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A Practice-Based Evidence Approach to Change Pre, During and Post COVID-19 During Psychotherapy: Time Period 2: Relapse and Recovery

Philip H. Friedman, Ph.D¹
John Freedom, CEHP²

1. Founder, Foundation for Well-Being
2. Executive Director, Finding Recovery and Empowerment from Abuse

Abstract

Please Note: This article is a follow-up to my previous article on psychotherapy with two patients with COVID-19 (Friedman, 2022, June):

<http://www.societyforpsychotherapy.org/a-practice-based-evidence-approach-pre-during-and-post-covid-19-during-psychotherapy>

In this article we discuss the use of a digital assessment and tracking approach to monitor changes in affect, emotional stability, depression, anxiety, happiness, life balance, beliefs, spiritual awakening, the working alliance, outcome, and benefits of psychotherapy. Using the online assessment systems developed by Pragmatic Tracker (PT) and Blueprint (BP), two clients were assessed weekly, showing significant changes pre, during, and post COVID-19. The clients were monitored during therapy for 15 weeks; it took about nine weeks to recover to pre COVID-19 scores. Graphs in the article show these changes, which can be seen on the Pragmatic Tracker (PT) and Blueprint (BP) websites by clinicians. A variety of interventions following an ICBEST (integrative, cognitive, behavioral, energy, spiritual therapy) model were used.

The online digital assessment scales used to track change were: the Friedman Five Factor Personality Scale with an Emotional Stability Subscale (Friedman, 2020); the

Generalized Anxiety Disorder Seven Item Scale (Spitzer et al., 2006); the Patient Health Questionnaire Nine Item Depression Scale (Kroenke et al., 2001); the Friedman Affect and Friedman Belief Scales - Short Form (Friedman, 2021); the Friedman Life Balance Scale (Friedman, 2020); the Friedman Spiritual Awakening Scale (Friedman, 2020); the Clinical Outcomes in Routine Evaluation Ten Item Outcome Scale (Barkham et al., 2013); the Working Alliance Scale (Horvath & Greenberg, 1989); and the Friedman Helpfulness and Beneficial Therapy Scale (Friedman, 2020).

Keywords: Anxiety, Depression, Belief, Therapy, Spiritual Awakening

Introduction

A previous article, “A Practice-Based Evidence Approach Pre, During and Post COVID-19 During Psychotherapy,” (Friedman, 2022) discussed a therapeutic approach to healing from anxiety, depression and trauma. (The APA Dictionary of Psychology defines trauma as “*any disturbing experience that results in significant fear, helplessness, dissociation, confusion, or other disruptive feelings intense enough to have a long-lasting negative effect on a person’s attitudes, behavior, and other aspects of functioning*” (VandenBos, 2015, p. 478). Contracting a serious case of COVID-19, which for some individuals can be life-threatening, can be considered a specific kind of trauma. Note that “trauma” is not necessarily clinical PTSD as defined by the DSM-5).

Background

This approach is a practiced-based evidence (PBE) or “feedback informed therapy” approach (Savela, 2015). Both clients were seen virtually using Bluejeans (a Verizon product). Bluejeans is a HIPAA compliant video conferencing platform similar to ZOOM.

Both my previous article (Friedman, 2022) and this one track the

clients’ progress over two separate 15 week periods. In this current study I show their assessment scores on various scales every four weeks before, during, and after COVID-19. The graphs of change show their results from weeks four - 15, the period just before and after they contracted Covid-19, and thus do not show the whole course of therapy.

This model of psychotherapy is called ICBEST (Friedman, 2015), which stands for integrative, cognitive, behavioral, energy and spiritual therapy. These therapies include cognitive-behavioral therapy (Hollon & Beck, 2013); positive pressure point techniques (Friedman, 2010; Friedman, 2016), a variation of the emotional freedom techniques or tapping techniques (Church, 2018; Gallo, 2022); integrative forgiveness therapy (Friedman, 2010; Friedman 2015); an integration of eye movement desensitization and reprocessing (Shapiro, 2017) and accelerated resolution therapy (Kip et al., 2013), both of which use bilateral eye movements. The author’s approach includes weekly digital assessments in a practice-based evidence approach which provide client feedback while monitoring therapeutic change (Friedman, 2021). The spiritual component focuses on love, compassion, forgiveness, peace, and healing based on

A Course in Miracles (Friedman, 2010; Schucman, 2021). In the author’s approach major clinical goals include enhancing clients’ abilities to love and to experience compassion, forgiveness, and inner peace.

Changes Pre, During, and Post COVID-19

The two clients were “Bill,” a 55-year-old, White, cisgender male who worked as a contractor and was married for 25 years. He had been vaccinated. “Cindy,” a 49-year-old, Black, cisgender female, was employed as a teacher; she has been separated from her husband for one year. She originally contracted COVID-19 the day she was vaccinated.

Bill contracted COVID-19 a second time at week eight during his second series of psychotherapy. The graphs start at week four, with the graphs from the previous article superimposed, and therefore are labeled “Bill-1” and “Bill-2.” Cindy’s graphs for these two time periods are labeled “Cindy-1” and “Cindy-2.” See Table 1 for changes in depression.

Table 1 shows that Bill had scores of one and five on the PHQ-9 depression scale at week four of the first and second series of therapy sessions respectively, and scores of 13 and 13.5 at week eight of the first and second series, respectively (Bill-1 and Bill-2). He had scores of five and three at week 12 and scores of one and two at week 15. (PHQ-9 scores of five, 10, 15, and 20 represented mild, moderate, moderately severe, and severe depression, respectively.). Bill contracted COVID-19 the second time at week eight, and had recovered from Covid-19 by week 12 both times.

Cindy had scores of zero and 0.5 at week four of the first and second series of therapy sessions, respectively, and scores of 10 and 1.5, respectively at week eight (Cindy-1 and Cindy-2). She had scores of three and two at week 12, respectively, and five and one at week 15. Cindy had recovered by week 12 the first time but did not need to recover again, as she did not contract COVID-19 a second time as Bill did.

Here are the scores presented for weeks 4, 8, 12 and 15.

Weeks	4	8	12	15
Depression: Bill-1	1	13	5	1
Depression: Bill-2	5	13.5	3	2
Depression: Cindy-1	0	10	3	5
Depression: Cindy-2	0.5	1.5	2	1

Table 1: Changes in the PHQ-9 Depression Scale

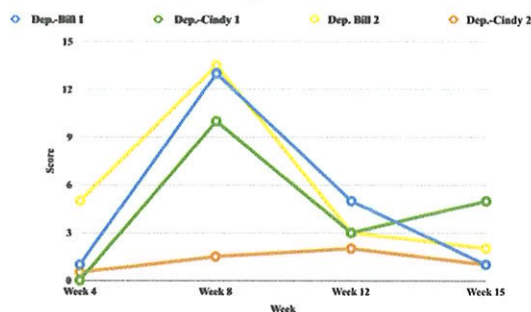


Table 2 shows that Bill had scores of three and five on the GAD-7 anxiety scale at week four of the first and second series, respectively, and scores of 11.0 and 12.5, respectively, at week eight. Bill contracted COVID-19 a second time at week eight, and his higher GAD-7 score reflects that. He had mostly recovered by week 12 the first time, and

had recovered fully by week 12 the second time. He had GAD-7 anxiety scores of eight and four, respectively at week 12, and four and six, respectively at week 15, with his lower scores reflecting a return to normalcy. (The GAD-7 measures seven anxiety symptoms on four-point scales. Scores of five, 10, and 15 represent cutoff points for mild, moderate, and severe anxiety).

Cindy had scores of zero on the GAD-7 in both series at week four; and 14 and one, respectively at week eight. She had scores of three at week 12, and nine at week 15 in the first series, and zero at weeks 12 and 15 in the second series. Her score increased somewhat in the first series from week 12 to week 15, but in the second series her score of zero remained the same both times.

Both Bill and Cindy's anxiety levels were strongly affected by COVID-19 in the first series, and Bill was strongly affected by anxiety the second time as well. Cindy did not get COVID-19 the second time, and so her anxiety scores remained low.

Here are the scores for weeks four, eight, 12 and 15:

Weeks	4	8	12	15
Anxiety: Bill-1	3	11	8	4
Anxiety: Bill-2	5	12.5	4	6
Anxiety: Cindy-1	0	14	3	9
Anxiety: Cindy-2	0	1	0	0

Table 2: Changes in the GAD-7 Anxiety Scale

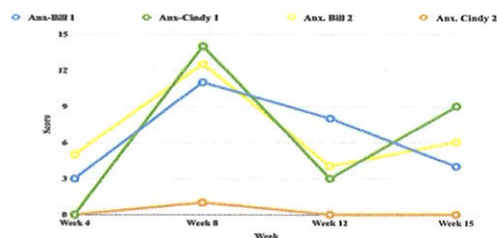


Table 3A shows changes on the Friedman Negative Affect Scale for Bill and Cindy at all four time points. The Negative Affect Scale consists of five subscales for hostility, guilt, fear, fatigue and sadness, with three items each. (Total Negative Affect can vary between 0 - 60, with 60 being the highest level (i.e. the worst) of negative affect). At week four Bill had scores of zero and 13, respectively and 21 and 22 at week eight the first and second time he contracted COVID-19. He recovered quickly in the first series at weeks 12 and 15 with scores of three and zero, but recovered more slowly the second time with scores of 19 and two at weeks 12 and 15, respectively.

The first time that Cindy contracted COVID-19 she had scores of zero at week four, which then went to 23, 13 and finally three. Cindy had a score of zero all four times (weeks four, eight, 12 and 15) in the second series.

Here are the scores for weeks four, eight, 12 and 15.

Weeks	4	8	12	15
Neg Affect: Bill-1	0	21	3	0
Neg Affect: Bill-2	13	22	19	2
Neg Affect: Cindy-1	0	23	13	3
Neg Affect: Cindy-2	0	0	0	0

Table 3A: Changes in the Friedman Negative Affect Scale

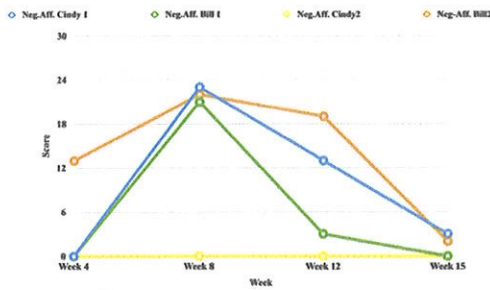


Table 3B shows the changes on the Friedman Negative Affect Subscale: Tired, Sluggish, Worn-Out (TSW). Data were only available for the second time period during which Bill contracted COVID-19. Bill had scores of four, 11.8, nine and two, respectively on Fatigue for weeks four, eight, twelve and fifteen. Thirty is an average score; lower scores indicate less fatigue.

Inspection of the data indicated that the Fatigue developed before Bill was coming down with COVID-19 and continued for a month or so afterward while he was recovering from COVID-19. It seems reasonable to hypothesize that the Fatigue factor affected his resistance to getting COVID-19, and perhaps this could be monitored in clients over time as a possible precursor to serious illness.

Cindy had scores of zero for all four assessments during this second time period when she did not have COVID-19.

Here are the scores for weeks four, eight, 12 and 15, for the second time period only.

Weeks	4	8	12	15
TSW: Bill-2	4	11.8	9	2
TSW: Cindy-2	0	0	0	0

Table 3B: Changes in the Friedman Negative Affect Subscale: Tired, Sluggish, Worn-Out

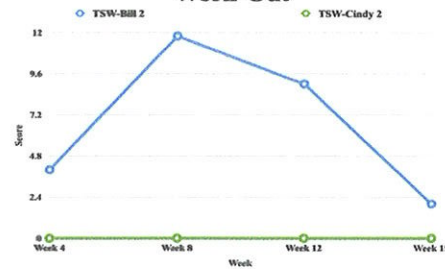


Table 4 shows changes on the Friedman Positive Affect Scale. This scale consists of five positive emotions of joy, self-assurance, attention, peace and love, with three items each. Bill-1 scored 60, 46, 34, 47, respectively, at weeks four, eight, 12 and 15, after partially recovering from COVID-19 he contracted at week eight. The second time Bill-2 contracted COVID-19, he had scores of 51.5, 37, 39 and 56 at the same time periods, showing that he recovered well on Positive Affect by the end of the series. (Thirty is an average score on the Friedman Positive Affect Scale and 60 is the maximum score).

Cindy-1 had scores of 51, 28, 55, and 57 at weeks four, eight, 12, and 15 in the first series. She dropped down further at week eight than Bill-1 (28) but recovered more at week 15 (57). In the second series Cindy-2 had scores of 57, 58, 56.5, and 58 for the four time periods (60 is the highest score).

Here are the scores for weeks four, eight, 12 and 15.

Weeks	4	8	12	15
Pos Affect: Bill-1	60	46	34	47
Pos Affect: Bill-2	51.5	37	39	56
Pos Affect: Cindy-1	51	28	55	57
Pos Affect: Cindy-2	57	58	56.5	58

Table 4: Changes in the Friedman Positive Affect Scale

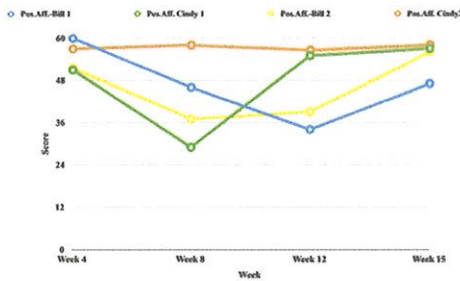


Table 5 shows the scores for Bill and Cindy across the four time periods on the Friedman Life Balance Scale. There were only slight dips on this measure which has three subscales; reflect, clarify and sort; understand self and others; and self-forgive, compassion and love. There are five items each for a total of 15 questions. An average score is 55, so both Bill and Cindy maintained fairly high scores (well above average) during their psychotherapy sessions even during COVID-19. Note that not all measures change during experiences with COVID-19 or other illnesses.

Here are the scores for weeks four, eight, 12 and 15.

Weeks	4	8	12	15
Life Balc: Bill-1	71	70	63	65
Life Balc: Bill-2	81	77	72	80
Life Balc: Cindy-1	75	71	69	69
Life Balc: Cindy-2	81	82	84	81

Table 5: Changes in the Friedman Life Balance

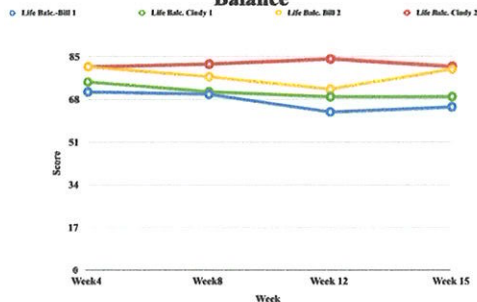


Table 6 shows the changes for Bill and Cindy on the Friedman Spiritual Awakening Scale. This scale measures dimensions of spiritual awakening such as an awareness of one's true nature; general spirituality; an awareness of a higher power that inspires one's actions; a general sense of awareness and inclusion of all things; a sense of inner and unfolding perfection; and love, empathy and compassion. Cindy had very high scores on this measure across all four time points whether she had COVID-19 or not (Cindy-1 and Cindy-2). Her lowest score was 87, which is relatively high. Fifty-five is an average score on this scale.

Bill dropped down modestly both times he had COVID-19, at week 12 (for both series). Even then, his scores of 73 (Bill-1) and 66 (Bill-2) were still well above average. Again, this indicates that not all measures show substantial changes during psychotherapy when COVID-19 occurs, and not at the same time points. Overall, both Cindy and Bill had high spiritual awakening scores, well above average. Many clients enter therapy with much lower scores that often change during psychotherapy.

Here are the scores for week 4, 8, 12 and 15.

Weeks	4	8	12	15
Spir. Awake: Bill-1	85	81	73	81
Spir. Awake: Bill-2	78.3	78.5	66	82
Spir. Awake: Cindy-1	88	88	88	89
Spir. Awake: Cindy-2	88	87	90	90

Table 6: Changes in the Friedman Spiritual Awakening Scale

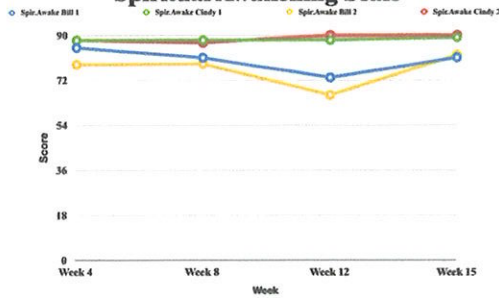


Table 7 shows Cindy’s Changes in Energy and CORE Outcomes. The Energy measure is a one-item assessment of the client’s energy level, taken from the Goals-Based Outcome Measure (Duncan et al., 2022). The CORE-10 is a short 10 item easy-to-use assessment measure for common presentations of psychological distress. The measure is a shortened version of the 34 item CORE-OM, both of which ask respondents to self-report symptoms over the past week (Barkham et al., 2013).

When she contracted COVID-19, Cindy’s scores increased from three to 10 by week 8 on the CORE outcome measure, and then decreased at weeks 12 and 15 (scores of four, then two), while her energy level dropped at week eight and week 12 but came back at week 15 (scores of nine, six, six, eight). A good score on the CORE outcome measure is five or below (i.e. lower is better), while the highest score on the energy measure is 10.0. During the second series of 15 sessions, Cindy had scores of 3.8, 3.8, 2.5, 2.5 on the CORE outcome measure and eight, nine, 8.5, 8.8 on the energy measure. Both scores are excellent and consistent with her not having COVID-19.

Data were not available for Bill on these measures.

Here are Cindy’s scores for weeks 4, 8, 12 and 15.

Weeks	5	8	12	15
CORE 10 – 1	3	10	4	2
CORE 10 – 2	3.8	3.8	2.5	2.5
Energy – 1	9	6	6	8
Energy – 2	8	9	8.5	8.5

Table 7: Cindy’s Changes in Energy and CORE Outcomes

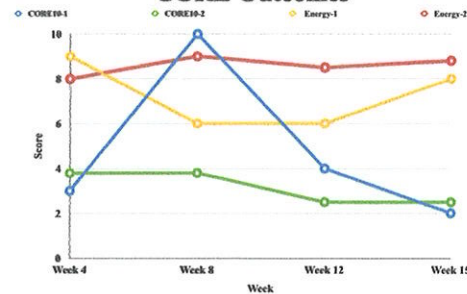


Table 8 documents the Changes in the Ability to Sleep. Bill’s ability to sleep decreased both times he contracted COVID-19. It decreased substantially at week eight and week 12 (scores of 10, five, six, 10 for Bill-1); he recovered by week 15. In the second series when he contracted COVID-19 his sleep recovered more quickly (scores of 10, 4.3, 10, 10 for Bill-2) at weeks 12 and 15. The highest possible score is 10, indicating deeply restful and satisfying sleep.

Cindy’s ability to sleep decreased at week eight when she contracted COVID-19 (scores of nine, seven, six, seven for Cindy-1) and never really recovered at weeks eight, 12 and 15.

Even during the second group of sessions when she did not contract COVID-19, her ability to sleep scores never completely recovered (scores of seven, 6.8, 7.3, six for Cindy-2), and may have gotten slightly worse. This is the only measure indicating a long-term negative carryover for Cindy from contracting COVID-19 the first time.

Here are the scores for weeks four, eight,

Weeks	4	8	12	15
Sleep: Bill-1	10	5	6	10
Sleep: Bill-2	10	4.3	10	10
Sleep: Cindy-1	9	7	6	7
Sleep: Cindy-2	7	6.8	7.3	6

12 and 15.

Table 8: Changes in the Ability to Sleep

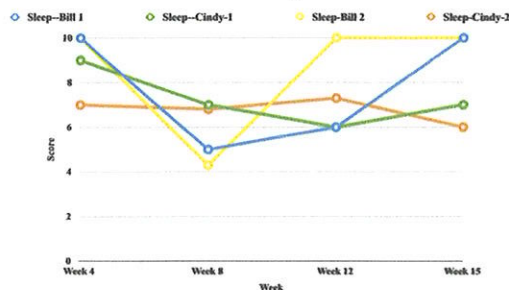


Table 9 shows the Working Alliance Inventory (WAI) scores for Bill and Cindy. They both had very high scores of 59 or 60 (60 is the maximum score) at weeks four, eight, 12 and 15 during both series. These scores suggest that they both had an excellent working alliance with me, and that COVID-19 had no effect on this. Early in treatment WAI scores can sometimes be 40 or 50. When that is the case, they typically improve through the process of therapy (Horvath & Greenberg, 1989).

Here are the scores for weeks 4, 8, 12 and 15.

Weeks	4	8	12	15
Work Alliance: Bill-1	59	59	59	59
Work Alliance: Bill-2	57	57	57	57
Work Alliance: Cindy-1	60	60	60	60
Work Alliance: Cindy-2	58	58	58	58

Table 9: Changes in the Working Alliance Inventory (WAI)

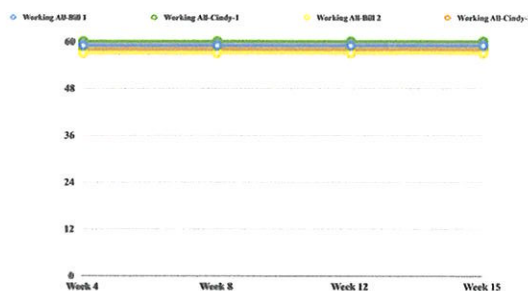
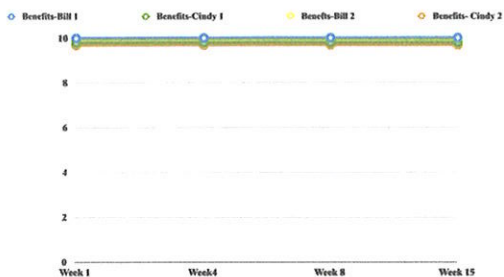


Table 10 shows the Benefits of Therapy scores for Bill and Cindy. At weeks four, eight, 12 and 15 both Bill and Cindy reported scores of 10.0 on the benefits from therapy measure. Since ten is the maximum score on this scale, they both reported that they were benefiting from therapy a great deal whether they had COVID-19 or not. COVID-19 had no impact on this measure. Sometimes very early in treatment, clients will give scores of two, three or four, reporting little benefit from therapy.

Here are the scores for weeks 4, 8, 12, and 15.

Weeks	4	8	12	15
Benefits: Bill-1	10	10	10	10
Benefits: Bill-2	10	10	10	10
Benefits: Cindy-1	10	10	10	10
Benefits: Cindy-2	10	10	10	10

Table 10: Changes in the Benefits of Therapy



Clinical Implications

COVID-19 can be contracted suddenly and unexpectedly, and can vary in severity and impact. When severe, it would be wise to treat it as an ongoing disturbing event that impacts clients and their immediate family, friends and colleagues. Clients often feel isolated and alienated from their family and network because of concerns that they may transmit COVID-19 to others.

Calls by the therapist between sessions, especially at first, can be very helpful and reassuring. Receiving a call is perceived by the client as very caring. I teach my patients that every communication is either an expression of love or a call for love. Experiencing distressing feelings associated with COVID-19 symptoms can be considered a call for caring and love.

Some clients will benefit from knowing that you are praying or offering blessings for them (Piedmont & Friedman, 2012). One of the goals of the therapy process is to help clients feel safe, so they can self-regulate or co-regulate their emotions (Porges, 2017). Sessions with spouses and children may be beneficial. This is an uncertain time for both clients and therapists. Especially during challenging circumstances, the therapist needs to stay calm and peaceful, insofar as possible (Friedman, 2010; Schucman, 2021). Pro-active self-care can help facilitate this.

Medical doctors generally treat physical illnesses and their symptoms, with little attention paid to their patients' beliefs, emotions, or psychological condition (Cherry et al., 2014). Psychologists focus on treating psychological, emotional and behavioral issues, while often ignoring physical symptoms (Yates & Koran, 1999). This case study utilized a bio-psycho-social-spiritual perspective (Sulmasy, 2022) to explore how the course of a physical illness (COVID-19) affected the progress of two clients in therapy, and how that illness affected both psychological and spiritual parameters.

Summary

This article shows how digital assessment and tracking tools can be used to monitor therapeutic progress before, during, and after a physical illness. Graphs document changes in two clients who were assessed weekly using the online assessment systems Pragmatic Tracker (PT) and Blueprint (BP). The author used a variety of interventions following an ICBEST (integrative, cognitive, behavioral, energy, spiritual therapy) model, including cognitive-

behavioral therapy; positive pressure point techniques, a variation of the emotional freedom techniques or tapping techniques; integrative forgiveness therapy; and an integration of eye movement desensitization and reprocessing and accelerated resolution therapy.

Most variables that showed marked changes during COVID-19 during the first series of treatments (e.g. measures of anxiety, depression, energy, and negative affect) reverted to the positive range during the second series. Some measures (e.g. sleep, energy levels) were affected by COVID-19; while others (e.g. the Working Alliance, Benefits of Psychotherapy) were not. It is not known whether this pattern characterizes all COVID-19 clients, whether in or out of therapy. Due to the small sample size, generalizations cannot be inferred. More research including case studies like this one is needed to enhance our understanding of how physical illness affects people psychologically, and how psychological interventions can enhance the process of healing.

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Bio

Philip H. Friedman, PhD, is a licensed psychologist and Director of the Foundation for Well-Being in Plymouth Meeting, Pennsylvania. He is the author of “The Forgiveness Solution” and “Creating Well Being” in addition to the Friedman Assessment Scales on Well-Being, Beliefs, Quality of Life, Affect, Life Balance, Spiritual Awakening and the Mini-5 Factor Personality Scale. He is also the developer of the ICBEST model of psychotherapy.

Dr. Friedman is an adjunct professor on the faculty of Sophia Univ. (formerly the Institute of Transpersonal Psychology). He is the founder of Integrative Forgiveness Psychotherapy (IFP), the Positive Pressure Point Techniques (PPPT), the Practice Based Evidence Approach (PBEA) and the Digital Assessment and Tracking Approach (DATA) to assessment and change.

email: PhilF101@comcast.net

John Freedom. CEHP

John Freedom. CEHP, is the executive director of Finding Recovery and Empowerment from Abuse (FREA), sits on the Board of Trustees of EFT International and has been the coordinator of research for the Association for Comprehensive Energy Psychology (ACEP) for many years. John teaches all over the world and is the author of *Heal Yourself with Emotional Freedom Technique*.

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