (Boulanger, 2007). Often such patients describe fears that sharing their traumatic memories will traumatize the listener. The physical proximity of the therapist can evoke a patient's sense of themselves as a potential contagion, compelling them to quarantine damaging, shameful material contained within themselves. For these patients, the screen can serve as a psychic filter, protecting the therapist from the full brunt of the patient's imagined toxicity. One therapist described working with a Veteran with PTSD, whose index trauma involved his role as the perpetrator of domestic violence in a past relationship. The Veteran described significant shame and guilt and noted that he avoided discussing this history in past in-person treatments. The Veteran specifically described concerns about the therapist's wellbeing and noted that the distance created by the screen allowed him to feel less anxious about the impact of his words on the therapist. This allowed him to show increased vulnerability and examine his complex feelings about his history of violence and its impact. Alternatively, for some patients with trauma, proximity to the therapist can evoke fears of harm and result in an additional barrier to developing the trust and alliance necessary to engage fully in treatment (Herman, 1997). For these patients, the absence of the therapist from the physical space can add to a sense of safety, as the possibility of physical harm is reduced, allowing trust in the therapy relationship to develop more rapidly.

TMH may also increase the therapist and patient's willingness to explore intense feelings of rage. Physical distance from patients may allow therapists greater safety and freedom to explore aspects of the patient's experience that might otherwise be frightening, for the therapist, to invite into the room. One therapist noted an example of seeing a couple with a history of severe intimate partner violence. The husband made efforts to unnerve the therapist with threats regarding what would happen to the therapist and his wife if his wife decided to leave the marriage as a result of couples' therapy. Knowing that he could not physically harm her, the therapist was better able to manage her own fear which helped her set firm limits in treatment. Other patients fear that their rage will become overwhelming and dangerous. These patients are inhibited by fears of harming the therapist. The physical absence of the therapist may allow some patients to access these feelings knowing that the distance serves as protection from the patient's perceived destructiveness.

"Mike," a 55-year-old, Latino, male Veteran was referred for long-standing depression and anxiety. He had a tendency to largely avoid his own affect and described feeling fearful of allowing himself to fully connect to the depth of his emotions. While he described feeling "numb" much of the time, he occasionally had powerful anger outbursts that frightened him. After several sessions over telehealth, Mike began describing his relationships with his family, from whom he was estranged. During one session, he began sweating and turned red when talking about his father. When he was asked to share his in vivo emotional experience, he broke down in tears and shared the rage he felt towards his parents for their estrangement from him. He was encouraged to stay with his emotions, and despite obvious discomfort, he was able to verbalize his feelings. A similar pattern happened throughout the treatment course, and over time, he became better able to identify, tolerate, and share his affect.

As termination neared, Mike was asked to reflect on the treatment. He described it as his "first truly successful course of therapy" despite many previous courses of in-person treatment, and he relayed feeling a greater acceptance of himself and his emotions. He specifically attributed this to telehealth. He had previously been fearful that he would fly into a fit of rage if he let himself fully feel his emotions. In prior therapies, this worry about scaring his therapists inhibited him from showing anger. The physical distance offered by TMH allowed Mike to fully experience his rage as he worried less about the harm he might cause the therapist. The therapist also noted that the physical distance allowed her to feel safer as well, making room for greater curiosity that may have been otherwise taken up by anxiety. As a result, Mike was able to see that both he and his therapist could tolerate and survive the full depth of his affect, which facilitated decreased numbness outside of session. Over time, Mike was also able to express these feelings in more skillful ways and, during stressful times could access support from others rather than detaching and isolating himself.

The exploration of erotic feelings in the therapy can also be facilitated by TMH. While for some, the absence of the therapist's physical body in the room results in a deadening of impulses and fantasies; for others, the physical presence of the therapist may be overstimulating or dangerous as the "real" possibility of physical touch results in panic and a disconnection from these overwhelming feelings. The therapist's physical distance from the patient may allow the patient permission to explore aspects of their inner life and fantasies that they would not otherwise dare touch.

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"Jonathan," a 27-year-old, White, male sought treatment for depression and longstanding social isolation. During the treatment, Jonathan disclosed details of sexual abuse by his mother during childhood as well as violence that he himself perpetrated. In the face of the shame he described experiencing, the therapist was able to retain her capacity to be supportive and warm rather than react with the judgment and criticism he feared. As the treatment progressed, Jonathan began to express feelings of warmth, affection, and desire towards the therapist – feelings that he rarely allowed himself to acknowledge. When asked about what allowed him to express these feelings, Jonathan reported that the distance created by TMH made him feel safer and more willing to both experience and share these feelings. The physical distance of TMH created a transitional space where his fears of being violated by the therapist as well as fears of rejection or criticism could be better managed. Speaking about his feelings of love towards the therapist and describing his fantasies about the relationship he wished he could have with her led to the Veteran's increasing contact with these desires that had long been too dangerous to allow into his awareness. This exploration became a starting point for deepening his connection to his desire to be cared for and challenged core beliefs that he was undeserving of this care. Over time the Veteran was able to generalize these experiences with the therapist to other relationships in his life.

Intimate spaces

The location of psychotherapy sessions can impact therapeutic intimacy. While tele-psychotherapy is sometimes provided between medical institutions, it can also be delivered from the therapist's home to a patient's home. Particularly during the COVID-19 pandemic, for therapists and patients following shelter-in-place orders, this became one of the few options for continuing treatment. For both parties, video sessions provide a window into the other's private space.

What therapists see in the patient's background sometimes reveals new aspects of the patient's life. Therapists can catch glimpses (or be deliberately shown) bookshelves, artwork, family photos, or other aspects of the spaces within which our patients reside. The features of the patient's space (e.g. how disorganized, cramped, clean, etc.) provide new information about the patient's daily life in ways that patients themselves may struggle to convey or believe are insignificant.

Explicit discussion of what is seen and being shown and its impact on the therapist's understanding of the patient or the therapy relationship can be critical for using this information to further the treatment and to navigate complex issues that may arise around unintended "visual disclosures." Additionally, the patient's capacity to set clear boundaries and keep others (e.g. children, older parents whom they provide care for, etc.) from intruding into the private space of the session also provides therapists with information and opportunities to empathize in ways that might not otherwise be available in the controlled environment of the therapist's office. Pets sometimes make unexpected appearances during sessions and have been observed helping patients to regulate their distress and tolerate sitting with emotions, thoughts, and memories that would otherwise have been overwhelming. Family members have also made unanticipated "intrusions" into the session. One male patient, who presented with panic disorder and complex trauma from childhood and military combat, lit up with joy when he heard his young daughter returning home a few minutes early from school. Seeing how dramatically his mood shifted in her presence opened up exploration of the meaning and significance of this relationship and furthered exploration of his childhood trauma and the ways he strove to differentiate his own parenting from what he endured.

Patients can also peek into the therapist's private space. Despite their best efforts, patients may catch unplanned glimpses of unruly pets or children in ways that, for some patients, can create a greater sense of closeness to the therapist as a real person or open up unexpected avenues of exploration. While sometimes disruptive, there are instances when these serendipitous moments precipitate responses from patients that catalyze the therapeutic work.

"Linda," a 75-year-old, African American, woman came to treatment for longstanding PTSD symptoms connected to extensive childhood trauma. During one of her sessions, the patient could hear the therapist's daughter crying in the background. As Linda observed the therapist becoming distracted and concerned about the noises his daughter was making, Linda's eyes welled up with tears. The therapist inquired into her experience and Linda began to describe her fantasies of what she believed the therapist was like as a father, how that contrasted with her own history as a child, and how she wished to be cared for in the ways she imagined the therapist cared for his daughter. Greater access to these feelings helped Linda to connect to, reflect on, and mourn her own painful childhood and explore new possibilities for herself and her relationships in her present life.

What is possible for patients and therapists to think, feel, and do is context dependent. The characteristics of the session setting will both evoke and inhibit certain associations, memories, feelings, and actions.

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While some authors have expressed concerns regarding the potential "informality" that may result from tele-psychotherapy (Fleuty & Almond, 2020; Russell, 2018), the "informality" does not necessarily result in superficial or frivolous engagement. The "formality" of meeting in a professional setting, such as a medical center, may inhibit some patients' capacity for creativity and play. The less formal environment of the patient's home may open up possibilities to engage in the serious work of playing with difficult material. Furthermore, a patient speaking about the argument they had with their partner from the room where the argument occurred may allow closer connection to a range of feelings that may not be as accessible in the therapist's office. Additionally, for couples therapists delivering treatment through TMH, observing who gets up to let out the dog, subtle ways members of the couple may care for one another (e.g., getting the other a glass of water), or who handles intrusions from children can provide greater clarity around patterns of interaction that may not be easily observable in the therapist's office.

Finally, for both therapist and patient, inviting the other into a space that can be associated with intimacy and safety may help facilitate similar feelings within the therapy relationship. For some patients, travelling to the therapist's office may include enduring a range of stressors (e.g., harassment, an unsafe neighborhood, lengthy commutes, environmental triggers for those with PTSD, etc.) that cause the patient to arrive to session with defenses activated. While exploring those defenses and aspects of the patient's lived experience can be helpful, TMH may offer a method of gaining more rapid access to vulnerable or sensitive aspects of the patient's inner life that may have been closed off otherwise.

The space created by absence

Patients can react differently to the physical presence of an other. For some patients, the therapist's physical presence can help regulate the patient's emotional reactions and evoke a sense of calm and safety (Beebee & Lachman, 1988; Geller & Porges, 2014). However, for other patients, the therapist's physical presence can be overstimulating or implicitly demanding. The physical and psychological distance created by meeting a therapist on a screen can mitigate some of these barriers to accessing the patient's feelings. For these patients, distance reduces awareness of the therapist's presence in ways that can facilitate the treatment. For example, one patient seen via TMH for eating disorder treatment spoke of her envy, rage, and shame in the presence of women whom she perceived as thin and described her pattern of immediately discontinuing treatment with providers who evoked those feelings.

This patient noted that it was difficult to clearly see the therapist's body on the screen and admitted that because of that ambiguity, she was able to tolerate engaging with the therapist in treatment. Decisions around what of the therapist's body is shown and what remains ambiguous are not available in the same way for patients seen in person. If these choices are made in deliberate, thoughtful ways, they have the potential to facilitate patients' engagement.

Similarly, patients who are hyper-attuned to others and become distracted from their inner life can experience a greater sense of freedom to direct their attention to and explore themselves when not "needing to" attend to an other in the room. The utilization of TMH can serve to remove some of the therapist generated cues that inhibit free association. Additionally, for some patients who tend to make negative attributions for other's behavior, TMH may mitigate these tendencies. For example, "Mike" (described above), noted that he had been hyperaware of the body language of his prior in-person therapists, vigilantly scanning for signs that therapists were judging him. This caused Mike to prematurely end multiple treatments due to his belief that the therapist was critical and did not empathize with him. In contrast, in TMH Mike described assuming that any misunderstanding or miscommunication was a result of technical issues with sound or visual quality. This unanticipated effect of TMH contributed to Mike's ability to engage in the treatment and begin to explore the assumptions that had caused him to abruptly end other therapies.

Staying safe by connecting on video

The shared global experience of the COVID-19 pandemic serves to both isolate us and bring us together. Individuals across the world end conversations with the send-off "stay safe." Across co-workers, friends, lovers, and family, we are attempting to bridge physical distance with technology. While social distancing helps to both individually and collectively keep us safe, the virtual world has become a primary method for maintaining real connection. Therapists and patients are "in it together" in ways that make it clear that we are all "more human than otherwise." In the context of these world events, many therapists self-disclose aspects of their own fears, frustrations, and uncertainties in ways that can help to validate the patient's reality. Therapists are also forced to share (intentionally or unintentionally) aspects of their life circumstances or situation as the voices (or crying) of children can be heard in the background or school closures require navigation of childcare responsibilities that impact session scheduling. These disclosures allow some patients to see therapists more clearly and fully. For some, this can manifest in a recognition of the therapist's vulnerability and expressions of concern and care towards them. For others, this can induce rage and envy as the patient's fantasies of being the most important person to the therapist are challenged.

cont'd on pg. 12

Ultimately, this increased authenticity through awareness of a shared humanity has the potential to lead to deeper work and is only possible through the virtual connections that allow us to maintain our relationships despite the isolation imposed by the pandemic.

Conclusion and future directions

New technologies often elicit mixed reactions across people. There are those who enthusiastically adopt and excitedly tout the advantages of the novel. Some are indifferent. And there are others who express skepticism and concern about the technology's potential unforeseen implications and effects. Tele-psychotherapy certainly provokes this range of responses. Some focus entirely on its convenience and capacity to provide access to patients who desperately need help. Some observe its increasing use with apathy – unthreatened and secure in the continued need and utility of in-person treatment and largely unchanged in how they practice. Others see tele-psychotherapy as a threat to the core values of the profession, a reflection of broader problems of alienation and disconnection in society, and a harbinger of a world where technology replaces "real" human connection. Perhaps, like most tools, tele-psychotherapy contains within it a range of possibilities – the potential to be either weaponized or curative.

The therapist's mindset in approaching tele-psychotherapy has a significant impact on the experience of the dyad in the room. The therapist's apathy or fear may have a concordant impact on the treatment, deadening or paralyzing the work as tele-psychotherapy's anticipated dangers preoccupy the therapist's consciousness. While it can be easy to say that its differences from in-person treatment represent "grist for the mill," without recognition of the grains that can be productively harvested the therapist may mistake the newly nourishing for the dangerously indigestible. This paper attempts to provide therapists with a "field guide" to assist in recognizing various possibilities for how tele-psychotherapy can be used to nurture connection. It is hoped that future work will elaborate on the details of the therapeutic process, specific implications for technique, or provide a nuanced discussion of the artistry critical to the work of this mode of psychotherapy.

COVID-19 is presenting a range of new challenges for tele-psychotherapy. Many therapists have been forced to transition from in-person treatment to tele-psychotherapy and greater exploration and reflection on how therapists navigate these transitions amid the chaos would be valuable.

Additionally, COVID-19 has brought with it a range of health and economic anxieties that have had significant interpersonal implications – potentially leading to greater loneliness, isolation, and/or interpersonal conflict. The too frequent experiences of loss, bereavement, and mourning, absent the typical rituals and processes used to help navigate those experiences, has been a challenge for many and must be addressed by therapists who are themselves providing support at a distance. Furthermore, while we previously discussed the shared experience of the pandemic having the potential for creating a sense of shared humanity, the impact of the pandemic varies based on ones' relative resources and privilege. While we are all attempting to weather the "same storm," we are also not in the "same boat." Those with more resources may weather the pandemic in beach homes while those who were barely making ends meet further struggle to remain afloat. These discrepancies in experience have been brought into stark relief and must also be navigated by therapists who themselves may experience a range of reactions and feelings about their greater or less degree of privilege compared to their patients. Future work that specifically attempts to examine the range of ways that tele-psychotherapy has been deployed, navigated, and leveraged to address these issues is critical. Finally, empirical research that goes beyond the question of "does it work" and moves towards examining questions of "how it impacts the treatment process," "for whom," "under what circumstances," "at what moment" have the potential to refine our ability to deploy these new approaches most effectively and with greater nuance.

Adversity demands creativity and innovation. If, as Freud suggested, helping our patients to "work and love" represent key goals of psychotherapy, the immense global economic and relational impact of the COVID-19 pandemic makes our work critical for navigating the suffering of this moment (Erikson, 1950). As therapists, we are called upon to adapt to changing needs and evolving barriers to our work and relationships with our patients. While tele-psychotherapy represents one way of bridging the gap that separates therapists and patients during this crisis, it also offers a range of new possibilities and opportunities for connection. It is critical for therapists to remain open to the frustration and mourning associated with losing our routine modes of relating. And we must also remain flexible, hopeful, and open to the potential for creative surprise and growth that comes with holding the tension between the safely familiar work our field has been engaged in for over a century with the unknown possibilities for closeness that greater space and distance may evoke.

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MC-CAMFT is dedicated to the advancement of marriage and family therapists, to the promotion of high standards of professional ethics and qualifications of its members, and to expanding the recognition and utilization of the profession in Monterey County.

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