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Adapting a mood disorders group therapy programme for the screen in the time of COVID-19

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INTRODUCTION

The Mood Disorders Unit (MDU) at the Institute of Mental Health is the only specialised service that is providing tertiary psychiatric treatment for adults with depression and bipolar disorder in Singapore. One of the hallmarks of our therapeutic approach is the transdisciplinary group-based therapy programmes that are offered in both the inpatient and outpatient settings. While the inpatient therapy programme promoted stabilisation and insight, the outpatient day therapy programme was designed to provide critical ongoing interventions and support following short-term acute inpatient treatment, alongside individual follow-up. With the onset of the COVID-19 pandemic, social distancing and infection control measures implemented at the national and hospital levels disrupted access to mental health services, including the physical gathering of staff and patients for these groups. In order to preserve the urgent need for treatment continuity and to respond to the rise in COVID-19-related distress, the group therapy programme was promptly adapted for remote online delivery and access. This paper describes the chronological development of the provision of online day therapy services, including barriers, successes and strategies encountered by patients and facilitators, and concludes with our preliminary reflections.

BACKGROUND AND EVIDENCE

Group therapy for mood disorders

The MDU Day Therapy Programme originated from research demonstrating the efficacy of group therapies in treating individuals with mood disorders.⁽¹⁾ Treatment delivery in a group format provides benefits through therapeutic factors unique to groups, such as universality, group cohesiveness and interpersonal learning.⁽²⁾ Further, group formats have been found to produce statistically equivalent outcomes to individual formats when comparing identical treatments, patients and doses.⁽³⁾

In major depressive disorder, psychosocial interventions delivered in a group format are efficacious in acute treatment as well as in reducing the rates of relapse and/or recurrence of depression in pharmacologically treated individuals.^(4,5) Specifically, group-based psychotherapy,^(6,7) psychoeducation,⁽⁸⁾ peer support,⁽⁹⁾ music therapy⁽¹⁰⁾ and art psychotherapy have been shown to have positive effects on depressive symptoms, quality of life and overall mental well-being. Similarly, in bipolar disorder, adjunctive group-based psychosocial interventions have been found to be useful for acute depressive episodes as well as in maintenance treatment to prevent relapse and restore quality of life to the individual and family.⁽¹¹⁾ There is positive evidence for psychoeducation, psychotherapy and peer support being delivered in a group format during the maintenance phase of bipolar disorder.

Evidence for telemental health

Telemental health refers to the delivery of mental health services via digital means in a non in-person situation. Research has demonstrated that telemental health is as effective as in-person care and increases access to care for patients from a range of age groups and conditions.⁽¹²⁾ A recent systematic review has found that telepsychology delivered by video teleconferencing and phone is effective for depression, anxiety and adjustment disorder.⁽¹³⁾ Another systematic review comparing video teleconferencing or telephone-based telemental health treatments to in-person treatment delivery also found comparable levels of treatment satisfaction as well as similar ratings of therapeutic alliance.⁽¹⁴⁾ However, some results suggest the potential for decreased satisfaction associated with technological factors that influence video teleconferencing quality and poorer perceived alliance between individual patients and the group therapist when such delivery methods are used for group treatment. The authors concluded that deliberate onboarding and focus on the patient experience in treatment may be useful in group treatments delivered via telemental health.

Mood Disorder Unit's Online Therapy Programme

The original in-person MDU Day Therapy Programme consisted of a range of peer support, activity, psychoeducation and therapy groups facilitated by peer support specialists, an art psychotherapist, medical social workers, clinical psychologists and case managers in the hospital setting. Some of these groups, such as the psychoeducation, peer support, activity and music therapy groups, were non-chargeable, had minimal patient selection and were on a drop-in basis, while the more structured psychotherapy groups were more selective, chargeable and required a compulsory commitment of 4–12 sessions.

To expeditiously close the treatment gap caused by social distancing measures and maximise access to treatment in the initial phase, priority was given to transitioning to an online format the non-chargeable open groups that had minimal patient selection and would be of most therapeutic value in the context of the pandemic. An exception was the art psychotherapy group, which was selective, chargeable and required a minimal participation of four sessions. Table I describes the groups that were transitioned to the online format.

Table I. Description of the Mood Disorders Unit online groups.

Group and description	Group type	Duration (hr)	Facilitators	Online platforms and materials
Peer support: Peer-led support group with open sharing of experiences, setting of short-term goals and receiving of feedback.	Open	1.5	2 peer support specialists	Zoom meeting
Psychoeducation: Topical workshops surrounding the management of mood disorders.	Open	1.5	2 peer support specialists	Zoom meeting with polls and screen sharing of slides and YouTube videos
Activity: Group-based activities and games with brief check-in.	Open	1.5	2 peer support specialists	Zoom meeting and external websites that host activities, e.g. Zentangle, Pictionary
Family-focused: Family-focused group that explores family dynamics and relationships as contributing factors that help or hurt illness. Special attention is paid to the parenting journey, as families spend more time together at home during the pandemic.	Open	1	2 medical social workers	Zoom meeting with screen sharing of slides
Music therapy: Various types of music experiences e.g. receptive or listening composition, improvisation, and re-creative or performance, which addresses issues of self-concept, self-efficacy, and quality of life through music engagement that allows individuals to be heard, to build relationships, and to re-experience the wholeness of their own humanity.	Open	1	1 music therapist	Zoom meeting and any available musical instruments
Art psychotherapy: Visual art making involving processes of expression, creation, and reflection within an intentional and witnessed holding environment, that fosters self-awareness, increases one’s sense of well-being, promotes reconciling of emotional and/or interpersonal conflicts, and offers insight and different perspectives.	Closed	1	1 art psychotherapist	Zoom meeting and any readily available materials

Between mid-May and mid-August 2020, a total of 51 group sessions were conducted with a total attendance of 140 participants and an average adherence rate of 66% among those who self-registered for the sessions. The majority of those who registered but did not attend cited last-minute scheduling conflicts. At the same time, due to the drop-in nature of the groups, there were also 13 participants who turned up without prior registration. Group attendance ranged from one to nine participants with an average of five participants per group. Unsurprisingly, the closed and chargeable art psychotherapy group had the highest adherence rate but also the lowest attendance due to challenges with recruitment. Patients who declined to transition to the online group stated a strong preference for the in-person format. Table II illustrates the number of sessions, attendance and adherence rates for the respective groups.

Table II. Sessions conducted, attendance and adherence rates.

Group	No. of sessions	Attendance (mean \pm SD)	Adherence rate (%)
Peer support	11	40 (3.72 \pm 1.42)	68
Psychoeducation	12	46 (4.00 \pm 2.26)	63
Activity	9	30 (3.57 \pm 1.45)	75
Family-focused	4	11 (3.50 \pm 0.58)	61
Music therapy	8	13 (1.80 \pm 0.71)	59
Art psychotherapy	7	11 (1.57 \pm 0.53)	79
Total	51	140 (5.00 \pm 1.72)	66

SD: standard deviation

ETHICAL AND CLINICAL CONSIDERATIONS

Initial reservations regarding the shift to Internet-based group interventions centred around potential clinician and patient resistance, ethical issues such as privacy and confidentiality, safety, maintaining of boundaries and ensuring fair access to treatment, as well as possible dilution of the therapeutic alliance and group cohesion. At the same time, offering the opportunity for connection in a time of social isolation and delivering group content relevant to the ongoing pandemic in a time-sensitive manner seemed paramount. Informal focus group

discussions among existing patients suggested that transitioning from physical to online groups was generally acceptable given the context. Group facilitators also agreed that, on balance, it was worth adapting the processes and contents of the groups to meet the demand for service. A review of the literature yielded one result, an exploration of the benefits and challenges experienced by patient care and providers at a specialty obsessive-compulsive disorder service that transitioned to virtual programming amid the COVID-19 outbreak.⁽¹⁵⁾ The authors concluded that anecdotal evidence appears to suggest that virtual intensive therapy may be a more feasible and cost-effective option for some individuals. However, it was necessary to address challenges such as patient motivation to transition to online therapy, confidentiality, privacy and a diluted sense of social interaction.

Consequently, the MDU team adapted existing best practice guidelines⁽¹⁶⁻¹⁸⁾ to the local context and patient population to address the ethical and clinical considerations through the following: (a) logistics management; (b) onboarding participants to take ownership of protecting the frame; and (c) adapting the tasks of the facilitators during sessions.

LOGISTICS MANAGEMENT

Secure technological platforms

Given the rapid development of stay-home measures, existing technology was creatively adapted to allow for the provision of the MDU Online Day Therapy Programme. Referrals to the group programme were made during online Zoom team meetings, via the team's TigerText instant messaging group chat or via emails. Interested participants were provided a web link via email to kickstart the onboarding process. Before the start of each week's programme, participants were required to register their attendance for their preferred sessions and acknowledge informed consent and treatment agreement forms online via FormSG, a self-service form builder for public officers to create online forms that capture classified data. In

the backend, group facilitators kept a Microsoft Excel database tracking all referrals and used a shared Microsoft Exchange email account and calendar for communication and scheduling.

The online groups were conducted using a licensed Zoom account from public healthcare agency Integrated Health Information Systems with default settings to enforce password authentication for joining meetings, use of the waiting room feature (i.e. only the host can validate and allow participants to join the meeting) and disabling of meeting recording to safeguard patients' privacy and confidentiality. In-meeting file transfer capabilities were also disabled, and the meeting host controlled sharing of content to prevent any unauthorised party from sharing content or 'Zoombombing'. Only patients who had registered and acknowledged the treatment agreement were admitted into the respective Zoom sessions. Existing group materials were broadcast to participants using the in-application share screen function. At the end of each week, feedback on programme satisfaction was collected online via FormSG.

Technological upskilling and support

With the rapid introduction of new processes, an immediate challenge was helping facilitators and patients gain access to the online platforms. To mitigate challenges in navigating the online shift, a facilitator's guide detailing process flows and technical instructions was created. Facilitators who were more technologically savvy were also on hand to provide assistance to those with less experience. Similarly, patients who were unfamiliar with using Zoom were given a phone tutorial. Patients who were hesitant about attending the group via video conferencing were encouraged to try it at least once before deciding. Unfortunately, the online group format did exclude patients who remained uncomfortable with the format or did not have the necessary information technology resources such as a smartphone, computer or Wi-Fi connection. For these patients, one-to-one telecommunication was offered instead.

ONBOARDING PARTICIPANTS

Online treatment agreement

Moving a group from a physical to a virtual setting constitutes a loss of control over the holding environment on the part of the facilitator.⁽¹⁹⁾ On a video conference, patients can choose their physical environments as well as what can be seen by other participants. As such, facilitators have to guide patients on taking ownership to protect the session. Facilitators onboarded patients for the online group programme through a revised treatment agreement with an additional segment designed to safeguard privacy, confidentiality and safety as well as to maximise the therapeutic potential of the online modality. Key features of the additional online group guidelines are described in Box 1.

Box 1. Mood Disorders Unit online group guidelines:

1. The agreements on limits of confidentiality and safety that apply during your regular face-to-face sessions similarly apply to online video sessions.
2. The Meeting ID, URL and room password provided to you to join the online video group are for your use only and are not to be shared.
3. Participation in the online video group should be done in a quiet and private space. It is important that there be no one within hearing or visual proximity of your digital device during the group. This honours the privacy of others in the group and allows everyone to engage fully and safely.
4. It is important to be punctual. No participants will be allowed to enter the room ten minutes after the group session has started.
5. Confidentiality of materials that arise from the group session applies. This includes, and is not limited to, personal sharing, images and music created, and discussions by all in the group.
6. There will be no unauthorised recording, screenshot/photo-taking at all times during the online group, and therefore no unauthorised dissemination of audio/visual recordings to others.
7. It is strongly encouraged that your webcam/video device remains on during the online group. This allows us to check in with each other during the process and offers each other visual cues. In the event you may need to step away from or turn off the video, please inform the facilitator using the chat function.
8. Please try to stay focused on the group interactions, ensuring that there are no interruptions, including phone calls, emails or texting, during the entire session.
9. Should you need to leave the session prematurely, please inform the facilitator via chat or video before doing so.

Reinforce boundaries

In spite of the revised treatment agreement, there were instances where participants were late for sessions, contributed unnecessary background noise or went about their daily activities (e.g. walking around, eating, working) during a session. To overcome the disruption caused by latecomers, reminder messages were sent 15 minutes before the session, the alarm bell that signalled the arrival of a new participant on Zoom was turned off, and the first ten minutes of some groups were used for icebreaker activities instead of introductions. In fact, it was observed that having 10–15-minute ice-breakers, such as getting each participant to connect over some fun facts about each other, facilitated the forming stage of the peer support groups. While facilitators initially used the mute function to silence participants who were making background noise, they eventually found that encouraging participants to keep themselves unmuted allowed for spontaneous responses such as laughter, exclamations of surprise and expressions of acknowledgement through ‘mm-hmm’, which contributed to a more natural atmosphere of warmth within the group. Nevertheless, after being reminded to adhere to the terms of the group agreement, participants were more able to stay focused on the group interactions and minimise interruptions.

Psychological safety

It is worth acknowledging that the provision of and participation in groups online required a creative and courageous spirit on the part of both facilitators and patients. This was especially apparent in the art psychotherapy and music therapy groups. Engaging in deep and personal processes of reflection, creation and expression in a space outside of the therapy room can be foreign and friendly at once. Where patients previously had art media and a holding environment provided for them within the controlled setting of the outpatient clinic, they now used what was available in their personal spaces and sat alone physically with the images

produced.^(20,21) Participants who attended these groups reported that while trying something different was frightening, they also felt safe to explore, take risks and maintain relationships during this time of social distancing.⁽²²⁾ As for patients who lack the physical or emotional safety, personal space or privacy at home that are required to commit to engaging in a therapeutic encounter, one-to-one sessions or support through phone may be offered.

ADAPTING TASKS OF GROUP FACILITATORS DURING SESSIONS

Increased facilitator presence

Apart from a shift in ownership of the physical setting of the group from the facilitator to participant, the sense of embodied presence that is so valuable in face-to-face interactions may be diluted within an online modality.⁽¹⁹⁾ The absence of the body and of actual body-to-body and body-to-environment communication and regulation made it challenging to create a holding environment.^(23,24) Having multiple distractions together with the screen barrier further diluted the perceived presence of the facilitator. The gaze was also missing and participants could not see that the facilitator or another member was looking at them. The focus of the camera on participants' faces at the exclusion of the rest of the body also limited the non-verbal cues available. Affect regulation through the somatic, physical and emotional presence of the facilitators and participants seemed compromised. Consequently, facilitators had to create more online presence by using deliberate self-disclosure of their experiences in the moment and be more active and creative in eliciting and bridging the experiences of participants. Similarly the facilitators had to overcome the limitations of the disembodied environment by learning to better read facial expressions and asking group members to report their bodily sensations and internal processes.

Increased engagement with technological functions

In the peer support, psychoeducation and activity groups, participants were encouraged to use the Zoom in-app reactions (clap and thumbs-up) to provide validation and encouragement to each other. To engage participants at a deeper experiential level, external websites hosting activities (e.g. guided Zentangle and Skribbl.io), Zoom polls as well as screen sharing of presentation slides and YouTube videos were also employed. In social work groups, to aid participants who had difficulty accessing their internal processes, visual cues were provided in the form of pictures on the session slides using the share screen function, for participants to select from and identify with. This proved to be an effective way to not only help participants to express themselves but also promote group cohesion, especially when they identified with each other over a common picture. Group facilitators discovered that when participants kept their video turned on when interacting over the online platform, it allowed for the observation of oneself on the screen in real time, akin to looking into a mirror. This function, when tapped on, has the potential of putting participants into an observer perspective, where they can examine themselves and how they come across to others. This is especially relevant in social work groups where there is a strong emphasis on systemic ideas, requiring participants to contend with the fact that what they do can create an impact on others, and vice versa. This ability to look at oneself on the screen provided a powerful and unique opportunity for facilitators to invite participants into a process of examining their relationship with themselves, which is a systemic idea valued within the discipline of social work.

Adapting the group process

In the music therapy group, the use of facilitated song discussion, music improvisation and music composition as a group promoted group cohesion, elevated self-esteem and fostered a sense of accomplishment. In the art psychotherapy group, a single camera setup (most common

for participating patients) limited the ability of the patients and therapist to observe the group and the processes of artmaking, as outward expressions of self, and concurrently gaze at the completed artworks, as they would in a physical meeting. The art therapist thus relied more heavily on the patients' awareness and mindfulness to track their personal processes, prompting patients to notice their own reactions as they made art.

Co-facilitation

It was unsurprisingly that juggling the technicalities of the online tools while mindfully attending to the new clinical aspects of working within a virtual space could be taxing for facilitators. In groups that required more technical administration such as groups that were larger, open and that required the use of external applications, as in the psychoeducation, activity and social work groups, having a co-facilitator to share the tasks was found to be particularly helpful. Additionally, facilitators reflected that regardless of group size, as with in-person groups, it was clinically advantageous to have a co-facilitator who could exit the online group to attend to the needs of a participant who became distressed or disruptive, although there was only one such occasion in course of this pilot.

OUTCOMES

Preliminary feedback from patients indicated an 86% average positive satisfaction rating based on the eight-question Client Satisfaction Questionnaire.⁽²⁵⁾ Qualitative feedback indicated that participants felt they benefited from having a safe space to “*reflect and gain new perspectives*” and “*share their views, feelings and experiences*”, and felt “*supported*”, “*encouraged*” and “*not alone*”. In terms of preference for the online or in-person group format, the response was neutral, although there were some requests for the online groups to be run during non-working hours. As outcomes were collected for the programme as a whole, we were not able to report

outcomes for individual groups. Future outcomes could be segregated to account for inter-group differences.

REFLECTIONS AND CONCLUSION

The COVID-19 pandemic has shaken our sense of physical and psychological safety on a global scale. It has also given us the opportunity to re-examine the way we way we live and work. Social distancing measures had threatened to worsen an already growing sense of social isolation. Devoid of the option to meet physically, the team at MDU was offered the chance to recreate the way we use technology to connect. Telemental health comes with its own host of ethical and clinical quandaries. However, in such an unprecedented time of crisis, we are grateful for how technology has allowed for the continued provision and participation of our therapy groups. In transitioning the day therapy programme to an online format, we had sought to attend closely to what happens behind and on screens to safeguard confidentiality, privacy and safety while maintaining quality of care.

Privacy, confidentiality and safety were protected through the use of secure licensed online platforms, a revised treatment agreement and onboarding of participants. To aid facilitators in adapting to the new processes and technicalities, the team found it helpful to provide a step-by-step facilitator's guide and have experienced facilitators on hand to provide technical assistance. Having a co-facilitator to assist in tech administration while attending to the physical and psychological safety of the group was advantageous. Similarly, to transition participants to the online format, it was helpful to have an onboarding process: offering individual technical tutorials; talking them through a revised treatment agreement that detailed guidelines designed to safeguard privacy, confidentiality and safety; and reinforcing these guidelines through ongoing socialisation. In particular, we found it necessary to reinforce punctuality and that participation should be done from a quiet and private space, video and

audio should be turned on for the whole duration of the session as much as possible, and participants should remain focused on group interactions. For patients who did not have access to technological resources or a conducive physical environment, it was important to make available alternative means to access treatment, such as one-on-one telecommunication.

While addressing issues of diluted therapist presence and social interaction associated with being in a disembodied environment, it was crucial for facilitators to be more active in eliciting and bridging the experiences of participants. Regardless of the type of group, inviting participants to take ownership by attending to their internal reactions as they unfolded moment by moment and reporting them offered them the opportunity to introspect on their relationship with themselves, others and the group content (i.e. art, music, family or subject). Further, creative use of technological tools such as Zoom in-app reactions, poll and chat functions as well as other online multiplayer activities served as another avenue for increasing social interaction among participants who may have more difficulty verbalising their experiences.

Anecdotally, it appeared that attendance was higher for online groups that were open, non-chargeable and inclusive, while adherence was better when it was a chargeable group with patient selection and prior agreement to commit to the course of the packaged intervention. In this case, as our primary objective in the initial phase was to promote treatment access and extend support in a timely manner to patients experiencing pandemic-exacerbated social isolation and distress, the former approach may have been more suitable. As for improving the attendance of formal packaged psychotherapy groups, more time to recruit a suitable pool of participants before beginning the group would be beneficial.

Overall user satisfaction ratings for the online group programme were high, and participants reported that they most valued having a safe space to share, relate and gain new perspectives while experiencing a sense of mutuality and universality. Facilitators also generally found the group format feasible and acceptable, with a notable preference for having

a co-facilitator to share in technical and clinical administration. An exception was the art psychotherapy group, for which, given the relatively poorer attendance, the facilitator and participants opted for individual online or in-person formats instead.

On balance, the team concluded that continuing to offer group-based telemental health services, and especially so during this pandemic, is a worthy pursuit that benefits tertiary psychiatric outpatients with mood disorders. We are currently in the midst of transitioning the programme's manualised psychotherapy groups (transdiagnostic Cognitive Behavioural Therapy⁽²⁶⁾ and Interpersonal and Social Rhythm Therapy⁽²⁷⁾) to an online format. This pilot has offered valuable insights into navigating ethical and clinical challenges related to offering online therapy groups in a local context. Other services wishing to offer group-based telemental health may benefit from these lessons learnt.

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