Kate Dunn A multi-modality response, the Joanna Case Study and Working Online

In preparation for the 2014 Multi-Modality conference at which Philippa Weitz is speaking about working online she asked a number of clinicians from different modalities to comment on the Joanna case study.

Please be aware that this is "work in progress" for this conference and that each of the contributors will be continuing to work on their reflections for a book planned on the subject.

The Case Study

Joanna is a 42 year old married lady. She has presented at the GP requesting help for her depression and panic attacks. Joanna has been more or less a weekly attender at the GP practice for the last 10 years, since she moved to the area with a wide variety of symptoms, none of them life threatening. The GP has exhausted all physical tests.
What the GP doesn't know or discover is that Joanna has been physically and sexually abused throughout her childhood by her mother who wanted only a boy. She has struggled throughout her life with night terrors and depression and has made several suicide attempts. She is not suicidal at the moment, just very distressed. She also has had some NHS based in-person psychoanalytic psychotherapy which she found interesting but it did not move her forward in any meaningful way. She has a very supportive husband and three young children whom she adores but finds difficult to look after when in her blackest moment. She has been on Paroxetine for 6 months which she has found helpful, but she is keen not to stay on it for ever.
The GP is at a loss as to what to do with her and has referred her on to a locally contracted counselling service which has spaces for working online. The online service can offer 6 sessions initially, but this can be renewed in an ongoing way where needed. She was given a choice of formats - video conferencing, email or text based (like chat). She chose text based but was open to other formats. The service is flexible enough to be able to allow clients to change between formats if they wish.

Introduction

It feels appropriate to begin with a reflection on what is meant here by a 'multi-modality response', especially in the context of online therapy. Therapists often apply a number of different approaches concurrently, consecutively or by oscillating between models using a systemic and structured pathway, individualised for the individual client. We declare themselves to be working 'integratively' and yet may be unclear about how, exactly, through this approach, we hope to provide optimum benefits for our clients. Integration or eclecticism? Is the therapeutic plan purposeful or dependent on a system more closely related to trial and error? In reality, most contemporary integrative psychotherapists probably aim for the former but might admit, on occasions, to having achieved some of their best results through an experience of the latter! Slavish adherence to prescribed manualised treatment plans, constructed by theorists for 'conditions' rather than individuals, rarely facilitate optimum conditions for empathy, establishment of therapeutic alliance and positive change, evidenced as critical for effective therapy (Cooper, 2008). Equally, to embark on therapeutic engagement without some form of plan or formulation would be questionable and possible unprofessional, having few links with any evidence-based practices. Most of us will find ourselves taking a middle course, being guided by our theoretical and experiential understanding, whilst being ever alert to the opportunities presented by the twists and turns of the dynamic therapeutic encounter.

Working online brings this into sharper focus. The use of technological media brings both new opportunities and also restrictions. Our traditional trainings which prepared us for face-

to-face interventions must be adapted and refined to reflect both. An honest acknowledgement of this is likely to enhance the online relationship from the outset. It is unlikely that any single traditional therapeutic model can be 'purely' applied by the online therapist; the very nature of the technological media demands adaptation and incorporation of wide-ranging techniques that optimise the benefits and minimise the limitations.

I shall discuss here ways in which I might approach online work with Joanna from a multi-modality perspective. As with any case study discussion, this presupposes many aspects of her character which are unknown and unknowable, but will hopefully be embraced by the reader! Where I indicate possible progress through the therapy, there always lurks the likelihood that things might, in reality, take a very different turn, not least because of unexpected events cropping up in her life during the work, as well as those that have preceded it. Any case study proposal is always an imaginative fiction.

We are made aware, from the information given, that we have an initial 6 sessions, but also the possibility of further sessions, which offers the potential for a variety of different interventions. What happens beyond 6 weeks will depend very much on how Joanna responds to the primary intervention. Given that her difficulties are long-standing and entrenched, the goals for that initial period of time will incorporate the seeds of longer-term plans too, should therapy prove helpful, but it is hoped that the first sessions will provide relief and positive gain whatever the future may bring.

Assessment

Joanna's GP referral has provided some very information relating to the history of her presentation at the surgery (of 10 years duration, very regular and seemingly with a strong somatic bias, physical tests providing no evidence of major physiological difficulties). She is requesting help now with depression and panic. She engaged with interest in face-to-face psychoanalytic psychotherapy for a while, but this did not relieve her symptoms, which are now being treated pharmacologically with anti-depressant medication.

In the case description we have privileged information about matters she has not discussed with her GP and also about her current life situation. The abuse that she endured throughout her childhood and which occurred within her primary relationship with her mother is unknown to the GP and also to us, when we receive the referral. What is possible is that, during online therapy, she may feel able to disclose some of this, and perhaps at an early stage, if she feels sufficiently secure and contained. We are informed that she has chosen to engage in a therapy that is 'live' or synchronous, but text-based and without video or audio representation.

I would suggest beginning with an asynchronous form of assessment, in order for her to have an early opportunity to share the nature of her difficulty in a written format and in her own time (Dunn, 2012), and I would use an intake form as a starting point, on which she is invited to answer some gentle questions not only about her current difficulties but also about her background and previous therapeutic experiences. How she completes this form is likely to give me considerable insight into how things might progress subsequently as she

attempts to explore her feelings and emotions with an unseen other, through text. If she responds in detail, using complete syntax and descriptive language, this is likely to indicate a positive orientation towards giving a written account of herself and a willingness to articulate in this form. (A word of caution too – a very lengthy response on the intake form could indicate possible future challenges that may arise connected to keeping to session-time boundaries etc!) If her responses are brief, involving incomplete phrases and perhaps limited use of personal pronouns (Pennebaker, 2011 and Zinken et al, 2010) she may need more encouragement and active modelling from the therapist from the outset.

If she discloses or hints at the abuse on her intake form, this may indicate that she is demonstrating a disinhibition effect often noted in online work (Suler, 2004), something that may lead to fruitful and rapid self-expression, but that also needs very careful handling in terms of maintaining feelings of safety and containment and preventing an overwhelming flood of feeling which could initially threaten to overwhelm her.

Through exploring the intake form carefully, the next steps emerge. I could decide on one of the following approaches:

- To invite her to send an initial, free-flowing account of the nature of her difficulty, before engaging in our first chat session. (I would first ensure that we set up a secure and encrypted process to enable this.) My purpose would be two-fold: to encourage her to share with me the nature and essence of her difficulty at the outset (see Pennebaker, 1997) for evidence around the efficacy of written accounts of trauma) – which would then be 'known' between us from the outset – and also for her to have a chance to 'expel' some of the repressed material that has weighed so heavily for so long. I could gently draw attention to some of the specific responses on her intake form and invite her to tell me a little more. I have found that victims of abuse and/or trauma frequently choose to write a long and sometimes shocking account of this at the outset; to 'get rid of it' and also to know that it is shared by the 'unseen other'. In my experience, this initial 'outpouring' is unlikely to be repeated in intensity; it often provides relief and opens the door to much gentler and shared reflection. (I would only take this approach if I felt that it was strongly indicated by her response to the intake form.)

  In this situation, I would be considering an intervention aimed at facilitating some articulation of the trauma, engaging the left side of the brain and reducing the overwhelming and uncontrollable feelings wrought by right-brain activity, (see Fonagy et al, 2003 on mentalization). 6 weeks is relatively brief, but Pennebaker has achieved powerful results in surprisingly short periods of time. I would try to help Joanna understand a little of the theory behind the approach as my experience has taught me that this is welcomed by such clients.

- Alternatively, I might write an initial 'containing' email, acknowledging Joanna's intake form responses, suggesting some themes for our work together and contracting for our first chat session to take place as soon as possible. This approach might be indicated should she seem less willing to open up (perhaps needing to have a better sense of me first). The initial form might have raised her

anxiety levels and I would hope to be able to engage with her speedily to address this.

The ongoing sessions

The chat sessions would be contracted (usually weekly for 50 minutes). Online work by its very nature demands a more active stance from the therapist (which clients have reported often helps them to feel more 'equal' and less 'judged') and this is likely to establish the initial relationship.

The assessment processes described above might predicate two quite different approaches and outcomes during the following 6 weeks. In the first example, I might use a narrative approach to facilitate an exploration of feelings, perhaps working between past and present and exploring current relationships in the context of those from the past. This could well reflect a psychodynamic and/or developmental theoretical orientation.

The second example might take a very different turn. Without the abuse having been disclosed, I would focus on relieving the current symptoms of depression and anxiety, taking a CBT-informed perspective and using tools and strategies to increase awareness of automatic thoughts and behaviours and encourage change. I might suggest homework activities between sessions, including worksheets (thought records, questionnaires etc.) which could be emailed to me between sessions. This might help Joanna to feel supported enough to gradually engage in a freer writing style, which might lead towards fuller disclosure at a later date.

Whichever pathway we follow, it could prove helpful to introduce Joanna to some mindfulness techniques. These could be an additional self-help provision (again delivered online and involving engagement between chat sessions) where I might take a supportive role. Evidence suggests that self-help is more effective when personalised and employed within the context of a strong therapeutic relationship (Mains & Scogin, 2003). Whether or not Joanna has disclosed her childhood history of abuse, mindfulness may well provide symptomatic relief and help her to reduce or cease medication.

The 'ending' and beyond

We would review the outcome of the 6 weeks of therapy together, both informally and perhaps using a more formal evaluation measure. We would summarise our work together. (Due to the necessarily collaborative nature of online work and the need for clear and explicit communication, this becomes a very mutual process). The sixth session is likely to involve some relapse-prevention planning, another effective way of reinforcing and summarising the therapy.

In either situation, I would want to suggest possibilities for ongoing work. If writing emerges as a positive tool, and Joanna finds it therapeutic to remain 'unseen' to her therapist, I might suggest further online work, which could include more detailed therapeutic writing activities. Longer term goals could be considered, relating either to further symptomatic relief or disclosure of previously unarticulated difficulties (or, hopefully, both).

Acknowledgement of the positive elements of Joanna's current life will have been included during the six weeks of therapy and could be built on further, perhaps using elements of Acceptance and Commitment Therapy (ACT – Hayes et al, 2004) which can be delivered very effectively online.

It may be that Joanna becomes curious about meeting her therapist. Although this is not necessarily an automatic goal for online clients it can become a powerful next step for some (Dunn, 2012). It is certainly something that can be explored in the chat sessions and facilitated for Joanna should she choose it, as she lives locally to her online service. Development of the therapeutic relationship can take many forms, and it may be helpful to explore different approaches, both asynchronous (eg email) and synchronous (eg teleconferencing). If the initial chat sessions have taken a more directive, CBT-oriented approach, a subsequent change to email counselling may facilitate disclosure for which Joanna was not initially ready. Video therapy may be a useful stepping stone on from 'unseen chat'. As indicated at the start of this response, any further therapy will be chosen collaboratively and individually in the light of all that has gone before.

References

Cooper, M. (2008). *Essential research findings in counselling and psychotherapy.* London, Sage.

Dunn, K. (2012). A qualitative investigation into the online counselling relationship: To meet or not to meet, that is the question. *Counselling and Psychotherapy Research*, *12*(4): 316 – 326.

Fonagy et al (2003). *Affect regulation, mentalization and the development of the self*. Karnac: London.

Hayes, S. et al. (2006). Acceptance and commitment therapy: model processes and outcomes. *Behaviour Research and Therapy*, *44* (1): 1-25.

Mains, J.A. & Scogin, F.R. (2003) The effectiveness of self-administered treatments: a practice-friendly review of the research. *Journal of Clinical Psychology*. *59*: 237-246.

Pennebaker, J. (1997). Writing about emotional experiences as a therapeutic process. *Psychological Science*, *8*(3): 162-6.

Pennebaker. J. (2011). *The secret life of pronouns.* New York: Bloomsbury.

Zinken, J. et al. (2010). Analysis of syntax and word use to predict successful participation in guided self-help for anxiety and depression. *Psychiatry Research*, *179*: 181-186.