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Highlights in psychology for clinical settings: The ascent of digital psychotherapy

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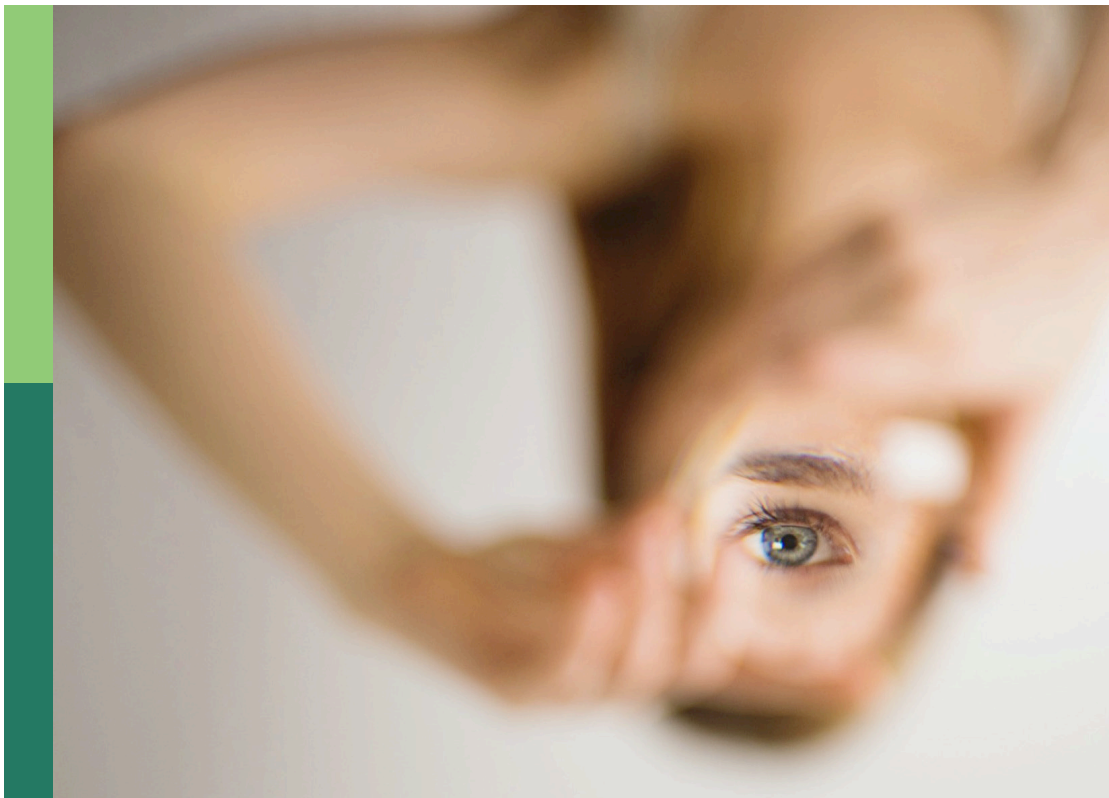

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Highlights in psychology for clinical settings: The ascent of digital psychotherapy

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Editorial: Highlights in psychology for clinical settings: the ascent of digital psychotherapy

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Editorial on the Research Topic
Highlights in psychology for clinical settings: the ascent of digital psychotherapy

Traditional face-to-face treatment sessions conducted within the boundaries of a therapist's office have long represented the primary practice of mental health. However, since the COVID-19 pandemic outbreak, digital evolution has introduced intensive changes in psychotherapy. Digital psychotherapy (DP), also often known as telepsychotherapy, remote psychotherapy, online therapy, videoconferencing psychotherapy or telemental health, uses technological advances to provide mental health services outside the traditional in-person synchronous therapeutic context. This Research Topic, *Highlights in psychology for clinical settings: the ascent of digital psychotherapy*, examines aspects of DP and emphasizes the need to further develop this transformative approach to mental health care.

The Research Topic consists of 13 original articles focusing on various aspects of DP, including challenges and opportunities, the efficacy of DP from patients' and psychotherapists' perspectives, and mechanisms of change. Challenges and opportunities are discussed in Fernández-Álvarez and Fernández-Álvarez's perspective article about the therapeutic alliance and adapting interventions to fit the patient's preferences. Additionally, this paper outlined how the field of psychotherapy could benefit from the unprecedented situation presented by the COVID-19 pandemic. Gueta et al.'s qualitative pilot study examined the cultural accommodation of an existing Internet intervention for substance use and related disorders in Israel. Thematic analysis of interviews with patients and therapists and a literature review yielded a comprehensive cultural accommodation framework.

Several articles explore the efficacy of online therapy modalities and techniques. Sperandeo et al.'s preliminary study examined the digital empathy gap in DP between Italian psychotherapist and patient dyads, showing that unlike psychotherapists, patients perceived their therapists as significantly more empathic and supportive in the remote setting compared to perceived empathy in in-person settings. From the psychotherapists' perspective, Stefan et al.'s longitudinal mixed-methods study showed that remote psychotherapy in Austria could be a credible and trustworthy alternative to in-person treatment, which most psychotherapists could adopt and implement regardless of theoretical orientation. Reatto et al. showed that Italian patients with insecure attachment styles had greater difficulties adapting to DP, thus confirming that insecure attachment is a

vulnerability factor for psychopathological problems and for a well-functioning therapeutic collaboration. Finally, Békés et al. presented a validation of the Teletherapy Intervention Scale for clinicians and researchers; the scale was found to be positively related to the working alliance, the real relationship, and the therapeutic presence in teletherapy sessions, as well as to positive attitudes toward teletherapy and intention to use teletherapy in the future.

From the patient's perspective, the experience of DP was complex and nuanced. Werbart et al.'s qualitative study in Sweden showed that some aspects of switching from face-to-face to DP were perceived as harming the quality of treatment, whereas other patients may experience more freedom in DP compared to an in-person setting. Their findings indicated the importance of considering patient characteristics when transitioning to DP formats. Harris et al.'s brief research report found that the average outcome trajectory for patients in the USA who received DP was statistically like those in an earlier cohort who received in-person services before the COVID-19 pandemic onset. Wesołowski et al.'s thematic analysis with Polish potential therapy patients indicated that DP frustrated the need for psychological contact, contributed to negative emotions, but sometimes was perceived as better than in-person therapy. DP served as a solution during the pandemic by providing a sense of continuity during a lockdown and enabling adapting to exceptional circumstances; however, some participants expressed concerns about the effectiveness of DP and its credibility. von Below et al.'s thematic analysis of interviews with Swedish patients' experiences of transition to DP at the start of the pandemic and then later back to the office indicated that the patients experienced the process in DP as impeded. Patients reported that emotional expression was hampered by the loss of non-verbal communication, the emotional relationship was altered, and at the same time, DP allowed the patients to incorporate therapy more into their everyday lives. In a brief research report, Drüge et al. used a mixed methods study to investigate whether innovative moments (IMs) occur in Swiss patients' telephone-based cognitive-behavioral therapy (t-CBT). They examined the association between IMs and symptom improvement, reconceptualization, and symptom improvement and found that IMs also occur in t-CBT and can be reliably rated by external observers.

Some papers in the present Research Topic also discussed mechanisms of change in therapy. Several of these mechanisms are a product of the translation of in-person techniques to a digital format, and some are unique to the digital arena. In this context, Domhardt et al., in their perspective article, highlighted the increased opportunity to conduct more precise psychotherapy process research to understand change mechanisms that were only feasible with digital tools and outlined essential future directions for this novel branch of research. Furthermore, they indicated several challenges and pitfalls to be solved to advance DP research. Another reviewed digital tool was the incorporation of virtual reality (VR) technology into DP. In their brief research report, Horigome et al. conducted a feasibility study in Japan using VR technology in the framework of exposure therapy with four patients with social anxiety disorder. This feasibility study hints at the possibility of incorporating new technologies into digital clinical work.

To conclude, DP represents a revolutionary paradigm shift in mental health care, emerging as a significant tool during times of crisis (such as natural disasters or pandemics) and, increasingly, as a standard treatment model. However, several areas of research within DP require more empirical attention. First, more research is needed regarding the mechanisms of change in DP, such as therapeutic alliance, power balance, and empathic accuracy, which may play different roles in DP compared to in-person therapy. Second, a better understanding of the comparative efficacy between traditional and digitalized therapy techniques is needed. Finally, more research is necessary regarding tailoring procedures to patients' needs, such as personal characteristics and cultural background. Such data can inform personalized treatment plans, optimize the therapeutic process and enhance the overall efficacy of mental health interventions through DP.

Author contributions

MB: Conceptualization, Project administration, Writing—original draft, Writing—review and editing. MB-N: Writing—review and editing. VB: Writing—review and editing. EA: Writing—review and editing. KG: Conceptualization, Writing—original draft, Writing—review and editing.

Conflict of interest

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Videoconferencing Psychotherapy During the Pandemic: Exceptional Times With Enduring Effects?

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With the advent of COVID-19, a sudden, unexpected, and forced shift has been produced in the field of psychotherapy. Worldwide, many therapists closed their offices and started to deliver psychotherapy online through a screen. Although different media started to be incorporated, videoconferencing is undoubtedly the most common way in which therapists are doing therapy these days. This is catalyzing a rapid change in the practice of psychotherapy with probable lasting effects and deserves to be carefully reflected upon. Therefore, in this paper our aim is to outline the main challenges for a medium that may have arrived to stay. In that sense, we review the literature to describe the state-of-the-art regarding the main aspects of videoconferencing psychotherapy as well as to suggest possible avenues for future research and practice.

Keywords: COVID-19, psychotherapy, psychotherapists, telehealth, videoconferencing psychotherapy, telemental health, e-mental health

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INTRODUCTION

Although no consensus exists among experts regarding what comprises Internet-delivered interventions (Smoktunowicz et al., 2020), there is no doubt that they have gained a central role in the clinical psychology realm. A large body of evidence supports the incorporation of different technologies, with different media and degrees of human support (Andersson et al., 2019). Even psychotherapy, which has historically involved an in-person shared space, has slowly but gradually incorporated more and more use of technologies. Fundamentally, the application of videoconferences in routine practice has been progressive and is mainly explained by practical reasons, such as geographical barriers, treatment-seeking stigma, or flexibility in scheduling sessions (Nickelson, 1998; Backhaus et al., 2012). Research on the remote delivery of therapy has increased along with this increasing use, and accordingly, a large body of evidence has been produced during the last two decades showing the efficacy of delivering psychotherapy through videoconference, even with comparable results to in-person therapy (Varker et al., 2018; Batastini et al., 2020). However, its application in routine practice has not been widespread, with almost all therapists having no experience.

With the advent of the coronavirus disease (COVID-19), a sudden, unexpected, and forced shift has been produced. Worldwide, many therapists closed their offices and started to deliver psychotherapy online. The use of technology became the only way in many countries to provide psychotherapy, and an overnight transition from in-office to online practice occurred. Given that videoconferencing constitutes a similar way of delivering therapy to traditional in-person psychotherapy, it has been rapidly incorporated (Sammons et al., 2020; Wind et al., 2020).

Although this massive dissemination is positive since millions of people could potentially benefit from these treatments, a series of questions remain unanswered. In this paper, we aim to outline the main challenges for a modality that may have arrived to stay.

ISSUES IN WORKING WITH VIDEOCONFERENCING

General Therapeutic Targets

The use of videoconferencing psychotherapy (VCP) does not change the needs of patients and thus the general therapeutic goals. Patients' specific demands may have changed due to the pandemic, but their suffering will still be centered around their difficulties with the two main components of dysfunction: self-dysfunction and interpersonal dysfunction (Hopwood et al., 2013). Besides, it is important to focus the work on the two dimensions in which the psychophysiological functioning of the organism is deployed: behavior and experience.

Demanding scenarios such as lockdown or uncertainty about the aftermath of the pandemic constitute stressors that may particularly affect people who already had maladaptive strategies for coping with reality. In many cases, the context merits exacerbated dysfunctional reactions regarding our mental health. However, it is key to keep in mind that although the context operates as a fundamental variable in peoples' lives, the core aspects regarding the ways of organizing experience are personality and its components, such as schemas, attachment styles, regulatory capacities, and interpersonal functioning, among others (Livesley, 2012).

It is necessary to think outside the box and not just consider the dangers and negative aspects of the pandemic. The current context obliges us to live under constant threat, and therefore, the situation reminds us that we are fragile beings (Wong, 2020). Implementing VCP, in particular due to a forced situation like COVID-19, may be an opportunity to work on issues that otherwise would not have been possible to address. The presence of a difficult situation may facilitate the setting of new goals. That is, this context may also foster the promotion of positive changes such as meaning in life as an important therapeutic target (Hill et al., 2017). Meaning in life has proven to be a very powerful way of regulating emotions as well as promoting positive psychology principles that, far from focusing on the positive as a superfluous thing, considers existential sorrow to be a way to find freedom (Wong, 2011). The unexpected consequences of the pandemic foster a discussion that is more important than ever: What should we pursue in life? Are we living according to our values?

Therapeutic Alliance

There are substantial differences between in-person psychotherapy and VCP that may have an impact on how the therapeutic alliance is developed. For instance, in VCP, both patients and therapists have the possibility of having feedback from their own cameras. Certain patients and therapists (e.g., narcissistic or socially anxious individuals) may pay too much attention to their own behavior, and this may be detrimental to therapeutic communication (Payne et al., 2020). Moreover, in-person psychotherapy uses a physical shared space, entailing the immediacy of the sensory experience and thus an undoubtedly qualitatively different exchange. The most evident difference between in-person psychotherapy and VCP is the potential technical difficulties that may arise during the latter. As explained by Markowitz (2020), an unstable connection, a frozen screen, delayed audio or poor lighting are some of the difficulties that may impair engagement in therapy. Additionally, as described by Thompson-de Benoit and Kramer (2020), direct eye contact, tone of voice, the ability to have an open posture, body movements, synchrony, and attunement are some of the communicative channels that may be hampered in VCP. That is, the paralinguistic, non-verbal and prosodic aspects of communication may be affected. Principles that ground embodied cognition enable one to grasp how physicality is key for information processing, involving bodily aspects that may not be transferable to remote modalities (Caramazza et al., 2014). A stooped posture, a shaking leg or a clenched fist are invisible in VCP. That relevant information is missed in VCP both for therapists and patients.

Not taking into account these differences that exist between modalities may affect the development of the therapeutic process and, consequently, result in early dropouts. Other ruptures in remote psychotherapy may be exacerbated due to the aforementioned technical problems or disappointment with the restricted possibilities that this modality permits. Identifying both confrontational and withdrawal ruptures and implementing techniques to resolve them is crucial, and there are initial suggestions regarding how to deal with this issue in VCP (Dolev-Amit et al., 2020).

Beyond the conceptual debate around the establishment of therapeutic alliance in VCP, a growing body of evidence shows that it can be established, presumably with comparable results to in-person psychotherapy (Simpson and Reid, 2014; Norwood et al., 2018; Lopez et al., 2019). The results of these studies converge on the conclusion that a therapeutic alliance can be successfully formed in VCP. Indeed, Lopez et al. (2019) conclude that VCP "*…is a viable modality with the potential to improve access to care with a low impact on therapeutic alliance*." The authors suggest that the therapeutic alliance is not particularly affected, and therefore, it does not hinder any therapeutic progress. Although therapeutic alliance can be well established in VCP, it is premature to conclude that it is equal to in-person psychotherapy.

Undoubtedly, the therapeutic alliance constitutes a core element in all psychological treatments (Flückiger et al., 2018). Indeed, the therapeutic alliance may be conceived as a moderator or an active mechanism of change (Zilcha-Mano, 2017; Baier et al., 2020). The longstanding tradition of therapeutic alliance research in in-person psychotherapy has produced several lines of research that have provided profound insight into how it is deployed (Norcross and Lambert, 2019). However, there is little research thus far on the role of the therapeutic alliance in treatment in VCP research compared to in-person psychotherapy. One topic it would be relevant to conduct research on in VCP research is the reciprocal dependency

between the therapeutic alliance and symptomatology, as there is mounting evidence in research on in-person treatment, which suggests that the formation of a strong therapeutic alliance precedes symptomatic change (Zilcha-Mano et al., 2014; Zilcha-Mano, 2017). For now, there are only a few examples of VCP research on this issue, without the same complexity as research on in-person psychotherapy (Bouchard et al., 2020).

From a neurobiological point of view, the attachment bond is usually associated with the 9-amino-acid cyclic neuropeptide oxytocin (Schneiderman et al., 2014), which in turn is a marker of the therapeutic alliance and alliance ruptures (Zilcha-Mano et al., 2018, 2020). Additionally, based on the Polyvagal Theory (Porges, 2007), there is research showing that higher in-session heart rate variability (specifically the high-frequency power) facilitates the establishment of therapeutic alliance, and this predicts symptomatic improvement (Blanck et al., 2019). It will be important to demonstrate that these associations occur in remote modalities as well. Should research be conducted on these more nuanced aspects, it would not be surprising to find that differences between in-person and remote psychotherapy emerge concerning the quality of the therapeutic relationship.

There is a great difference regarding the establishment of the therapeutic alliance between treatments that begun with an in-person modality and transitioned to VCP and treatments that were delivered remotely from the beginning. In treatments that make a transition to VCP, it is important to consider the necessity of making a new contract (Inchausti et al., 2020). Beyond the bond, the classical conceptualization of the therapeutic alliance entails objectives and tasks. Even though the bond may be very strong, the tasks and specific goals previously agreed upon should be closely examined to determine whether it is necessary to introduce changes given the new circumstances. Concerning specific objectives, there may be some nuances, but overall, they are also transferable from in-person to VCP. The greatest difference between in-person and VCP may lie in the tasks. Due to either the modality or the context, the usual tasks cannot be conducted. Commonly used techniques in in-person psychotherapy may need a process of adaptation to be implemented in VCP. An illustrative example is the delivery of tele-chairwork (Pugh et al., 2020).

On a positive note, it has been found that VCP can promote more disinhibition and openness due to the possibility of producing a sense of safety and a more neutral power balance. At the beginning of treatment, this neutral disposition in the bond can foster greater disclosure among patients who have certain interpersonal patterns (e.g., submissive patients) and may benefit from a less confrontational relationship (Simpson et al., 2020).

Adapting the Interventions to the Patients' Preferences, Characteristics, and Clinical Problems

Evidence-based practice in psychology entails the integration of best available research, clinical expertise, and patient preferences and values (APA Presidential Task Force, 2006). Taking into account the preferences and values permits to adapt the treatment to each individual. Cultural sensitivity emerges more than ever as an essential aspect to consider, given that there are substantial differences depending on a range of factors for the practice of VCP during critical times such as the current COVID-19 pandemic. Therefore, it is relevant to tailor the treatment according to the following aspects:

Clinical variables such as psychopathological severity

It is still very important to assess suicide risk, in particular in the context of disasters like COVID-19 in which suicide rates are expected to increase (Gunnell et al., 2020). It is crucial to adopt emergency measures if suicidal thoughts or attempts are detected (Gilmore and Ward-Ciesielski, 2019; Jobes et al., 2020). For serious mental illness as well as for particular clinical groups that may be hindered from working properly through videoconferencing, specific guidelines should be elaborated and followed.

There are certain clinical situations that may be more challenging than others. For instance, dealing with a person with a severe eating disorder entails obtaining session weights or having family meals, which demands specific solutions for working remotely (Matheson et al., 2020). Likewise, the procedure for conducting exposure therapy may be drastically changed. An exposure task for social anxiety disorder in remote psychotherapy can be adapted by including unknown people in a videoconference call (OxCADAT, n.d.). Numerous papers have been published for treating clinical conditions *via* remote therapy, including obsessive compulsive disorder (McKay et al., 2020), bipolar disorders (De Siqueira et al., 2020), suicide (Mcginn et al., 2019), psychosis (DeLuca et al., 2020; Hasson-Ohayon and Lysaker, 2020), post-traumatic stress disorder (Aafjes-van Doorn et al., 2020b; Fina et al., 2020), sleep disorders (Arnedt et al., 2020), among others.

Sociodemographic variables

The socioeconomic background or digital literacy should be particularly taken into consideration before starting a VCP treatment (Nelson et al., 2017; Markowitz et al., 2020). That means that the therapist needs to design the specific goals and tasks in accordance with the patient's characteristics, needs, and preferences. This is particularly true given that, worldwide, people who suffer the most are vulnerable and underserved populations (Frankham et al., 2020). The present situation involving the presence of the COVID-19 pandemic is not exceptional in this regard. Socioeconomically excluded people or people at high risk such as elderly people are logically those who potentially would need more help under these circumstances, but paradoxically also have less access to psychotherapy, including to VCP.

Acceptance and attitudes toward technology

Although it was thought that patients were resistant to VCP in its early days, research shows that overall patients have a positive attitude toward VCP (Trondsen et al., 2014; Bleyel et al., 2020). Hence, it is essential to consider the experience of the patients with technology as well as with previous psychological

treatments and, accordingly, to determine the extent to which the patients consider that such a treatment may be beneficial for them. Patients' resistance may be explored and potentially coped with motivational interviewing strategies (Walker et al., 2020).

Adapting the Interventions to Different Modalities and Settings

VCP was first delivered fundamentally in individual formats, for adults and in private practice. Recently, as a consequence of the need for rapidly adapting practice to remote delivery, VCP has extended to all formats (family, couple, and group therapy formats), populations (children, adolescents and elder people) and settings (e.g., hospitals, university counseling centers, community clinics, prisons).

Family therapy is particularly necessary for certain clinical situations (Amorin-Woods et al., 2020), such as those that affected younger people and adolescents (Burgoyne and Cohn, 2020). An illustrative example is the work with patients having an eating disorder (Matheson et al., 2020) or cases involving child maltreatment (Racine et al., 2020). Couple therapy has been in increasing demand recently, due to the significant rise of conflicts that emerge as a consequence of the adverse aftermath of confinement and the pandemic (Lebow, 2020; Sahebi, 2020; Stanley and Markman, 2020).

A variety of circumstances affect the usual functioning of group therapy, but the preliminary evidence suggests that efficacy has been similar to that observed previously (Marmarosh et al., 2020). There is also evidence that group VCP allows for the development of cohesion to a similar extent as in in-person group psychotherapy (Gentry et al., 2018; Lopez et al., 2020). Among the barriers, the participation of several patients in VCP may reduce the communication fluency of the group and hinder the usual dynamics (Weinberg and Rolnick, 2019). Working with groups necessarily increases the number of interactions and, accordingly, the complexity of any system such as therapeutic groups (Aureli and Schino, 2019). If, normally, group therapists have to have a higher degree of attentional flexibility and more diverse intervention procedures than individual therapists in VCP, this is particularly relevant.

The Person of the Therapist

There are still a lot of unknown aspects, but it is an undoubted global phenomenon that VCP became an essential tool regardless of therapists' therapeutic orientation, the clinical conditions, and even the therapists' previous experience with technology (Humer et al., 2020b; Sammons et al., 2020). Besides, several studies (e.g., Békés and Aafjes-van Doorn, 2020; Humer et al., 2020a; Jurcik et al., 2020) have demonstrated that since the massive incorporation of videoconferencing, therapists' attitudes toward it have improved.

Psychotherapists would greatly benefit from developing a self-reflective attitude during the whole process of therapeutic alliance building in remote psychotherapy as well as other aspects that may hamper (and potentiate) the therapeutic work. Under these exceptional circumstances occurring during the COVID-19 pandemic, people and therapists all over the world are not the exception, had their routines disrupted and their sense of wellbeing challenged. For the first time, many therapists may be overwhelmed by the same complaints and problems as their patients (Hasson-Ohayon and Lysaker, 2020). Besides, in many cases, the caseload of patients has been reduced, impacting their income (Sammons et al., 2020). Moreover, therapists are not particularly prepared for this kind of modality, and therefore, initial evidence suggests that therapists find it more wearying to do VCP, probably as a consequence of the aforementioned reduced channels of communication (Hoffmann et al., 2020). Likewise, therapists inexperienced with VCP have higher levels of self-doubt and anxiety and feel less competent and confident about their professional skills (Aafjes-van Doorn et al., 2020a).

It has been demonstrated that the adoption of VCP depends a great deal on the attitudes of the providers, including psychotherapists. In a systematic review of 38 studies, it has been found that previous experience with VCP is highly related to having positive attitudes toward it. Besides, therapists' satisfaction levels with VCP are overall high throughout the studies, although the samples do not represent all psychotherapists (Connolly et al., 2020).

All these aspects necessarily entail an unusual professional and emotional impact. Indeed, ample evidence has recently emerged showing that in COVID-19 times, health professionals are prone to suffer, not only due to the same stresses as everyone else but also due to the necessity of responding to the contextual demands of working in the health care system in such an unusually stressful time (Braquehais et al., 2020). However, mental health professionals working remotely may also have a great burden. Hence, self-care practices that psychotherapists can adopt are essential (Hoffman, 2020).

Supervision and Training

Fortunately, in recent years, online supervision has become practiced and studied more often, leading to a set of recommendations regarding how to best implement it (Rousmaniere et al., 2014). Just like the work with patients, videoconferencing supervision is more flexible in terms of scheduling meetings, which can be especially important in critical situations. The potential difficulties that may arise in videoconferencing supervision can be counteracted with a clear framework at the time of development of the supervisory alliance. In that sense, it is relevant to consider possible variations in the alliance, which is a matter of importance just as between patients and therapists (Watkins, 2014). The principles that govern group therapy should also be applied to group supervision. Both peer and traditional supervision could be taken as a first step toward the training process of psychotherapists doing VCP.

According to trainees receiving online supervision, it is a valuable component for the training process (Bernhard and Camins, 2020). Indeed, online supervision may serve as a first step toward the establishment of structured training programs. Actually, given the massive dissemination of VCP, it is urgent that psychotherapists be trained to incorporate VCP efficiently into their routine practice. So far, there are a few existing studies of VCP training programs (Colbow, 2013; McCord et al., 2015; Dopp et al., 2017; Perle, 2020), and despite the undoubted attention that has been recently given to the topic due to the onset of the pandemic, there

is still a dearth of systematic knowledge regarding VCP training (Hames et al., 2020). Until now, it seems a mere intuitive transition from traditional in-person training.

Training programs should be based on the evidence-based principles that have been shown to enhance therapeutic effects, such as deliberate practice (Prado-Abril et al., 2018). The valuable progress that has been made in in-person psychotherapy should be applied to VCP. In this sense, it is important to avoid disseminating manualized treatments and instead train therapists in general principles of change (Castonguay and Beutler, 2006; Castonguay et al., 2019; Goldfried, 2019; Boswell et al., 2020). It is important to avoid incurring the infructuous dispute between specific therapeutic schools and focus the efforts on achieving therapeutic competence (Cooper et al., 2019). There were already examples of VCP guidelines even before the outbreak of the pandemic (Yellowlees et al., 2010; Turvey et al., 2013; McCord et al., 2020; Smith et al., 2020), but it is expected that the mounting evidence that is being produced and disseminated due to the pandemic will yield valuable insights regarding how best to practice VCP.

Ethical Considerations

These days, ethical considerations are usually reduced to the privacy dimension. That includes informed consent from patients doing VCP, the security of the platforms, and the guarantee that any stored data will be treated according to data protection regulations, among other aspects. However, ethical issues also include accounting for the safety of the patients, competence of the therapists, legal issues regarding the regulation of the practice, consultants' autonomy, and commercial contracts (in particular for liberal and third parties' professionals), among other issues (Lustgarten and Elhai, 2018; Stoll et al., 2020a,b).

CONCLUDING REMARKS

Certainly, remote human interaction will increase in the coming years. This has already been happening for at least a decade. Yet, the outbreak of the pandemic has notably accelerated this process. Psychotherapy will definitely not be the exception to the rule, and therefore, it is crucial to outline how the field will be transformed in the near and long term. Most probably, the implementation of VCP psychotherapy will increase in the next few years (Norcross et al., 2013), and this will happen in a context of the decline in the consumption of psychotherapy (Gaudiano and Miller, 2013). Therefore, we should guarantee the highest standards to differentiate psychotherapy from pseudoscientific disciplines and to demonstrate the value of incorporating psychotherapy into the ever-growing pharmacological treatments.

While it may be true that preliminary research comparing in-person therapy to VCP yields comparable results in terms of efficacy, it would be inaccurate to conclude that both approaches have similar empirical support. Despite presenting promising results, VCP is only in its beginning as a research field. Thus, research and training are key for the advancement of VCP, and this scenario should be taken as an opportunity to foster also the advancement of the field of psychotherapy.

Real world implementation of evidence-based principles would mean strengthening the active collaboration between researchers and practitioners, redounding to the proliferation of practice research networks in which the practice is evidence based and the evidence is practice based. That would mean a reciprocal enrichment both for practitioners and researchers (Castonguay et al., 2015). However, this context undoubtedly facilitates the possibility of improving the attitudes of therapists and consultants toward VCP and by extension toward other technological tools (Wind et al., 2020). Accordingly, a brighter future can be expected if more collaborative research in naturalistic settings occurs.

On a relative but different note, it is important to reflect on the role that VCP will have in the future of psychotherapy. That is, for many psychotherapists, the use of remote modalities constitutes a suboptimal resource that is necessary in order to continue their work. However, many stakeholders consider this an efficient way of increasing the prevalence of mental health treatment. Although many therapists may indeed prefer this modality, and for a range of mild conditions, it is proving to be equally efficacious, the possibilities of in-person therapy seem to still be superior.

Indeed, there are stakeholders that are advocating for the incorporation of completely self-applied online interventions with minimal contact. In fact, the evidence is conclusive regarding the usefulness of low-intensity treatments mainly through Internet interventions to improve access to treatment of common mental disorders (Andersson et al., 2019). In that sense, it is timely to review the paper by Barlow (2004) in which he differentiated psychological treatments from psychotherapy. Briefly put, for public concerns and to diminish the massive clinical manifestations related to mental health, all evidence-based psychological treatments may be of importance, including brief protocolized procedures. However, psychotherapy is only one of the possible psychological treatments and most often differs from other psychological treatments in the sense that the main objective is not only symptomatic reduction but also the reorganization of the personal system and the improvement of the quality of life. This situation is helping to distinguish the respective value of "psychological treatments" as an umbrella term for many different psychosocial interventions and "psychotherapy" as a more specific non-manualized practice for dealing with the complexity of experience and behavior. Our stance is that both should coexist and even in blended treatments could be simultaneously harnessed in the same situation. Accordingly, it is essential to acknowledge that there are nuances that psychotherapy permits, and at least for now, the optimal way of delivering psychotherapy is in a shared physical space. However, VCP will definitely be expanded and hopefully integrated as a modality through which complex psychotherapeutic interventions can be delivered.

AUTHOR CONTRIBUTIONS

JF-Á drafted the manuscript and HF-Á provided critical revisions. Both authors reviewed and edited the final version of the manuscript.

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More Light? Opportunities and Pitfalls in Digitalized Psychotherapy Process Research

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While the evidence on the effectiveness of different psychotherapies is often strong, it is not settled *whereby* and *how* these therapies work. Knowledge on the causal factors and change mechanisms is of high clinical and public relevance, as it contributes to the empirically informed advancement of psychotherapeutic interventions. Here, digitalized research approaches might possess the potential to generate new insights into human behavior change, contributing to augmented interventions and mental healthcare practices with better treatment outcomes. In this perspective article, we describe recent findings of research into change mechanisms that were only feasible with digital tools and outline important future directions for this rather novel branch of research. Furthermore, we indicate several challenges and pitfalls that are to be solved, in order to advance digitalized psychotherapy process research, both methodologically and technologically.

Keywords: psychotherapy, mechanisms of change, e- and m-health, mediators, components, active ingredients, digital factors

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INTRODUCTION

Despite decades of research efforts to unveil the working mechanisms in psychotherapies for common mental disorders, the evidence base on the causal factors and therapeutic processes in most of these interventions remains largely uncertain (Cuijpers et al., 2019). Most researchers would probably agree that comprehensive knowledge on the mechanisms of change (i.e., the actual processes responsible for change) is central to develop more powerful intervention packages with optimized outcomes though. We highlight that certain features of digitalization convey novel opportunities for psychotherapy process research, which hold the potential to lift this kind of research on another level and shed *more light* upon an enduring *black box*. At the same time, we also point to important challenges and hurdles that might obstruct the full evolvement of this new branch of research.

Here, we conceive *digitalized* psychotherapy process research rather broadly, comprising different methods and means, which share the commonality that they are all technologically realized and were not available to prior psychotherapy research of the pre-digital age. Established examples of these digital approaches are video-taped analyses of therapeutic processes (e.g., Koole and Tschacher, 2016), videoconference-based psychotherapy (e.g., Etzelmueller et al., 2018), or routine outcome monitoring (e.g., Lutz, 2002; Lambert et al., 2018). These digital tools might be predominantly applied for research purposes only, but might also directly

support psychotherapeutic practices in clinical routine. Most prominently, eHealth and mHealth interventions (i.e., psychotherapeutic treatment programs that are either delivered via personal computers and web-browsers, or smartphones and mobile applications, respectively) are extensively researched in recent years and show promise to extend mental healthcare, given their particular features, like flexibility and anonymity in conduct, possible cost-effectiveness, and outreach on a population scale (Andersson et al., 2019; Linardon et al., 2019; Domhardt et al., 2020a). Moreover, internet- and mobile-based interventions (IMIs) might not only augment the capabilities in mental healthcare (Ebert et al., 2017) but also hold a considerable potential for psychotherapy research on change mechanisms because of their specific properties.

NOVEL METHODOLOGICAL AND TECHNOLOGICAL OPPORTUNITIES

To begin with, a major asset of the implementation of IMIs in psychotherapy process research is the possibility to reach a higher standardization of interventions and their components, which was not possible with previous conventional research approaches within face-to-face therapy settings. This methodological progression enables a more reliable detection of the effects of single components in dismantling and additive design studies (Steubl et al., 2019), as previously hard to control confounds, like therapist factors (e.g., personal views, professional experience, and skills) or the actual presentation of manualized therapeutic content, can be hold constant. Thereby, dismantling studies have revealed several important insights so far, for example, the superiority of IMIs with guidance compared to pure self-help interventions (Baumeister et al., 2014) or the comparable effectiveness of transdiagnostic and disorder-specific interventions (Domhardt et al., 2019). These preliminary findings suggest that the therapeutic alliance might play a prominent role as common factor in digitalized psychotherapeutic interventions as well (Berger, 2016), and the potential of IMIs for scalability purposes might be further amplified by means of transdiagnostic treatment manuals (e.g., Weisel et al., 2019). Yet, future studies must expand our knowledge by disentangling the incremental or surrogating effects of central other components, like automation of support (as a possible cost-efficient alternative of human support in IMIs) and tailoring of intervention content to patients' needs (in contrast to "one-size-fits-all"-interventions), in order to fully grasp the actual potential and limitations of IMIs to extend and augment mental healthcare efforts on a global scale.

Another advantage of experimental studies with IMIs is that they enable an unprecedented way to break down the utterly complex and dynamic processes of psychotherapeutic interventions into paradigmatic fragments, with the direct manipulation of isolated and clearly operationalized specific factors. In this sense, digital interventions might serve as a "mouse model" for psychotherapy process research and allow for the evaluation of distinct psychological and biological mechanisms of therapeutic change in original experimental designs. For instance, Hirsch et al. (2018) investigated the effects of experimentally inducing positive interpretations by means of a priming task before internet-delivered cognitive bias modification training (CBM) in patients with symptoms of depression and anxiety. The authors found that changes in interpretation bias partially mediated the effects of CBM on worry and rumination at follow-up, contributing to our understanding of the causal role of interpretation bias in worry and rumination, as a relevant target for face-to-face and online psychotherapy alike (Hirsch et al., 2018).

Moreover, ecological momentary assessment (EMA) and smart sensing studies make the step out of laboratories and facilitate the immediate detection of variables, irrespective of the constraints of space and time (Myin-Germeys et al., 2018). This can eventually lead to more valid multimodal assessments (i.e., "digital phenotyping"; Jain et al., 2015; Baumeister and Montag, 2019), free from several biases (e.g., recall, social desirability; Shiffman et al., 2008) and without overlapping measurements of outcome and mediator constructs in ordinary paper–pencil self-reports with similar—or even identical—items. Future research is needed however, to investigate, if novel biases arise within EMA studies themselves (e.g., reactive assessment; van Ballegooijen et al., 2016). The ease and high-intensity of data collection with EMA (Schuster et al., 2020) and digital tools will ultimately lead to larger sample sizes and big data sets that would alleviate the problem of limited statistical power, which is a long-lasting impediment of psychotherapy (process) research (Domhardt et al., 2021). This assumption is corroborated in a recent review, showing that mediation studies with IMIs for depression (Domhardt et al., 2021) exhibit a substantial larger amount of study participants on average (M = 262, SD = 243), when compared to conventional psychotherapy process research for depression (Lemmens et al., 2016; M = 173, SD = 145).

Fine-grained longitudinal data on therapeutic processes, gathered within or outside therapy sessions, can be shared among researchers conducting individual patient data meta-analyses, in order to develop multivariable algorithms that contribute to precision mental health (Furukawa et al., 2018, 2019; Lin et al., 2019). Innovative machine learning approaches might predict trajectories of change based on these data, which can inform pre-treatment and in-session decisions of mental healthcare practices (Cohen and DeRubeis, 2018; Goldberg et al., 2020; Rubel et al., 2020). Additionally, virtual reality (VR) interventions reveal novel findings on change mechanisms that were not conceivable with conventional studies so far. For instance, in their original study Pot-Kolder and colleagues randomized 116 patients with psychotic disorders either to VR-based Cognitive Behavior Therapy (CBT) or waitlist (treatment as usual). The VR-CBT intervention consisted of 16 sessions (8–12 weeks) with therapist-guided virtual-reality exercises, comprising reflections and challenges about the patients' suspicious thoughts, safety behaviors, and harm expectancies. At this, the virtual social environments were individually designed for each patient, matching the idiosyncratic cues and paranoid fears of the individual patient. It goes without saying that the variations in the number, characteristics and responses of human avatars in VR would have not been controllable in real life exposure

sessions. Overall, the findings of this recent RCT indicate that safety behaviors and modified social cognitions were mediators of treatment change and contributed to reductions in momentary paranoid ideation and anxiety (Pot-Kolder et al., 2018).

CURRENT CHALLENGES AND IMPLICATIONS FOR FUTURE RESEARCH

However, to exploit the full potential of digitalized approaches to psychotherapy process research, it is essential to address several prevailing pitfalls and ethical considerations. These are, amongst others, fundamental data security, confidentiality, and emergency issues, as well as concerns in regard to certain unresolved research questions (Stoll et al., 2019). For example, a major confinement in IMIs is a comparatively high attrition rate and limited engagement of patients in these digital interventions, especially when they are unguided and transferred from controlled research settings into routine healthcare (Domhardt et al., 2019; Graham et al., 2019). Numerous research efforts are currently committed to find effective ways to increase the engagement—i.e., the frequency patients adopt and interact with IMIs (Graham et al., 2019)—such as user-centered design (Graham et al., 2019), product quality and therapeutic persuasiveness (Baumel and Kane, 2018), striving for higher completer rates and, as a consequence thereof, better treatment outcomes (Yardley et al., 2016). Likewise, several attempts and efforts are currently underway, in order to reach a better understanding of the attitudes of patients, therapists and stakeholders toward IMIs (Topooco et al., 2017; Apolinário-Hagen et al., 2018), as well as to establish legal and regulatory frameworks for the implementation of IMIs (Ebert et al., 2018), in order to pave the way for a broader dissemination of digital psychotherapeutic interventions in research and practice.

Aside these current challenges, there are conceptual and methodological confines that hampered the field of psychotherapy process research for decades. This holds true for divergent operationalizations of central constructs of psychotherapy research, which ancillary obstructed the long-lasting debate about the relative importance of common and specific factors (Mulder et al., 2017). For instance between "factors" and "components" that are part of the therapy (e.g., problem solving training), versus "mediators" and "mechanisms of change" that occur in the patient (e.g., application of newly acquired problem solving skills). Other examples of somewhat tenacious misconceptions in the literature are between "moderators" and "mediators" (Johansson and Høglend, 2007). Thus, next to the importance to stick to consistent operationalizations of existing constructs, it is also key to conceptualize certain unique features of digital interventions that might represent novel *digital common* or *digital specific factors*. Therewith we refer to factors that are *common* to all (e.g., technological design and delivery) or *specific* to certain digital health interventions (e.g., persuasive design, mobile sensing and ecological momentary interventions, and continuous automated feedback with smartphones or wearables)—but are not constituent of face-to-face psychotherapies. Future research must disclose, which of these digital factors are indeed active ingredients of technology-delivered interventions (or are merely facilitating or obstructive moderating variables for genuine therapeutic processes), and if they induce the same or separate working mechanisms when compared to conventional face-to-face psychotherapies. Albeit, these questions of comparative research are hardly to answer, as long as there are substantial differences between these two branches of research concerning recruitment strategies and sample characteristics (Torous and Firth, 2018). Another current confinement of digital approaches to psychotherapy research is their primary focus on interventions based on CBT-principles to this point (Andersson et al., 2019; Domhardt et al., 2020b). Hence, IMIs developed from other therapeutic backgrounds (such as psychodynamic, interpersonal or mindfulness-based approaches) are of value to expand the evidence base—therewith omitting an imbalance still observable in conventional psychotherapy research today (Leichsenring et al., 2018).

An additional major current concern lies in the light-minded interchange of correlation and causality with flawed conclusions on presumed psychological processes (Antes, 2016; Caliebe et al., 2019), as observed in some privately funded studies resorting to big data gathered by large tech companies. Hence, it is of utmost importance to comply with the traditional explanatory research sequence: hypothesize, model, and test (Anderson, 2008). Alongside the cautious contemplation of central notions of epistemology (i.e., verify vs. falsify; Carnap, 1928; Popper, 1959) and approaches to causal inference (Ohlsson and Kendler, 2019). Thereby, an attentive awareness of the differences between conventional and digitalized research methods in deriving knowledge from big data is of high relevance, as certain automated approaches lack testable hypotheses, conceptual frameworks or theoretical foundations (Kriston, 2020), as indispensable theoretical presuppositions for causal inferences (Wilkinson et al., 2020). As such, some methods relying on machine learning and artificial intelligence are not suitable to detect causal mechanisms in clinical settings, as they might impede transparency and replicability, which have to remain indispensable criteria for various decisions in healthcare. Hence, the consideration and advocacy of theory-driven explanatory research with falsifiable scientific models might be of particular relevance at the present time, so as to convey the scientific achievements and epistemological methodologies from decades of research efforts into an ever-increasing digitalized world, with the concomitant advancement of technologized psychological and medical research.

CONCLUSION

Last but not least, in our view, the discussion about the opportunities and limitations of digitalized approaches to psychotherapy process research must not attend to technological

and methodological aspects alone, but urgently needs to weigh the clinical and societal implications of their (non-)utilization hereafter. Accordingly, forthcoming research efforts ought to reveal, to which degree the innovations of digitalization will actually add *more light* on the mechanisms of change in psychotherapeutic interventions, and if we make the most out of technological opportunities to improve global mental health.

DATA AVAILABILITY STATEMENT

The original contributions presented in the study are included in the article/supplementary material, further inquiries can be directed to the corresponding author/s.

AUTHOR CONTRIBUTIONS

MD wrote the first draft of the manuscript. All authors have contributed to the further writing and have approved the final manuscript.

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Exploring the Question: "Does Empathy Work in the Same Way in Online and In-Person Therapeutic Settings?"

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Providing remote psychotherapy using technology is a growing practice, especially since the outbreak of the COVID-19 pandemic. Even if in numerous studies video conferencing psychotherapy (VCP) was found to be clinically effective, some doubts continue to exist about how the psychotherapeutic alliance works in the online setting, and the characteristics of the empathic process are still poorly understood. This is an exploratory study aimed at analyzing the degree of empathy between the psychotherapist and client pair, and the degree of support perceived by the client who shall be referred to as the patient interchangeably in this study, comparing the sessions in person with those online, during the current pandemic, in order to discriminate the impact of empathy in the digital setting. The sample analyzed was composed of 23 patients with different severity of pathology engaged in online and in-person therapeutic sessions with five psychotherapists of different theoretical leanings. The scores of the support and empathy scale, obtained by both members of the psychotherapeutic couple in the two settings, were analyzed and compared. The test used belongs to an Italian adaptation of the Empathic Understanding (EU) of the Relationship Inventory. What emerged from comparing the scores was interesting: Unlike the psychotherapists, the patients perceived their therapists as significantly more empathic and supportive in the remote setting. These are rather important data, because the literature documents that client empathic perception measures represent a more accurate measure of the empathic relationship and, in general, can predict a good treatment outcome. Although these results need further investigation, they represent an important contribution in filling the scientific gap in the understanding of digital empathy. Also, this study provides new insights for future research on the characteristics and impact empathy has on the practice of remote psychotherapy.

Keywords: video conferencing psychotherapy, digital empathy, electronic-based therapy, telepsychology, remote clinical psychology, online therapeutic settings, in-person therapeutic settings

INTRODUCTION

Since the day the World Health Organization declared the new SARS-CoV-2 coronavirus as a pandemic because of its global outbreak, unprecedented changes have happened in the personal and professional activities of the whole Italian population (Di Corrado et al., 2020). In this challenging period, the coronavirus has not been the only health risk, since everyone has to continue to manage stress (Maldonato et al., 2020) and take care of their personal, physical, and psychological wellbeing. For this reason, a lot of health specialists have been able to continue working online, assisting their patients from home too (Reilly et al., 2020). Among them are a lot of psychotherapists who have been able to carry on with their psychotherapy sessions remotely, through video conferencing psychotherapy (VCP), thus ensuring health benefits (Cioffi et al., 2020).

Since the beginning of this century, international studies have analyzed the benefits, possibilities, limits, and faults of various online psychological interventions (Cipolletta et al., 2018); they highlighted that VCP can be practicable, clinically effective, and suitable to patients. VPC has been used in a multiplicity of therapeutic plans and with different kinds of patients, it is generally associated with good user satisfaction, and it is found to have clinical outcomes comparable to traditional frontal psychotherapy (Backhaus et al., 2012; Berryhill et al., 2019a,b; Dolce et al., 2020).

Video conferencing psychotherapy has a lot of advantages, first of all, it can reduce and almost eliminate the distance between one and another, which is an important factor for those who live in under-served regions; moreover, it makes it possible to overcome many challenges, for example, time restraints, scheduling troubles, and other customer inconveniences regarding the concern of social stigma in seeking care, enabling the latter to overcome these difficulties by engaging with professional services in the privacy of their home (Sperandeo et al., 2020). VCP is an opportunity for those organizations that serve geographically disperse or isolated populations for different reasons. It is also useful for people with special needs, with mobility problems for different reasons, with specific psychic disorders limiting travel, with socialization problems, or with serious pathologies (Cioffi et al., 2020). However, some doubts continue to exist about VCP use and usefulness.

One of these has to do with some debates on the possibility to form a satisfactory working alliance within the psychotherapist-client couple when psychotherapy is provided through such a medium.

Evidence coming from a systematic literature review demonstrated both an adequate working alliance and suitable outcome for VCP; while two recent meta-analyses found that the working alliance in VCP seemed to not be as good as that which is obtained in face-to-face sessions, while that difference had nothing to do with the distinctive pathologies of patients (Norwood et al., 2018).

The hypothesis that therapist empathy is a key element in the process of change in psychotherapy has ancient roots. The results of a meta-analysis on the relationship between therapist empathy and client outcome showed that empathy is a reasonably strong predictor of therapy outcome (Elliott et al., 2018). Consequently, empathy is certainly one of the fundamental factors capable of determining an adequate working alliance between psychotherapist and client within a session, regardless of the psychotherapeutic approach (Elliott et al., 2011). The fundamental role of empathy in patient care and the patient-psychotherapist relationship is well recognized in literature (Feller and Cottone, 2003; Nascivera et al., 2018).

Empathy is a complex construct and there are lots of definitions of it according to the various disciplines or the author's backgrounds. A definition that takes into account the different definitions comes from Batson (2009), who described empathy as a psychological state, that is at the same time a skill and a process, of which there are eight phenomena parts (see **Supplementary Appendix Table 1**).

Starting from this complex vision of empathy and how it is able to influence the therapeutic process in the face-to-face sessions, we asked ourselves if the latter had the same characteristics in online sessions.

The advent of digital information and communication technology has converted human interactions into digital conversations in which people can instantly share thoughts, feelings, and behaviors through digital channels. The concept of digital empathy has its roots in these changes in the way human beings interact during the digital age. In particular, Terry and Cain (2016) gave the following definition of the concept: "*traditional empathic characteristics such as concern and caring for others expressed through computer-mediated communications*." Then Friesem (2016b) underlined how digital empathy pushed us to a broader understanding of traditional empathy, in order to be able to understand its expression in the digital universe. This latter author, taking up the model of Batson's "*eight empathy phenomena*," deepens and further describes the characteristics of digital empathy: "*digital empathy explores the ability to analyze and evaluate another's internal state (empathy accuracy), have a sense of identity and agency (self-empathy), recognize, understand and predict other's thoughts and emotions (cognitive empathy), feel what others feel (affective empathy), role play (imaginative empathy), and be compassionate to others (empathic concern) via digital media*" (Friesem, 2016a).

There are three main categories to measure empathy in psychotherapy settings: (a) self-reports filled out by the patients, the psychotherapist, or outside observer; (b) outside observer's assessments through specific assessment grids for evaluating recorded psychotherapy sessions; and (c) measurements of psychophysiological response variations (skin conductance, oxygen saturation, blood pressure, and heart rate) (Messina et al., 2013). Of these kinds of assessments, the empathy perceived by the patients was considered the best predictor of psychotherapy outcome (Grummon, 1972).

Among the most common instruments utilized to assess perceived empathy in psychotherapy, there is the Empathic Understanding (EU) of the Relationship Inventory (Barrett-Lennard, 1986), of which the Italian version is the Scale dell'Empatia Percepita (SEP; Messina et al., 2013). This Inventory gives an evaluation of empathy based on Carl

Rogers' theories on therapeutic helping and person-centered therapy (Meador and Rogers, 1984). The Italian version (SEP) contains the form for the client (SEP-A), to measure the empathy perceived by the client during the session; and the form for the psychotherapist (SEP-M), to evaluate the empathy that the psychotherapist thinks they have communicated to his/her client during the session. In research for validating the Italian version, it has been shown that SEP-A reflects sensory empathy while SEP-M reflects more complex affective empathy relating to emotion sharing and interpersonal relationships (Messina et al., 2013).

Beginning from these reflections about empathy and digital empathy, we wondered if empathy works in the same way in online and in-person therapeutic settings, and what the differences between the treatment and the outcomes are.

MATERIALS AND METHODS

This is an exploratory study aimed at analyzing the level of affective attunement and more precisely the degree of empathy among the members of the psychotherapist-client dyad, as well as the degree of support perceived by the patient, comparing the sessions in-person with those online, during the period of lockdown necessitated by the COVID-19 pandemic, in order to discriminate the specific characteristics of digital empathy.

Participants

The sample analyzed is composed of five psychotherapists (2 men and 3 women) of different theoretical orientations (psychoanalysts, transactional analysts, and Gestaltists) and 23 patients (4 men and 19 women) with different severity of the pathology (11 without current psychic disorders, 7 with mild psychic disorders, and 5 with moderate psychic disorders) engaged in weekly or fortnightly psychotherapeutic treatments.

Data Collection and Procedures

This is an open study due to the small number of subjects included. While the topic of the psychotherapeutic alliance in online settings is well studied, so there is a good amount of research on it, that of empathy (which is one of the components of the therapeutic alliance) is still a little-explored topic. We aimed to explore how empathy works in online settings, for this reason, we did not select the sample based on specific parameters to prevent our unconfirmed hypotheses from influencing the results. We kept the open observation typical of the exploratory survey without selecting specific inclusion parameters to ensure sample variability.

We opted to include in the study psychotherapists with various leanings who, in this period of the pandemic, were carrying out both face-to-face and remote treatments in their offices. The study is still open and the increase in therapists included in the sample will allow us, as soon as an adequate number of subjects is reached, to highlight any characteristics of the therapists related to the empathy experience.

Five psychotherapists from three different approaches voluntarily joined the study, they identified among their patients those who had voluntarily agreed to participate in the study (for a total of 23 subjects), informing them on the modalities of the study and asking them to sign the informed consent.

In particular, the psychotherapists identified among their patients those with whom they had a good alliance and were in an advanced stage of therapy (at least more than 3 months), this was to avoid that being included in the study could lead patients to drop out.

In this way, we had 23 dyads, all engaged in a healing relationship with the typical characteristics of the different psychotherapeutic models.

All online sessions took place via Skype or WhatsApp video call. Overall, 50% of patients used their PC, 15% used tablets, and 35% used a smartphone. While 88.2% of psychotherapists used their PC, 23.5% used tablets, and only one of them used a smartphone. A total of 70% of patients affirmed they had the online sessions alone from home or an office, while the remainder had the sessions in the presence of other people from home or at an office. Though 40% of psychotherapists affirmed they had the online sessions alone from home or an office, therefore most of them were at their home or office with other people in other rooms (see **Supplementary Appendix Figure 1**).

At the end of each psychotherapy session and for a consecutive number of four sessions, each couple (psychotherapist-patient) completed online an Italian adaptation of the Barrett-Lennard Relationship Inventory (version 3—developed by Godfrey T. Barrett-Lennard) and the Empathy and Support Scale (ESS). We have not selected specific psychotherapeutic interventions precisely to allow the breadth of perspectives of an open study. Since the experience of empathy perceived by the therapist and the patient is documented to be a phenomenon closely related to each separate session (Elliot et al., 2002), we randomly administered the test to the patient/psychotherapist dyad depending on the phase of the treatment. This allowed us to compare empathic perception in individual sessions (even if these data are not yet sufficiently confirmed from a numerical point of view, and for this reason they have not been presented) highlighting that even the same patient/therapist dyads present differences in perception of empathy in remote sessions compared to those in person.

The same patients had both online and face-to-face sessions, randomly, in accordance with their possibilities and needs. We did not give any indications regarding the alternation of sessions (in person or remote), but we simply observed the natural alternation that occurred between the dyads, in order to respect the naturalness of the therapeutic process, which is already tried by the difficulties of direct contact caused by the pandemic. Probably, the variable "personal predisposition" to the use of technological devices influenced the choice of the online setting. Moreover, for some people, the anguish of contracting the virus was a reason for preferring the online setting. Additionally, it must be said that this pandemic has also represented a sort of opportunity for some people who tended to be inconstant in their psychotherapeutic paths because they were very busy. What we mean is that for many patients the online setting has represented an opportunity to reconcile the various commitments that were often an impediment to go to the psychotherapy site.

A total of 72 sessions (33 in person and 39 online) were collected from November 2020 to January 2021. The averages scores obtained at the 72 sessions were compared, dividing and matching the sessions into two groups (one group of face-to-face sessions and the second group of online sessions).

Measures

For the assessment of psychopathology of the patients, at the first session, the psychotherapist filled out the Comprehensive Psychopathological Rating Scale (CPRS; Åsberg et al., 1978). The CPRS consists of 40 items that explore the psychopathology reported by the patient and 25 that refer to the psychopathology observable during the interview. At the end, the evaluator must express a judgment on the overall seriousness of the clinical condition and on the degree of reliability of the information collected. The items are rated on a 4-point Likert scale, from 0 to 3. For each item, the severity levels are carefully defined; three dimensions contribute to their definition: severity, frequency, and duration.

At the end of every session, for measuring the degree of support and empathy perceived by both the client and the therapist, as well as their concordance, the Italian version of the Barrett-Lennard Relationship Inventory (version 3—developed by Godfrey T. Barrett-Lennard) was used (Barrett-Lennard, 2015). This Inventory has two forms: Other Toward Self form (40 items) aiming to evaluate the empathy perceived by the client during the session; and the Myself to Others form (40 items) to evaluate the empathy that the psychotherapist thinks they have communicated to his/her client. The items are rated on a 3-point Likert scale. This inventory explores the degree of empathy and support through two subscales, with one having items formulated positively and the other one having items formulated negatively. This inventory was created to be adapted to specific contexts of use, for this reason, we have developed an Italian adaptation, the ESS, organized over 28 items (14 positively formulated, which form the Empathy and Support Positive Subscale-ESPS, and 14 negatively formulated, which form the Empathy and Support Positive Subscale-ESNS) for the client version (ESS-C) and 28 items (14 positively formulated, which form the Empathy and Support Positive Subscale-ESPS, and 14 negatively formulated, which form the Empathy and Support Positive subscale-ESNS) for that of the psychotherapist (ESS-P) (as shown in the **Supplementary Appendix**).

Analysis

The collected data were analyzed through the Statistical Package for the Social Sciences (SPSS) by performing descriptive statistics to show the qualitative and quantitative composition of the examined sample. Comparisons between the averages of the scores obtained from the two groups of subjects (online treated and in-person treated) to the empathy and support subscales were performed with Student's *t*-test. Comparisons between the concordance between patients and therapists were performed with the χ^2 test applied to the observations made in-person and online.

RESULTS

The perception of empathy and support was evaluated in parallel in the two members (patient and therapist) of the 24 therapeutic couples after four consecutive sessions. Overall, empathy and support perceived in parallel by patient and therapist were assessed after 72 therapy sessions, 39 of which were carried out remotely and 33 in person. Most of the therapeutic dyads that conducted three consecutive therapy sessions used only one type of setting (remote or in-person), three couples alternated between the setting in person and the remote one. The severity of current psychopathology in the patients was assessed by the therapist after the first of the sessions analyzed by applying the CPRS (see **Supplementary Appendix Table 2**).

The scores obtained by therapists and patients in the subscales test evaluating the perception of empathy and support after the face-to-face sessions were compared with those obtained after the remote sessions by taking the Student's *t*-test. Therapists do not show significant differences in perceiving themselves capable of offering empathy and support in the two types of settings evaluated. Patients, on the other hand, perceive therapists to be significantly more empathic and supportive in the remote setting (see **Supplementary Appendix Table 3**).

The two subscales allow an assessment of the agreement between patient and therapist. Overall, 980 observations were made for both subscales. With regard to the ESPS, the percentage of concordance of the responses between patient and therapist in remote sessions is 70.7%, significantly higher than the percentage of agreement (62.9%) found in face-to-face sessions. Similarly, for the ESNS, the percentage of agreement in remote sessions (82.9%) is significantly higher than that detected in-person (71.7%) (see **Supplementary Appendix Table 4**).

These data have no significant correlation with the psychopathological aspects of the patients.

DISCUSSION

This study was the second phase of a larger research in which the first step was to evaluate the degree of satisfaction of an Italian sample of psychotherapists in the use of VCP during the COVID-19 emergency (Cioffi et al., 2020). In that previous phase, the attention to the relational aspects, according to the theoretical and methodological background of the psychotherapist, was found to be an element capable of fostering the therapist's perceived satisfaction using VCP. For this reason, in this second phase, we hypothesized that the level of affective attunement and more widely the degree of empathy between the members of the psychotherapist-client dyad has specific characteristics and represents an efficacy factor for the success of the treatment. However, due to the small number of participants, we are still in an exploratory phase of the results.

In particular, during the current pandemic, the degree of empathy among the members of the psychotherapist-client dyad, as well as the degree of support perceived by the patient during the session, were analyzed. Successively the sessions in-person were compared with those online, in order to discriminate the

specific characteristics of digital empathy. What emerged from the Student's *t*-test, comparing the scores obtained by therapists and patients to the two ESS subscales after both the face-to-face sessions and the remote sessions, was really amazing. The therapists did not show significant differences in perceiving themselves as capable of offering empathy and support in the two types of settings evaluated. Patients, on the other hand, perceived therapists to be significantly more empathic and supportive in the remote setting.

This surprising finding is consistent with the results of another online group psychotherapy study (Weinberg, 2021). The authors pointed out that some group members may benefit from online groups more than in person, although they affirmed the online format is not for everyone. These pieces of evidence reinforce what has already been demonstrated about the effectiveness of this psychotherapeutic format and how the therapeutic alliance seems to be achievable also online.

The "personal predisposition" variable is certainly important and yet we believe that this was a self-selection feature of the field because many colleagues with a little predisposition to the use of telematics tools have not initiated treatments in a remote setting. Furthermore, in our previous study (Cioffi et al., 2020), we found that the therapists who liked and felt the effectiveness of the intervention at a distance were mainly those who had previously used this technique. Our previous findings are confirmed by other pieces of evidence that suggest psychotherapists' attitudes toward online psychotherapy are influenced by their past experiences (such as clinical experience and previous online psychotherapy experience) as well as their transition experience during the pandemic and their geographic location (Békés and Aafjes-van Doorn, 2020).

In another study that evaluated the effects of the telepsychological format on empathic accuracy and therapeutic alliance, there were no statistically significant differences between the conditions on the therapist's empathic accuracy or the therapeutic alliance. Attitudes toward telepsychology and empathic accuracy were both significant predictors of alliance in telepsychology delivery formats. The authors also argued that empathic accuracy may be a more important process for clients receiving services in the telepsychological format, so further investigation is needed (Reese et al., 2016).

We, on the other hand, focused on the subjective experience of the patient, as it is documented in the literature that the client's empathic perception measures represented a more accurate measure of the empathic relationship and, in general, they were able to predict a good outcome client (Elliott et al., 2018). Already several studies had overwhelmingly supported the idea that the therapeutic alliance could be developed during VCP, highlighting how clients, with different diagnoses, valued bonding and presence at least as strongly as face-to-face (Simpson and Reid, 2014). In another study coming from telemedicine, no differences were found between telemedicine and in-person visits in the patient's perception of the physician's empathy in acute stroke care. Therefore, the authors concluded that, in a telemedicine meeting, in the context of acute stroke care, empathy does not require physical touch or physical proximity to be transmitted, but can also be transmitted only through facial expression, vocal intonation, and attentive participation (Cheshire et al., 2020).

During the current pandemic, recent studies advise that VCP can lead to a renewal of the concept of the therapeutic relationship, i.e., it offers a powerful pathway for clients to experience improved chances for self-expression, connecting, and closeness. In particular, this presupposes that, during the VCP, people would find the chance to have a more neutral psychotherapeutic "place," where they could have more occasions for self-awareness, creative experience, and collaboration and at the same time feel they were more capable of acting on their own experience (Simpson et al., 2020).

In our study, the fact that patients feel psychotherapists are more empathetic and more capable of providing support in the online sessions cannot fail to take into account the particular moment due to the pandemic. In fact, due to the pandemic, face-to-face sessions do not enjoy the same comfort as online sessions and many patients say that. Currently, the in-person sessions are carried out with masks, plexiglass dividers, and the safety distances are strongly maintained. This is not the usual psychotherapy setting. Especially the patients who were already in treatment know the difference, they know that due to the pandemic, the psychotherapy setting has had to undergo changes to the detriment of comfort. Therefore, in agreement with what was found by Cheshire et al. (2020), we can affirm that facial expression, vocal intonation, and attentive participation are very important variables able to condition and influence the empathy perceived by the patients. In this sense, we could say that the patients in the study feel much more understood and supported by their psychotherapists during the online sessions because they can perceive facial expressions, intonations of voice, and compassionate attention of their psychotherapists, i.e., even though they speak through the PC screen, they do it without any security filters.

Moreover, to explain this result we can tap into the differences between face-to-face empathy and empathy mediated by a digital device. Authors found similar characteristics comparing digital empathy with that in the usual face-to-face setting (Friesem, 2016a,b; Terry and Cain, 2016). In particular, according to Friesem, digital empathy explores the ability [. . .] to have a sense of identity and agency (self-empathy), the latter seems to be a specific feature of digital empathy and leads us to reflect: During a VCP session, the therapist, thanks to the web camera, can observe her/himself and her/his expressions, as well as the patient and her/his expressions, this fact makes the therapist more aware of his/her behaviors and expressions, which sharpens her/his awareness process in offering help to the other and probably increases her/his capability to be supportive, compassionate, and empathic.

It is surprising to note the fact that the percentage of concordance of the responses between patient and therapist to the two ESS subscales in remote sessions is significantly higher than the percentage of agreement found in face-to-face sessions. First of all, these data did not show any correlation with

psychopathological aspects present in the patients. They describe the presence of a great therapeutic alliance between patients and psychotherapists in the online setting. It is generally known in the existing literature that the concordance index in the perception of empathy and support between patient and therapist is an element capable of predicting a good alliance between the two members of the couple as well as being predictive of a good outcome of the psychotherapeutic process. In our study, these data are really interesting and deserve further investigation. First of all, it allows us to affirm that VCP not only works but that it can be an adequate setting capable of promoting successful psychotherapy paths, in our study it even seems to work better than the face-to-face setting. Keeping aside for a moment the particular event created by the pandemic, it is certainly possible to say that adequate levels of empathy and support, which are functional to the success of the outcome, can also be achieved in a psychotherapeutic setting that involves the presence of a digital medium, such as a PC, a tablet, or smartphone. Therefore, even if the potential of online psychotherapy is still underestimated, we can say that online psychotherapy can be a good complement to face-to-face psychotherapy rather than a substitute for it (Longobardi et al., 2018).

Probably, in our study, the greater empathy and support perceived by patients can be explained by the fact that VCP allows a better and more channeled perception of those parameters other studies found to be fundamental to being empathic. Some of such parameters certainly include giving adequate attention to facial expressions and vocal intonation (Maldonato et al., 2018).

CONCLUSION

This paper describes the results coming from the second step of an already implemented study which, in the first phase, evaluated the degree of satisfaction of a sample of Italian psychotherapists in the use of VCP during the COVID-19 emergency, in a condition that has never occurred in the history of psychotherapy research.

In the previous phase, the theoretical and methodological backgrounds were found to be elements capable of fostering the therapist's perceived satisfaction using VCP.

For this reason, in this second phase, we hypothesized that the level of affective attunement and more widely the degree of empathy between the members of the psychotherapist-client dyad had specific characteristics and represented an efficacy factor for the success of the treatment, and also in the online setting.

Therefore, in order to discriminate the specific characteristics of digital empathy, we analyzed the degree of empathy between psychotherapist and client, as well as the degree of support perceived by the patient from his/her psychotherapist, through comparing the sessions in-person with those online, during the COVID-19 pandemic.

What emerged from comparing scores obtained by therapists and patients to the two subscales was amazing: Unlike the psychotherapists, the patients perceived their therapists as significantly more empathic and supportive in the remote setting.

These are rather important data, because the literature documents that client empathic perception measures represent a more accurate evaluation of the empathic relationship and, in general, can predict a good outcome.

Although these results need further investigation, they represent an important contribution in filling the scientific gap in the understanding of digital empathy. In fact, the characteristics and mechanisms underlying digital empathy are still too little studied and little known.

The innovation of this research is to highlight the real impact of digital empathy in the use of VCP, making it possible to obtain new contributions in an area that is still little known and investigated. We can conclude this study provides new insights for future research on the characteristics of empathy and the influence it has on the practice, the efficacy, and the good outcome of remote psychotherapy.

One of the limitations of the study, due to the still small size of the sample, concerns the impossibility of correlating the results relating to perceived empathy with individual aspects.

In particular, although we collected data relating to the digital setting (the quality and type of devices used, quality of internet connection, chosen location, etc.), the psychopathological characteristics, the personal predisposition of the subjects to be empathic, and the limited small size of the sample did not allow us to discriminate the significant differences between subjects regarding these variables.

In the literature, there are pieces of evidence about the fact that online therapy is more suitable for some types of patients than others (people with mobility problems, people with anxiety disorders, people who fear social stigma, people who have time constraints as managers or professionals, those who often move their residence for study or work reasons, those who are socially isolated for different reasons) (Longobardi et al., 2018; Cioffi et al., 2020), so it would be interesting to explore if and how these preferences could influence empathic perception.

Moreover, for future developments of this research, it might be a good idea to analyze the variability due to geographical and temporal differences in the experiences of the COVID-19 pandemic.

The current pandemic has made it necessary to change the setting of many therapeutic processes in progress. This study has collected the good satisfaction of patients in this change of setting in favor of the online one and certainly stimulates reflection on the opportunities that the online setting offers. The latter calls each psychotherapist to the challenge of adapting their clinical practice to changes in society, expanding the internal debate on the specificities of each model of remote work.

We intend to use these provisional results obtained from this first phase in the subsequent phases to explore further how empathy works in the online setting and what its specific features are, in order to improve the psychotherapists' ability to exploit technologies and meet the psychological needs of clients in online settings.

In particular, to understand better which are the specific characteristics of the digital affective attunement process (Maldonato et al., 2017, 2018; Sperandeo et al., 2018), in the next

step we intend to measure and compare the degree of tuning of psychophysiological parameters such as skin conductance, oxygen saturation, blood pressure, and heart rate. The detection of such psychophysiological parameters will take place through specific devices to obtain measurements both in in-person and remote settings.

DATA AVAILABILITY STATEMENT

The original contributions presented in the study are included in the article/**Supplementary Material**, further inquiries can be directed to the corresponding author.

ETHICS STATEMENT

The studies involving human participants were reviewed and approved by Consiglio del Dipartimento 11/26.05.2020 Prot. n. 46540. The patients/participants provided their written informed consent to participate in this study.

AUTHOR CONTRIBUTIONS

RS, VC, EM, TL, YA, and LM contributed to conception and design of the study. VC organized the database. RS and VC performed the statistical analysis. DC, CG, MA, and RS wrote the first draft of the manuscript. BM, CS, and NM wrote sections of the manuscript. All authors contributed to manuscript revision, read, and approved the submitted version.

SUPPLEMENTARY MATERIAL

The Supplementary Material for this article can be found online at: https://www.frontiersin.org/articles/10.3389/fpsyg.2021.671790/full#supplementary-material

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Remote Psychotherapy During the COVID-19 Pandemic. Experiences With the Transition and the Therapeutic Relationship. A Longitudinal Mixed-Methods Study

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Aims: Research conducted prior to the onset of the COVID-19 pandemic indicates that remote psychotherapy is as effective as in-person treatment. At that time, it usually was the therapist's individual choice to work remotely, whereas the pandemic pushed psychotherapists, including previous skeptics, to incorporate remote work methods into their routine due to limited face-to-face contact. There is little knowledge of the way therapists experienced this sudden and forced transition to remote psychotherapy as the only treatment option. The present study aims to assess psychotherapists' experience and proficiency delivering remote psychotherapy as well as to investigate perceived changes in the psychotherapeutic relationship.

Methods: An online survey was administered to psychotherapists of the Austrian Association for Group Therapy and Group Dynamics (ÖAGG). Three test periods (t) were set (t1: April, 2020 with N = 175; t2: May–June, 2020 with N = 177; t3: November–December, 2020 with N = 113). Research was conducted longitudinally using a mixed-methods research design.

Results: While psychotherapists' levels of experience with telephone-based psychotherapy remained similar across all test periods, they became slightly more experienced using video therapy over the test period observed. However, they continued to feel less experienced compared to the use of telephone-based psychotherapy. The therapeutic relationship appeared to improve over the course of the first two test periods, while the third period showed a slight decline. No general deterioration of the psychotherapeutic relationship was found in the timespan studied.

Conclusion: Despite many challenges and concerns, psychotherapists seem to adapt and enhance their skills in remote psychotherapy over time. The present paper confirms and enhances previous findings in the field due to its longitudinal approach. Remote psychotherapy can be a credible and trustworthy alternative to in-person treatment to

be adopted and implemented on principle by a majority of psychotherapists regardless of their orientation. Furthermore, it sheds light on chances, problems und general observations regarding the comprehensive provision of remote psychotherapy in a pandemic situation.

Keywords: remote psychotherapy, COVID–19, psychotherapeutic relationship, mixed method approach, videotherapy

INTRODUCTION

The onset of the COVID-19 pandemic sparked an unprecedented embrace of virtual health care technologies (Webster, 2020; Wind et al., 2020). Similar to most countries around the world, the first COVID-19 lockdown in Austria was imposed in mid-March 2020. The public healthcare system, which had not previously covered remote psychotherapy, quickly and unbureaucratically introduced partial reimbursement of remote psychotherapy (ÖBVP, 2020). Previously viewed with skepticism by many psychotherapists (Connolly et al., 2020), remote psychotherapy suddenly became routine practice for ongoing and new psychotherapies (Probst et al., 2020; Höfner et al., 2021a; for an overview see Wind et al., 2020). Research conducted prior to the onset of the COVID-19 pandemic indicates that remote psychotherapy is as effective as in-person treatment (Barak and Grohol, 2011). The efficacy of cognitive-behavioral approaches in remote psychotherapy is supported by many trials and respective meta-analyses (Mohr et al., 2008, 2012; Carlbring et al., 2018; Poletti et al., 2020). According to reviews by Poletti et al. (2020) and Markowitz et al. (2021), fewer data are available on psychodynamic, humanistic-existential or systemic psychotherapeutic approaches. In Austria, all of the above are equally accredited with the health care system (BMSGPK, 2020). The pandemic presented a unique opportunity to investigate how psychotherapists of various orientations dealt with the forced shift to remote psychotherapy, as numerous publications already show (Humer et al., 2020; Korecka et al., 2020; Höfner et al., 2021b; Mantl et al., 2021; Probst et al., 2021). The present study examined psychotherapists' experience of the sudden transition to remote psychotherapy and how possible changes to the psychotherapeutic relationship were perceived between March and November 2020. Psychotherapists of humanistic, psychodynamic and systemic orientations participated in this study.

AIMS

The first aim was to quantitively assess psychotherapists' levels of experience with the transition to remote psychotherapy and how capable they felt in its delivery during the pandemic. The study secondly aimed to qualitatively investigate perceived changes to the psychotherapeutic relationship by posing the open question "What changes in the therapeutic relationship do you perceive with the use of remote psychotherapy?" Research was conducted longitudinally with three test periods using a mixed-methods research design in order to cover both areas of interest.

STATE OF THE ART

Remote Psychotherapy

Despite considerable skepticism by many clinicians and patients (Connolly et al., 2020), mounting empirical evidence over the last three decades points to the effectiveness of remote psychotherapy and the emerging body of studies is very promising for most clinical conditions (Mohr et al., 2012; Carlbring et al., 2018; Swartz, 2020). Most research considers remote psychotherapy to be roughly equivalent to in-person treatment in its efficacy (Sucala et al., 2012; Poletti et al., 2020). As a limitation, it is frequently mentioned that participants in surveys on remote psychotherapy might be more computer-savvy and have a positive attitude toward remote psychotherapy; accordingly, this may lead to a positive bias as far as results are concerned (Markowitz et al., 2021).

As with most psychotherapy research, literature on remote psychotherapy is dominated by the cognitive-behavioral field (Poletti et al., 2020; Markowitz et al., 2021). Weinberg (2020) assumes that cognitive-behavioral forms of treatment are better suited for remote psychotherapy than treatments which focus on interaction and the psychotherapeutic relationship. According to Ogden and Goldstein (2020), relational therapist-patient interaction, especially non-verbal processes, which can largely be missing in remote psychotherapy, play a minor role in CBT. However, the body of research on psychodynamic and relational approaches which focus on interaction, transference and relational aspects indicates that these, too, can be effective via remote psychotherapy (Gordon et al., 2015; Dennis et al., 2020).

Markowitz et al. (2021) point out that, prior to the onset of the COVID-19 pandemic, research on remote psychotherapy was frequently conducted with selected populations (e.g., HIV-positive patients, war-veterans or women with postpartum depression in rural areas), often as an adjunct to in-person psychotherapy. The situation has fundamentally changed now. Wind et al. (2020) highlight that the present pandemic amounts to an unforeseen event which changes the ways we think, practice and research online mental-health care. A study by Boldrini et al. (2020) with psychotherapists of different orientations in Italy at the first peak of the pandemic in early 2020 unexpectedly shows CBT practitioners experiencing significantly more therapy interruptions than their psychodynamic colleagues when implementing remote psychotherapy. This comes as a surprise to the authors, since CBT practitioners had been deemed more up to task with remote psychotherapy and its implementation. A recent study by Humer et al. (2020) examined experiences of psychotherapists

across four different psychotherapeutic orientations accredited in Austria: psychodynamic, humanistic-existential, systemic and behavioral. Interestingly, it appears that psychodynamic and humanistic psychotherapists had better experiences with remote psychotherapy than their behavioral or systemic colleagues.

In light of the above, remote psychotherapy is a credible and trustworthy alternative to be considered and adopted by psychotherapists regardless of their orientation. It provides mental-health care in times of crises such as the COVID-19 pandemic and allows for treatment and supervision when in-person contact is not possible due to large geographical distances (Markowitz et al., 2021). Furthermore, it increases accessibility for hard-to-reach patients who may not attend in-person sessions due to certain pathologies such as social anxiety or simply a tight schedule (Simpson et al., 2021). Reduced financial and time cost is another key point frequently mentioned in favor of remote psychotherapy (Poletti et al., 2020).

Therapeutic Relationship

Therapeutic alliance and relationship are crucial factors for the effectiveness of the therapeutic process (Wampold and Imel, 2015). The carefully handled therapeutic relationship is an indispensable prerequisite for specific interventions and techniques such as transference interpretation, exposure or desensitization (Norcross and Lambert, 2019). In a systematic review, Sucala et al. (2012) point out that remote psychotherapy seems to be equivalent to in-person treatment in terms of therapeutic alliance as part of the psychotherapeutic relationship. Simpson et al. (2021) reviewed a number of studies showing that the quality of crucial factors of the psychotherapeutic relationship such as empathy and working alliance was not significantly different in remote psychotherapy compared to in-person treatment.

However, psychotherapists who suddenly had to deliver remote psychotherapy without training during the COVID-19 pandemic have reported challenges and constraints in establishing and maintaining the therapeutic relationship: Feelings of isolation in sessions, technical problems, difficulties maintaining the therapeutic attitude, rapid fatigue as well as feelings of lack of self-confidence and effectiveness (Békés and van Doorn, 2020; McBeath et al., 2020; Höfner et al., 2021a; Messina and Löffler-Stastka, 2021). According to MacMullin et al. (2020), reduced sensory perception of the person, the situation and the patient's whole body, could pose a risk to the therapeutic relationship in emotionally charged situations. Markowitz et al. (2021) indicate that some patients perceive video therapy as an invasion of their privacy, that remote psychotherapy as a whole lacks the safe-space setting outside of the patients' own, sometimes-precarious living situations. Furthermore, distractions and disturbances caused by family members may occur and the lack of warm-up and cool-down phases when traveling to and from the clinician's office may impair the therapeutic process.

Conversely, it has been shown that in remote psychotherapy some patients are able to be more open and feel safer, they may perceive the setting in front of the screen in their own familiar environment as more at eye level and less confrontational (Simpson et al., 2021). According to the authors, evidence suggests that for some patient groups, e.g., those with anxious-avoidant personality structure, for whom in-person contact is overwhelming, remote psychotherapy yields better results than in-person treatment. Even though psychotherapists experienced some professional self-doubt or anxiety and worry about technicalities and therapeutic relationship in the early phase of the pandemic in 2020, they reported a relatively good working alliance and strong real relationship with their patients in a remote setting (Aafjes-van Doorn et al., 2020). Despite reports of more directive and talkative behavior, a study by Mancinelli et al. (2021) shows an overall positive self-perception in psychotherapists.

MATERIALS AND METHODS

Study Design

Three test periods were set with the first (t1: April, 6th–April, 30th 2020) during the first lockdown in spring 2020, the second (t2: May, 12th–June, 14th 2020) when restrictions were lifted and the third (t3: November, 20th–December, 19th 2020) when lockdown came into force again in fall 2020 due to the second wave of COVID-19 infections. Psychotherapists of the Austrian Association for Group Therapy and Group Dynamics (ÖAGG) were sent a link to an online survey via SoSciSurvey. This survey contained a combination of 55 open and closed questions addressing fears and concerns of participants and their experiences with the transition to remote psychotherapy. Items and questions were developed by the authors of the present study. In addition, standardized questionnaires to assess quality of life (WHOQOL-BREF; Angermeyer et al., 2000), resilience (CD-RISC-10; Sarubin et al., 2015), and affectivity (PANAS; Janke and Glöckner-Rist, 2014) were included. The survey was conducted in German language and subsequently translated for the present paper. The study was analyzed using a combination of quantitative and qualitative approaches. The addition of open questions enabled the research team to gather further information on psychotherapists' individual experiences which might have been overlooked in a purely quantitative study. The questionnaire remained unchanged over the first two test periods. For the third test period, some questions were removed and those asking for "experiences over the last 3 weeks" were changed to ask for "experiences from November 2nd, 2020, onward" in order to specifically explore experiences of the November 2020 lockdown. In Austria, remote psychotherapy was not implemented in the health-care system until the pandemic emerged; thus, the study didn't examine experiences with this modality before the transition.

The survey's design allowed for the collection of a wide range of sociodemographic and other variables such as age (in 5-year categories), sex, marital status, main residence, highest level of education, psychotherapeutic experience and orientation as well as type and extent of employment before and during the COVID-19 pandemic. As the pandemic and accompanying restrictions presented an exceptional situation, data regarding psychotherapists' personal wellbeing were gathered, including

questions around their activities, emotions, thoughts and general health. In addition, the survey asked participants to assess thematic changes and experiences with specific work techniques in remote treatment, as well as gathering information on the number of hours worked, changes to patient numbers and sociodemographic variables regarding their patients. The items comprised of check boxes and scales of 1–5, several open questions for qualitative analysis were posed, allowing participants to type in their answers. The present paper focuses on psychotherapists' experiences with the transition and changes to the therapeutic relationship, whilst other aspects of the study have been published separately by Höfner et al. (2021a; 2021b) and Mantl et al. (2021).

Ethical and Legal Considerations

Participation in the survey was voluntary, confidential and anonymous, and could be discontinued at any time without disadvantage. Participants were informed of the purpose of the present research project. The authors could be contacted in case of difficulties completing the survey, however, none of the participants made use of this offer. The data collected was stored and analyzed electronically in accordance with the legal requirements. All researchers able to access the data were subject to the Data Protection Regulation (DSGVO) and its currently valid Austrian adaptation. Data was not passed on to third parties or countries outside the EU. Participants were made aware of the estimated time required to complete the questionnaire. In order to proceed with the survey, they had to confirm they were over the age of 18 and consent to the use of their data as outlined above. The participants provided their written informed consent to participate in this survey. In accordance with the local legislation and institutional requirements, no further ethical review or approval was required for the present study.

Participant Demographics

Currently, 23 psychotherapy methods are accredited in Austria. They comprise of four overarching orientations: psychodynamic, humanistic, systemic and behavioral (BMSGPK 2020). Compared to the distribution across Austria, the humanistic orientation is overrepresented in the present study over all three test periods with a participation rate of over 69%. The survey was administered to psychotherapists of the Austrian Association for Group Therapy and Group Dynamics (ÖAGG) and behavioral therapists are not part of this professional association. Thus, behavioral therapists did not participate in the present study.

175 online questionnaires were completed in full for the first test period t1, 79.4% of participants identify as female, 20.6% as male. 54 participants (30.9%) were still in training under supervision at the time of the survey. 177 online questionnaires were completed in full for the second test period t2. 79.1% of participants identify as female, 20.9% as male. 57 participants (32.2%) were still in training under supervision at the time of the survey. 113 online questionnaires were completed in full for the third test period t3. 77.0% of participants identify as female, 23.0% as male. 20 participants (17.7%) were still in training under supervision at the time of the survey. 25 psychotherapists who participated across all three test periods were identified based on the correlation and repetition of certain criteria (gender, age group, federal state, education, marital status, psychotherapeutic orientation). Of these, 76.0% of participants identify as female, 24.0% as male, 6 participants (24.0%) were still in training under supervision at the time of the survey. For further details on the therapist characteristics (see **Table 1**).

Quantitative Analysis—Experiences With the Transition

Statistics

The quantitative analyses were computed with SPSS 18.0. To measure experiences with the transition, psychotherapists were asked for their perceived levels of experience with remote psychotherapy on a scale of 1–5, with 1 representing minimal experience and 5 representing maximal experience. The same scale was used to ascertain the perceived level of experience in the use of individual types of media for remote psychotherapy. Medians were calculated based on the ordinal scale level. Since the requirements for the analysis of variance were not met, Friedman tests were used to verify if the central tendencies of the dependent samples t1, t2 and t3 differed. Based on significant differences, subsequent *post hoc* tests were applied using the asymptotic Wilcoxon test and Cohen's (1992) d calculations as a measure of effect size. For all analyses, the significance level was set at $p \leq 0.05$. A within-subject design was chosen. With regard

TABLE 1 | Selected sociodemographic variables of the psychotherapists.

		t1		t2		t3	
Variable		***N***	**%**	***N***	**%**	***N***	**%**
Sex	Female	139	79.4	140	79.1	87	77.0
	Male	36	20.6	37	20.9	26	23.0
	Diverse	0	0	0	0	0	0
Age	25–29 years	2	1.1	0	0	0	0
	30–34 years	8	4.6	5	2.8	4	3.5
	35–39 years	22	12.6	16	9.0	13	11.5
	40–44 years	29	16.6	25	14.1	11	9.7
	45–49 years	24	13.7	23	13.0	17	15.0
	50–54 years	33	18.9	25	14.1	19	16.8
	55–59 years	29	16.6	44	24.9	25	22.1
	60–64 years	12	6.9	21	11.9	15	13.3
	>64 years	16	9.1	18	10.2	9	8.0
Psychotherapeutic orientation	Psychodynamic	18	10.3	15	8.5	11	9.7
	Humanistic	122	69.7	132	74.6	82	72.6
	Systemic	32	18.3	25	14.1	17	15.0
	Missing entry	3	1.7	5	2.8	3	2.7
Year of approbation	Under supervision before approbation	54	30.9	57	32.2	20	17.7
	1–11 years	59	33.7	49	27.7	53	46.9
	12–23 years	31	17.7	33	18.6	15	13.3
	>23 years	31	17.7	38	21.5	25	22.1

Sociodemographic variables; t1–t3, test periods; N, sample size; %, percentage of participants.

to certain criteria (gender, age group, federal state, education, marital status, psychotherapeutic orientation) after completion of the surveys, 25 matching cases from t1, t2, and t3 could be manually identified in terms of a measurement repetition and were subsequently used in the statistical analyses.

Results

The vast majority of participants transitioned to remote psychotherapy at the onset of the COVID-19 pandemic, with 92% of respondents reporting the use of remote psychotherapy to treat patients at t1 and 75.1% at t2. When restrictions were lifted in May and June 2020, a large proportion of therapists continued its use, with a further increase to 85% at t3 in November and December 2020. Results show psychotherapists feeling "very experienced" in delivering remote psychotherapy at t1 ($M = 3.75$, $SD = 1.03$), at t2 ($M = 3.90$; $SD = 1.02$) and at t3 ($M = 3.88$, $SD = 1.02$) with a median of 4. A slight increase in level of experience appears from t1 to t2 and t3. There is no statistically significant difference when considering the measured values from the 25 matching cases identified [Friedman test: $\chi^2(2) = 0.59$, $p = 0.747$, $N = 25$].

Examining differences in psychotherapists' levels of experience offering telephone-based psychotherapy at all three test periods, results show them feeling "extremely experienced" at t1 ($M = 4.26$, $SD = 0.99$), at t2 ($M = 4.37$, $SD = 0.77$) and at t3 ($M = 4.28$, $SD = 0.94$) with a median of 5 at all three test periods. There appears to be no statistically significant variation regarding the level of experience delivering telephone-based psychotherapy across the test periods [Friedman test: $\chi^2(2) = 4.44$, $p = 0.109$, $N = 25$].

The results regarding video therapy show psychotherapists feeling only "rather experienced" at t1 ($M = 2.95$, $SD = 1.30$) and at t2 ($M = 3.28$, $SD = 1.18$), with a median of 3. At t3 ($M = 3.38$, $SD = 1.15$) psychotherapists perceive themselves as "experienced" in video therapy with a median of 4. Over the period of t1 and t2 as well as between t1 and t3, a slight increase in the perceived level of experience was reported. No statistically significant difference was observed when considering the measured values from the 25 matching cases identified [Friedman test: $\chi^2(2) = 1.49$, $p = 0.476$, $N = 25$].

Upon examination of participants' level of experience using laptop or desktop computers, tablets or iPad, results show that at t1 ($M = 3.61$, $SD = 1.14$), at t2 ($M = 3.93$, $SD = 0.93$) and at t3 ($M = 3.81$, $SD = 1.00$) the respondents feel "experienced" with a median of 4 at all three test periods. There was no statistically significant difference in the use of laptop or desktop computers, tablets or iPad across the test periods [Friedman test: $\chi^2(2) = 2.35$, $p = 0.309$, $N = 25$].

Regarding the level of experience using web-based applications (Skype, Zoom, Facetime, WhatsApp, Signal, TheraPsy Connect, Instahelp, Telegram, Threema, fair-meeting, Jitsi Meet), the descriptive statistics show the participants feeling inexperienced at t1 ($M = 1.83$, $SD = 0.47$), slightly more experienced at t2 ($M = 1.99$, $SD = 0.52$) and at t3 ($M = 2.10$, $SD = 0.51$). With a median of 2, participants feel "inexperienced" with web-based applications across all test periods. The increasing trend shows a statistically significant difference when considering the measured values from the 25 matching cases identified [Friedman test: $\chi^2(2) = 6.71$, $p = 0.035$, $N = 25$]. The level of experience using these specific applications is significantly higher at t3 than at t1. Subsequent *post hoc* tests show that the level of experience using these specific applications is significantly higher at t3 than at t1 (asymptotic Wilcoxon test: $z = -2.70$, $p = 0.007$, $N = 25$). The statistical effect size is Cohen's (1992) $d = 1.28$, corresponding to a large effect. There is no significant difference in psychotherapists' experience with these specific apps between t1 and t2 (asymptotic Wilcoxon test: $z = -1.95$, $p = 0.051$, $N = 25$) or t2 and t3 (asymptotic Wilcoxon test: $z = -1.54$, $p = 0.125$, $N = 25$). **Table 2** presents these results. **Figure 1** illustrates changes to the perceived level of experience with different media and modalities.

Qualitative Analysis—Changes in the Therapeutic Relationship

Qualitative Content Analysis

Perceived changes in the therapeutic relationship were explored via the open question "Which changes in the therapeutic relationship do you perceive with the use of remote psychotherapy?" Some participants chose to respond in complete sentences, while others used keywords, phrases or lists.

The text content was analyzed by means of Qualitative Content Analysis (Mayring, 2015). The distinguishing feature of this method is its research-question-oriented procedure with a category-based approach, which additionally allows for quantitative analysis when required. Categories refer to certain aspects of the text analyzed, based on common denominators within the content of these aspects (Mayring, 2019). Several techniques for evaluation may be applied within the framework, the present study used a combination of structuring and inductive category formation. The software tool ATLAS.ti. 8.0 was used to process participants' responses, supporting the development of categories using systematic coding. The initial step comprised the deduction of central factors in the psychotherapeutic relationship based on the findings outlined in the "State Of The Art" section of the present paper in order to structure the content. Considering these points of reference, changes of the quality of the therapeutic relationship and perceived constraints handling the therapeutic relationship appeared to be the most important issues to the authors of the present study.

Based on this initial structure, inductive category formation was used to analyze the data. Subcategories were developed to expand the category system accordingly. In order to define inductive subcategories, the text material was analyzed line by line to see which concepts stood out and were repeated in the text. From the resulting lists of concepts, further categories were developed inductively, with statements of similar content subsumed in the respective categories. Each category was labeled with a term or short phrase highlighting the content. Any responses not suited for assignment to an existing category led to further expansion of the categories used. Answers not fitting any subcategories were grouped into the category "other". Ultimately, three main categories were formed: (1) Changes

TABLE 2 | Changes to the perceived level of experience with remote psychotherapy, different media and modalities during the transition over all test periods.

	t1			t2			t3			Changes t1–t3			
Item	***N***	***M***	***(SD)***	***N***	***M***	***(SD)***	***N***	***M***	***(SD)***	χ^2	***p***	***| d |***	***N***
Perceived level of experience delivering remote psychotherapy	175	3.75	(1.03)	177	3.90	(1.02)	113	3.88	(1.02)	0.59	0.747	–	25
Level of experience delivering telephone-based psychotherapy	175	4.26	(0.99)	177	4.37	(0.77)	113	4.28	(0.94)	4.44	0.109	–	25
Level of experience delivering video therapy	175	2.95	(1.30)	177	3.28	(1.18)	113	3.38	(1.15)	1.49	0.476	–	25
Level of experience using PC etc.	175	3.61	(1.14)	177	3.93	(0.93)	113	3.81	(1.00)	2.35	0.309	–	25
Level of experience using web-based applications	175	1.83	(0.47)	177	1.99	(0.52)	113	2.10	(0.51)	6.71	0.035*	1.281[1]	25

*The Psychotherapists' perceived levels of experience with remote psychotherapy were measured on a scale of 1–5, with 1 representing minimal experience and 5 representing maximal experience. Therefore, the means only could assume values between 1 and 5. N, sample size. M, mean. SD, standard deviation. t1–t3, test periods. p, Significance level. *Significant mean difference $p < 0.05$. | d |, Cohen's d.*

[1] *Large effect between t1 and t3.*

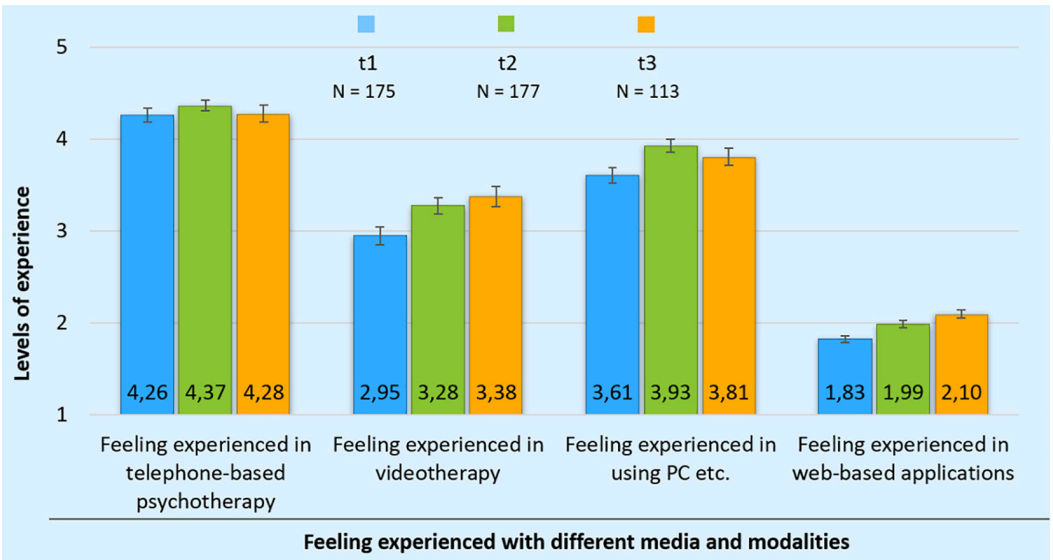

FIGURE 1 | Changes to the perceived level of experience with different media and modalities during the transition over all three test periods. Value "1" represents complete inexperience and value "5" an extremely high level of experience. N: sample size; t1–t3 test periods.

in the perceived quality of the psychotherapeutic relationship, comprising five subcategories; (2) Perceived constraints handling the therapeutic relationship, comprising four subcategories; (3) Summarized answers that did not indicate any changes to the psychotherapeutic relationship (see **Table 3**).

Results

Responses across the three test periods reported changes in the quality of the therapeutic relationship (t1: 90, t2: 92, t3: 63). A considerable number of responses indicated an increased intensity in the psychotherapeutic relationship at the onset of the COVID-19 pandemic and the transition to remote psychotherapy. However, a substantial decrease in intensity toward time period three (t1: 24, t2: 26, t3: 9) was noted. Some answers suggest that patients were able to open up more easily when speaking to their psychotherapist (t1: 4, t2: 9, t3: 7).

"For some people it even seems to be a relief to talk on the phone, different topics which are very shameful arose and thus became addressable", one psychotherapist wrote.

Psychotherapists continuously experienced a feeling of distance (t1: 16, t2: 14, t3: 17) and the psychotherapeutic relationship via remote psychotherapy was reported to feel more superficial (t1: 12, t2: 9, t3: 9).

"By using online tools, I think there is a greater emotional distance.", the relationship is "much harder to deepen, remains superficial."

A sense of togetherness based on the shared experience of the pandemic seemed to be important with the onset of COVID-19 but vanished with test period three (t1: 8, t2: 4, t3: 0). Nevertheless, the use of remote psychotherapy does preserve the psychotherapeutic relationship beyond mere keeping in touch, although a decrease in responses to that effect was noted (t1: 6, t2: 4, t3: 2). Psychotherapists also reported changes to their style of working across all three test periods:

"As a therapist, I often experience myself as 'overly active' to the point of just 'giving advice'."

During test period two, some responses indicated that therapists were very much looking forward to a return to

TABLE 3 | Main categories, selected subcategories and numbers for each test period t1–t3.

Main category	Subcategory	t1	t2	t3
Quality of the therapeutic relationship changes		90	92	63
	Psychotherapeutic relationship intensifies	24	26	9
	Patients are able to open up more	4	9	7
	Psychotherapeutic relationship feels more distant	16	14	17
	Psychotherapeutic relationship feels more superficial	12	9	9
	Other	34	34	21
Perceived constraints handling therapeutic relationship		80	42	64
	Full-sensory perception of the person and situation	22	9	11
	Empathizing with the patient	5	2	9
	Establishing and maintaining contact	4	4	1
	Technical problems	9	2	6
	Rapid fatigue and exhaustion	6	2	4
	Other	34	23	29
No changes of the therapeutic relationship		29	23	30

in-person treatment (t1: 0, t2: 7, t3: 0). A few participants noticed an increase in patients' concern for their therapist's wellbeing in the early stages of the pandemic. An increased inhibition or restraint on the patient's side was reported in some cases. A small number of responses indicated a reduced commitment in their patients, which was attributed to the use of remote psychotherapy. Occasionally, psychotherapists noticed a distinct change in the quality of the psychotherapeutic relationship at test periods one and two, reporting a degree of regression in their patients. Across the three test periods, psychotherapists frequently reported differences in psychotherapeutic relationship but no clear definition of the term "different" was given in many of the responses.

Across all three test periods, respondents experienced constraints regarding the psychotherapeutic relationship (t1: 80, t2: 42, t3: 64). These were primarily attributed to a decreased sensory perception (t1: 22, t2: 9 t3: 11) and difficulties to properly empathize with their patients during remote treatment (t1: 5, t2: 2, t3: 9). Psychotherapists found it harder to get to know their patients and maintain contact when using remote psychotherapy. One participant noted, "Building rapport is clearly more difficult." Test period three showed a decrease in the difficulty establishing contact (t1: 4, t2: 4, t3: 1). Participants attributed the perceived constraints to the lack of a physical encounter (t1: 2, t2: 1, t3: 5). "These tools never replace real contact", one psychotherapist wrote. Difficulties regarding initial interviews and keeping up the flow of the conversation were reported. Technical issues were perceived as potentially harmful to the quality of the therapeutic relationship and led to stress in treatment (t1: 9, t2: 2, t3: 6):

"Because of poor technical connection, [I] stress when establishing the connection", one psychotherapist reported.

Some participants experienced difficulties establishing the psychotherapeutic process, reporting an increased effort on their side. Few answers indicated an increased risk of therapy discontinuation at test period three (t1: 0, t2: 0, t3: 2). Occasionally, constraints were experienced in psychotherapy with children. Some responses pointed to the risk of not being able to pay sufficient attention due to the use of remote technologies. A few respondents mentioned blurred roles within remote psychotherapy and found it harder to cope with silence when on the phone compared to in-person treatment. Respondents continuously noted increased difficulties regarding their own mental and physical functioning (t1: 6, t2: 2, t3: 4). Some symptoms described were fatigue, eye pain or headaches. One participant commented on remote psychotherapy in comparison to in-person treatment: "I find it exhausting."

A considerable number of respondents reported no changes in the psychotherapeutic relationship due to the use of remote psychotherapy (t1: 29, t2: 23, t3: 26).

DISCUSSION

Remote psychotherapy might pose a challenge to the psychotherapeutic relationship and setting, particularly when it suddenly is the only option for treatment (Aafjes-van Doorn et al., 2020; Békés and van Doorn, 2020; Crowe et al., 2021; Höfner et al., 2021a; Messina and Löffler-Stastka, 2021). The longitudinal effects of a forced provision of remote psychotherapy were the primary interest of the present study. The vast majority of participants started to deliver remote psychotherapy with the onset of the COVID-19 pandemic. When restrictions were lifted at test period t2, most respondents continued to work remotely. At test period t3 in November and December 2020, with lockdown in effect again, the use of remote psychotherapy slightly increased, even though it was legally possible to offer in-person treatment in Austria at that time. Whether this was due to health concerns or remote psychotherapy being perceived as an effective means of treatment is beyond the scope of the present study. While the perceived proficiency in telephone-based psychotherapy remains relatively stable across all test periods, psychotherapists feel slightly more experienced with video therapy over the test period observed. However, psychotherapists remain less experienced using video therapy compared to telephone-based psychotherapy, which comes as no surprise. Telephone-based communication is often used in psychotherapeutic crisis intervention, therefore many therapists were familiar with it prior to the pandemic. Despite a significant improvement from t1 to t3, participants still feel rather inexperienced using web-based applications across all test periods. This might be cause for concern since a large proportion of remote psychotherapy is now delivered via web-based applications and videoconferencing tools in particular (Markowitz et al., 2021).

In line with previous findings (Sucala et al., 2012; Simpson et al., 2021), no general tendency toward a deterioration of the quality of the therapeutic relationship due to remote psychotherapy can be observed in the current study. This is relevant, as it disproves some prejudices critically discussed by Wind et al. (2020), particularly the notion that the therapeutic alliance can only be established in in-person treatment. Simpson et al. (2021) point out that some patients feel safer and may even talk more openly with remote psychotherapy. The present study shows this to be the case, too. Remarkably, the quality of the therapeutic relationship seems to improve during the first two test periods. Positive and negative changes in the psychotherapeutic relationship were reported in roughly equal amounts for test period t1 in the qualitative part of the survey. In the second test period t2, positive changes outweighed the negative. As some answers suggest, the mutual experience of clinician and patient going through the pandemic may have intensified the psychotherapeutic relationship; the shared outlook of getting through this together during the first lockdown in Spring 2020 might have contributed to this phenomenon. Nevertheless, these longitudinal findings are encouraging compared to cross-sectional surveys conducted at the first peak of the pandemic (Aafjes-van Doorn et al., 2020; Békés and van Doorn, 2020; McBeath et al., 2020). Surprisingly, many answers at t1 but only a few at t2 indicate that psychotherapists suffer from constraints regarding full-sensory perception of their patients during remote psychotherapy sessions. Psychotherapists seem to adapt and enhance their skills in remote psychotherapy over time, as Mancinelli et al. (2021) have similarly observed in Italian psychotherapists during the pandemic. With curfews imposed again at test period t3 in Fall 2020, the previously positive attitude changed. More constraints in handling the psychotherapeutic relationship were reported and the intensity of the therapeutic relationship seemed to slightly decrease, being perceived as becoming more superficial. This could indicate a time limit regarding the possibility of maintaining a therapeutic relationship via remote therapy, especially with psychotherapists very much untrained in this modality. In addition, from an affective neuroscience perspective, perceived physical distance has an impact on empathic reactions (Schiano Lomoriello et al., 2018), making it difficult to maintain the relationship over time, which could be the reason why participants in the present study found it hard to be empathic with the patient during the last time period t3. As pointed out by Cao et al. (2020) and Boldrini et al. (2021), psychosocial sequelae of the COVID-19 pandemic had a considerable impact on society and thus on clinicians and patients, presumably making it harder to keep up with the therapeutic relationship in Fall 2020. It is up to future research to determine if and how this could be improved by more specific training and supervision in remote psychotherapy, especially under non-pandemic conditions.

LIMITATIONS

A number of limitations in this study need to be addressed. The selection of psychotherapists could be a potential source of bias, as no representative sample was collected. Research conducted using online surveys may always be biased because psychotherapists who are open to electronic data processing and the use of online tools tend to participate (Markowitz et al., 2021). Accordingly, they may report a more positive experience and feedback on remote psychotherapy compared to a representative sample of psychotherapists. The link to the questionnaire was only administered to psychotherapists of the Austrian Association for Group Therapy and Group Dynamics (ÖAGG) via e-mail. The ÖAGG comprises of psychodynamic, humanistic-existential and systemic psychotherapists. Compared to the Austrian distribution as a whole, the humanistic-existential orientation was overrepresented and no behaviorally oriented psychotherapists took part. Another limitation regarding the analysis of the results was that no data are available on the situation prior to the involuntary transition to remote psychotherapy with the present sample. Furthermore, compared to t1 (N = 175) and t2 (N = 177), fewer responses were received with t3 (N = 113). This might be cause for bias, meaning the number of responses in the qualitative part in particular must be interpreted in light of this for t3. In a further limitation, the participants' ages were disregarded when evaluating their experience of web-based applications. No additional demographic data such as age or sex were controlled for the results in the analyses.

CONCLUSION

To conclude, psychotherapists of different orientations seem well able to meet the challenges of delivering remote psychotherapy when it is the only option. The current results confirm and enhance previous findings: Remote psychotherapy can be a credible and trustworthy alternative to in-person treatment to be adopted and implemented on principle by a majority of psychotherapists regardless of their orientation. However, difficulties described in literature, such as establishing and maintaining the therapeutic relationship (Cataldo et al., 2021) have been observed in the present study. Constraints regarding full-sensory perception and technical issues might play a considerable role in this, as well as problems with exhaustion or rapid fatigue, remaining attentive in front of a screen and missing physical encounter, as frequently reported in previous research (Békés and van Doorn, 2020; McBeath et al., 2020; Markowitz et al., 2021). Fortunately, psychotherapists seem to adjust and grow more comfortable over time when delivering remote treatment. This indicates that better training and education regarding remote therapy would enable psychotherapists to handle these challenges and use electronic media more confidently (Connolly et al., 2020; Grondin et al., 2020). Ultimately, this would also benefit patients, as it has been frequently shown that self-confidence and positive self-perception on the psychotherapist's side correlates with positive treatment outcome (Wampold and Imel, 2015). Psychotherapists need to continue to adapt but also require specific support measures from health care stakeholders and training institutions so that high quality treatment can be achieved.

DATA AVAILABILITY STATEMENT

The datasets presented in this article are not readily available because data are subject to the Data Protection Regulation (DSGVO). Requests to access the datasets should be directed to corresponding author.

ETHICS STATEMENT

Ethical review and approval was not required for the study on human participants in accordance with the local legislation and institutional requirements. The patients/participants provided their written informed consent to participate in this study.

AUTHOR CONTRIBUTIONS

CH, GM, and MH: conceptualization. GM, JS, and CH: methodology, formal analysis, investigation, and data curation. RS: writing—original draft preparation. RS, GM, and KP: writing—review and editing. All authors have read and agreed to the published version of the manuscript.

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Conflict of Interest: The authors declare that the research was conducted in the absence of any commercial or financial relationships that could be construed as a potential conflict of interest.

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Loss of Rituals, Boundaries, and Relationship: Patient Experiences of Transition to Telepsychotherapy Following the Onset of COVID-19 Pandemic

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Telepsychotherapy is an increasingly common way of conducting psychotherapy. Previous research has shown that patients usually have positive experiences of online therapy, however, with large individual differences. The aim of this study was to explore patients' experiences of transition from in-person psychotherapy sessions to telepsychotherapy during the COVID-19 pandemic, as well as variation in the experiences with regard to the patients' personality orientation. Seven psychotherapy patients in Sweden were interviewed and the transcripts were analyzed using thematic analysis. Additionally, the participants were asked to rate their dissatisfaction/satisfaction with the transition, how hindering/helpful the transition was, and how unsafe/safe they felt after the transition in comparison to before. Personality orientation on relatedness or self-definition was assessed applying a self-assessment instrument (Prototype Matching of Anaclitic-Introjective Personality Configuration; PMAI). The participants experienced telepsychotherapy as qualitatively different from in-person psychotherapy. They reported several essential losses: the rituals surrounding therapy sessions were lost, including the transitional time and space between their every-day life and the therapy sessions, less therapeutic work was done, the therapists could lose their therapeutic stance, the sense of rapport was impaired, and the patients felt less open and emotionally available. On the other hand, some patients could feel freer online. As six of the participants had an anaclitic personality orientation, the present study could especially contribute to the understanding of how patients with strong affiliative needs and fear of abandonment experience the transition to meeting their therapists *via* communication technology. The participants' self-ratings showed that they were only marginally dissatisfied with the transition and experienced the transition as slightly hindering, whereas they felt rather safe after the transition, indicating low concordance between qualitative and quantitative evaluations. New studies are needed to explore the introjective patients' experiences of the transition. An essential topic is also to collect evidence and to test how the impaired sense of rapport when using communication technology can be remedied by adequate, patient-tailored interventions, a topic that has to be included in psychotherapy education and training.

Keywords: remote psychotherapy, online therapy, communication technology, patient experiences, personality orientation, therapeutic boundaries, therapeutic relationship, thematic analysis

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INTRODUCTION

In spring 2020 the world was hit with the COVID-19 pandemic, which took many lives and forced the whole world to readjust to a new reality. With the aspiration to minimize spread of infection, restrictions were made worldwide. In March 2020, the Public Health Agency of Sweden (Folkhälsomyndigheten [The Public Health Agency of Sweden], 2020) recommended that everyone that could should work from home, as well as urging workplaces to find remote alternatives to in-person interactions. Simultaneously, the World Health Organization (WHO, 2020) declared the psychological consequences of the pandemic as a public health issue, stressing that it was critical that people in need of mental health treatment would still have access to treatment in an infection-proof setting, and the United Nations (2020) recommended mental health services to be delivered online. Accordingly, the COVID-19 pandemic has brought with it a rapidly increased use of telepsychotherapy, confronting many patients and therapists with the need of reliance, for the first time, on means of communication technology.

American Psychological Association (2013) defined telepsychology as the provision of psychological services using telecommunication technologies. According to a systematic review (Yue et al., 2020), remote care services play a central role in treating mental health consequences of infectious disease outbreaks, such as COVID-19 pandemic; however, there is a need of recognizing the limitation of such teleservices. Previous research shows that different modalities of remote psychotherapy (using phone, audio or video internet connection, or chat) are effective in reducing symptoms in a wide range of mental disorders, such as depression, anxiety, PTSD, and panic disorder (Foroushani et al., 2011; Andersson et al., 2019a,b; Bennett et al., 2020; Lindegaard et al., 2020; Lindqvist et al., 2020). At a group level, patients' experience of telepsychotherapy is often positive; nevertheless, there is a large variation at the individual level (Simpson, 2001; Simpson et al., 2005; Leibert et al., 2006; Bennett et al., 2020; Watts et al., 2020).

After the outbreak of COVID-19 pandemic, a growing number of studies focused on effects of forced transition to telepsychotherapy. In a survey on the experiences of 141 therapists in United States who transitioned to providing video therapy during the pandemic (Aafjes-van Doorn et al., 2021) the responders reported some anxiety and self-doubt. However, most felt that online sessions had a sufficient working alliance and a strong real relationship. Therapists with more online therapy experience, lower levels of self-doubt and anxiety, and those who experienced a strong online real relationship during the pandemic, or thought their patients viewed it positively, tended to be more accepting of video therapy. Likewise, a survey among 150 Israeli therapists (Nuttman-Shwartz and Shaul, 2021) showed that the more experience therapists had, the less they perceived the current situation as a threat to both themselves and their patients ("shared traumatic reality"). According to a worldwide survey among 1,490 psychodynamic therapists (Gordon et al., 2021), the therapist's empathy, warmth, wisdom, and skillfulness, and the patient's motivation, insightfulness, and level of functioning were considered as more important to effective psychotherapy than the differences between in-person and remote therapy.

In contrast to these survey results, therapists report several hindering, both practical and emotional, factors in the transition to telepsychotherapy. Safeguarding the therapeutic frame became more problematic. It could be difficult for the patients to have access to an undisturbed room with a stable internet connection. They could be distracted by things in their everyday life or be engaged in doing household chores during the remote session, turning therapy into a practical ingredient in everyday life, where the emotional closeness was lost (Dolev-Amit et al., 2021; Rizq, 2020). There was a risk of developing a certain relational distance when the communication technology provided limited sensory information about the patients' emotional presence (Ronen-Setter and Cohen, 2020). This might in turn also make the therapist more distant (Dolev-Amit et al., 2021).

Furthermore, the therapists and their patients might have discordant views of the transition. For example, according to an Austrian survey (Probst et al., 2021) the therapists reported using fewer therapeutic interventions in remote therapy than in in-person therapy, whereas the patients did not report any differences. Additionally, patients with different characteristics might have different experiences of the forced transition to telepsychotherapy. Some of them can experience telepsychotherapy as impersonal and distanced, whereas others can be less self-conscious and more open in remote sessions (Simpson, 2001; Simpson et al., 2005; Chen et al., 2021). Patients with generalized anxiety disorder in cognitive behavioral therapy *via* videoconferencing reported a better working alliance than patients in face-to-face psychotherapy (Watts et al., 2020). For some patients with severe depression or PTSD, the physical distance in telepsychotherapy can contribute to them feeling safer and more confident in the therapist, whereas patients with greater needs for the therapists' presence for emotional regulation and safety might feel more challenged in telepsychotherapy (Chen et al., 2021).

Extensive research has shown that personality characteristics influence what patients are looking for when seeking psychotherapeutic help, how they make use of therapy, and how helpful different forms of therapy are for them (Blatt et al., 2001; Blatt and Shahar, 2004a,b; Blatt and Luyten, 2009; Levander and Werbart, 2012; Werbart and Levander, 2016; Werbart et al., 2020). According to Blatt's (2008) empirically supported theoretical "double helix" model, psychological development is a lifelong interplay between two basic dimensions in human experiences: the anaclitic orientation on interpersonal relatedness (ability to develop empathic, reciprocally attuned relationships) and the introjective orientation on self-definition (ability to establish a coherent, realistic, differentiated and positive sense of self). A good balance between these two dimensions is a prerequisite for mental well-being; in contrast, different forms of psychopathology reflect an exaggerated and distorted preoccupation with one of them (Blatt and Luyten, 2009; Luyten and Blatt, 2013; Luyten et al., 2013). Higher levels of anaclitic and introjective orientation roughly correspond to attachment anxiety and attachment avoidance, respectively (Meyer and Pilkonis, 2005; Mikulincer and Shaver, 2007;

Luyten and Blatt, 2011), whereas low levels on both dimensions, together with an anaclitic-introjective balance, are connected with secure attachment (Werbart et al., 2016).

Predominantly anaclitic patients often seek psychotherapy for relational problems and usually adapt fast to the psychotherapeutic setting. Their main complaints include a sense of helplessness, loneliness, and a fear of abandonment. In therapy, they look for warmth and care, and they are often helped by more supporting interventions. Predominantly introjective patients usually seek therapy for issues regarding control, performance, and not being in contact with their emotions. Their main complaints center on excessive self-demands, feelings of inferiority, and fear of failure and criticism. They tend to keep others at a distance and make the best use of interpretative interventions in psychotherapy. Consequently, anaclitic patients seem to value and are more responsive to the quality of the therapeutic relationship, whereas introjective patients lay emphasis on increasing their understanding of themselves (Blatt and Shahar, 2004b; Blatt and Luyten, 2009; Levander and Werbart, 2012; Luyten and Blatt, 2013; Werbart and Levander, 2016; Werbart et al., 2017, 2020; Hennissen et al., 2020). Anaclitic patients seem to benefit more from therapy with a greater relational focus on interaction in a face-to-face setting, where the therapist and patient can see one another, whereas introjective patients seem to benefit more from psychoanalytic therapy with a greater focus on insight and self-reflection, lying on the couch, where the patient does not see their therapist (Blatt et al., 1988, 2007, 2010; Blatt, 1992; Blatt and Ford, 1994; Blatt and Shahar, 2004b). Furthermore, anaclitic patients are described as profiting from a warm and caring therapeutic relationship, whereas introjective patients are described as striving to interpret the therapist's non-verbal expressions and adjust to them in order to maintain their sense of control, ultimately avoiding shame and guilt (Blatt, 1991, 2008; Blatt and Ford, 1994; Blatt and Shahar, 2004a,b; Blatt et al., 2010). Thus, personality orientation can affect how well patients function in different forms of psychotherapy.

Experiences from clinical practice and supervision, as well as recent publications at the onset and during the COVID-19 pandemic (cf. Chen et al., 2021; Ehrlich, 2021; Essig and Isaacs Russell, 2021; Isaacs Russell, 2021) indicate that different patients reacted different to the transition. Some of them were lacking the direct in-session contact, physical presence at the same place, and the own time on the way to and from the therapist's office, and found it difficult to maintain a good enough therapeutic relationship online. Others were relieved not to have to travel, not to sit in the same room, and they could "open up" more than previously in the ordinary psychotherapy setting.

To sum up, the patient perspective on the transition to telepsychotherapy is still underexplored and most of the recent publications are based on therapist reports (e.g., Chen et al., 2021; Rizq, 2020; Essig and Isaacs Russell, 2021; Isaacs Russell, 2021; Sayers, 2021; Weinstein, 2021). There is still an urgent need of more research on which patient characteristics can contribute to more positive or more negative experiences of the transition, how these characteristics affect the treatment process and outcome, as well as in what circumstances telepsychotherapy might be a viable alternative to in-person psychotherapy. COVID-19 pandemic gave us a unique opportunity to explore for which patients the customary in-person psychotherapy setting with the patient and the therapist co-present in the same room is the treatment of choice, and for which patients remote therapy using communication technology might be more favorable.

The present study aims to examine patients' experiences of the transition from conventional in-person psychotherapy to telepsychotherapy, using video or audio communication technology, during the COVID-19 pandemic, and how the patients' personality orientation might influence these experiences. Based on previous research we assume that the effects of transition from in-person psychotherapy setting to telepsychotherapy will be experienced as more positive and facilitating by the predominantly introjective patients with their main focus on autonomy and performance, and as more negative and hindering by the predominantly anaclitic patients with their main focus on relatedness and intimacy.

MATERIALS AND METHODS

Participants

The initial goal was to recruit 12–15 participants for this study, with an equal amount of persons with anaclitic and introjective personality orientation, respectively. However, due to difficulties in finding enough participants who met all the inclusion criteria during the time frame of the study, the number of included participants stayed at seven. Inclusion criteria were that the participants must have been in psychotherapy during the COVID-19 pandemic 2020–2021 with a licensed psychologist or psychotherapist at least once a week during at least 4 weeks before transitioning to at least four sessions of telepsychotherapy. Recruitment was carried out through posters and advertising in social media, with a Facebook advert that reached 25,000 users. Despite the large number of people who viewed the advert, only 15 persons signed up for the study and eight of these were excluded because they did not fulfill all inclusion criteria. Of the seven included participants, five were female and two were male. Participants' age ranged from 27 to 51 (M = 33). Three participants were in cognitive-behavioral therapy, further three in psychodynamic therapy, and one participant did not know the therapeutic orientation. In five cases the transition to telepsychotherapy was initiated by the therapist and in two cases by the patient. Four participants were still in telepsychotherapy at the time of the interview, and one was back to in-person psychotherapy. Three participants were no longer in psychotherapy. All participants had been in telepsychotherapy through video link. Two of them had only video sessions, whereas five participants had both video and telephone sessions, of which two used both communication channels equally, two mostly used video and in exceptional cases telephone, and one participant initially used video link and later on preferred telephone. No data on the focus in psychotherapy were collected. All participants gave their informed consent before inclusion in the study. The consent forms were collected online applying the platform Survey and

Report, provided by the Stockholm University for research with human subjects.

Data Collection

Data were collected in March–April 2021 through semi-structured interviews, self-report scales regarding the experience of the transition to telepsychotherapy, and for assessment of personality organization. The interviews were conducted online using Zoom platform audio, lasted about 45 min, and were audio-recorded. The interviewers were the second and the third author, at the time of the study students in the final semester of the Swedish 5-year clinical psychology program (psychodynamic orientation). Each interviewer conducted three or four interviews. The self-report instruments were e-mailed to the participants, who completed them and subsequently brought them to the interview. When the qualitative interview was completed the participant reported their self-ratings.

Interviews

An interview protocol was developed to address the participants' experiences of the transition. The aim of the semi-structured interviews was to collect the participants' accounts covering the following areas:

- What kind of communication technology was used?
- How the decision on the transition to remote therapy was made.
- Positive and negative experiences of the transition.
- Hindering and helpful aspects of the transition.
- How the transition affected the therapeutic relationship, the therapy process and the experienced outcome.

The participants were asked to give specific examples and to elaborate their answers. The interviews ended with a question if there are another experienced aspects of the transition that the participant and the interviewer did not talk about.

Self-Ratings of Experiences of the Transition to Telepsychotherapy

In order to have some quantitative self-assessment of the participants' experiences of the transition they were asked to assess on 7-point Likert scales (a) how dissatisfied/satisfied they were with the transition, (b) how hindering/helpful the transition was, and (c) how unsafe/safe they felt after the transition in comparison to before. These scales were constructed for the present study and were used only for descriptive purposes and not for statistical analyses.

Prototype Matching of Anaclitic-Introjective Personality Configuration

The participants' personality orientation was assessed using Prototype Matching of Anaclitic-Introjective Personality Configuration (PMAI), a self-assessment form that presents prototypes for anaclitic and introjective personality orientation (Werbart and Forsström, 2014; Werbart and Levander, 2016). The prototype-matching method generates both categorical and dimensional assessments. The participants were asked to rate on a 5-point Likert scale how well they recognized themselves in each prototype and to specify which of the two prototypes that best corresponded with their own view of themselves. Because our aim was to compare anaclitic and introjective participants, the PMAI results were used to categorize the participants into predominantly anaclitic or predominantly introjective orientation. Cases were sorted as anaclitic or introjective, following the highest score on one of the two dimensions, and following the categorical self-assessment in cases when both dimensions were rated equally.

Analysis

The data were analyzed applying a rigorous qualitative methodology following Braun and Clarke (2006, 2013) six steps for thematic analysis. This was supplemented with a descriptive analysis of quantitative self-assessments of experiences of transition and of personality orientation.

The first step in the thematic analysis was familiarizing oneself with the data, which included transcribing and reading the material as well as taking notes. The next step was initial coding of the interview transcripts, conducted by the person who did not conduct the coded interview, thus being blind of the participants' self-assessments and keeping an inductive stance in the analysis. The third step was made jointly by both interviewers, bringing the codes from the individual coding together and developing preliminary themes. These preliminary themes were reworked and discussed to form more comprehensive themes. In the fourth step the themes were evaluated and compared with the initial codes and original data. Main themes and subthemes were sorted and a visual thematic map was created. In the fifth step all themes were defined and labeled with the aim of capturing the essence of the themes while still being clearly differentiated from other themes. The themes were then re-evaluated, comparing them once again with the original data. The sixth step was compiling a preliminary report and selecting quotes best illuminating each theme.

The guidelines from Hill et al. (2005) were used for indicating the frequency of each theme. Themes occurring amongst all or all but one participant were labeled *general*; themes occurring amongst more than half of participants were labeled as *typical*; and themes occurring amongst at least two up to half of the participants were labeled as *variant*.

The thematic analysis was complemented by a categorization of each participant's overall view of the transition to telepsychotherapy as *positive*, *mixed, and negative*. This judgment was made by the interviewers separately and then discussed until a consensus could be reached.

RESULTS

All participants described both positive and negative experiences of the transition. However, the participants expressed a general dissatisfaction with the transition, experiencing telepsychotherapy as less effective than regular psychotherapy. All participants uttered a wish to meet their therapist in person,

although one participant would have preferred to also have some of the sessions *via* telephone. The qualitative analysis showed that the already established safe relationship with the therapist worked as a buffer during the transition.

Themes of Transition

Thematic analysis resulted in seven main themes and 14 subthemes, together illuminating different facets of the transition (**Table 1**). All themes are presented below in order of their frequencies and illustrated by verbatim quotations from the interviews. Each quotation is followed by an indication in square brackets of the participant' personality orientation ([A] = anaclitic, [I] = introjective). All of the main themes were categorized as general, with an exception for the typical theme *5. Feeling freer*.

1. Loss of Therapeutic Rituals

This general theme captures how the therapy room as a physical and geographical place enhanced the experienced value of the therapy. The participants described how the therapy room became something more than simply a room and that the travel to and from therapy gave opportunity to thoughtfulness and reflection. They reported how routines surrounding their customary therapy became rituals helping them in transition to a more receptive state of mind. Loss of these rituals and of the intermediate room and time made the therapy feel less important and less valuable.

1.1. The Therapy Lost Some Value

Generally, the participants experienced less mental and emotional investment in telepsychotherapy. The material conveys a general feeling that the therapy was less charged when on distance. Customary in-person therapy was experienced as something exceeding everyday chores, and there was a sense of solemnity in the participants' descriptions of co-present work. Telepsychotherapy was less valued and was perceived as a routine and something to check off a list. The sessions felt like any other remote meeting and lost the quality of being something special.

> It was like "okay, I have therapy this Thursday, so then I'll be going there," so I scheduled it and made sure that I maybe didn't have too many demanding businesses afterward. . . but I could squeeze in that call during lunch at work when we had remote therapy. So then it became less. . . sort of less valuable. [A]

1.2. Loss of the Therapeutic Space

Generally, the participants experienced that the therapy lacked something essential when the usual therapy room was unavailable. The physical space also created a mental space, a neutral area demarcated from everyday life and allowing all kinds of thoughts and feelings. In telepsychotherapy, the setting always could be affected by something else. The process of traveling from everyday life to the therapist's office also created a mental process of leaving everyday life behind and entering the time and space of therapy. As expressed by one of the participants: "Like, in a [therapy] room there is much more. . . emotions. And also that it is somewhere else. That it's not. . . like a totally blank sheet that you get to go into." [A]

2. Less Therapeutic Work

Generally, the participants experienced that the frame alternation restricted the range of therapeutic work. This was not experienced as the therapist's intention but rather as a consequence of the online mode being new to them as well. Some exercises that had been part of customary in-person therapy fell away, the therapist's role changed, and the therapeutic boundaries became more ambiguous. There was a feeling that the therapy was lacking a movement forward and that some therapeutic aspects were lost.

2.1. The Therapist Lost Their Therapeutic Stance

Generally, the participants described how the therapist's approach to them changed in a way implying loss of the therapeutic attitude. The sessions were more like speaking with a friend, and the asymmetry constituting the therapeutic relationship was reduced. The conversations were more like socializing and the therapist became more self-disclosing. Such more friendly conversations could be experienced as less demanding and give a feeling of getting closer to the therapist, even if the participants questioned how therapeutically effective this was. The therapists became less exploring and less confronting, more absent-minded, and involved in something else, as doing cleaning or other home activities. This could be expressed as criticism from the participants, but often regarded as a natural consequence of the changed format.

> Well, it actually felt like it came from her! Because she started talking more like. . . or maybe it was me as well, but it felt a little bit like she was more. . . that the borders were more blurred for her as well. And that she started talking more like. . . chill talk. And she told me more about her life. . . I feel like that's nice as well, and that it might make me be more relaxed, but maybe it was a bit. . . I don't know if it was a huge problem, but it was a bit too much of it. [A]

2.2. Being Less in Focus

Typically, the participants felt that they no longer received the therapist's full attention. The therapeutic work was less centered on them as individuals and their problems; it was harder to highlight their needs and dare to confront the therapist. A feeling of abandonment colored the material, where participants felt uninteresting and replaceable to their therapist. Feeling no longer prioritized, they could be jealous and disappointed:

> When we last spoke it felt a bit like he didn't remember. . . like... I have quite a messy life right now, but he didn't quite remember what my life is like. And then I start to think "Is it because he has gotten more patients now or is it because. . ." well like "because we are at a distance now?" [A]

2.3. Blurred Therapeutic Boundaries and Methods

As a variant, the participants experienced that the therapeutic frames and working methods became vaguer, as if remote therapy lost its focus and direction. There was also more uncertainty regarding duration and frequency of therapy sessions. The

TABLE 1 | Themes and subthemes in the participants' experiences of transition to telepsychotherapy.

Theme	Frequency			Label
	A (*n* = 6)	I (*n* = 1)	Total (*n* = 7)	
1. Loss of therapeutic rituals	6	1	7	General
1.1. The therapy lost some value	6	1	7	General
1.2. Loss of the therapeutic space	6	1	7	General
2. Less therapeutic work	6	1	7	General
2.1. The therapist lost their therapeutic stance	6	0	6	General
2.2. Being less in focus	3	1	4	Typical
2.3. Blurred therapeutic boundaries and methods	3	0	3	Variant
3. Impaired sense of rapport	6	1	7	General
3.1. Impaired communication	4	1	5	Typical
3.2. Increased relational distance	6	1	7	General
4. Being less emotionally available and open	6	1	7	General
4.1. Feeling less emotionally present	5	1	6	General
4.2. Being less open	4	1	5	Typical
5. Feeling freer	4	0	4	Typical
5.1. The therapy became less demanding	4	0	4	Typical
5.2. Feeling less self-conscious	4	0	4	Typical
6. The online setting was both helpful and hindering	6	1	7	General
6.1. It was more convenient	6	1	7	General
6.2. The technology was hindering	5	1	6	General
7. The therapy became essentially different	5	1	6	General

Frequencies of participants in each theme and subtheme for anaclitic and introjective participants and totally [labeled following Hill et al. (2005): General = 6–7; Typical = 4–5]; Variant = 2–3.

telepsychotherapy was experienced as more indistinct and lacking an explicit agreement about how the therapy was supposed to be carried through.

> Maybe it also was a bit unclear what the plan. . . we didn't really have a plan or so, I was mostly there and sort of talked about my sorrow and anxiety. But since we didn't have a real plan it was more like that [a more general conversation]. [A]

> He also actually eh. . . cut down on our time! [laughing] and I haven't dared to talk with him about that yet! [laughing] . . . because you usually have 45 min for each session. And the last two times he asked after 30 min about the next time and then at 35 min we closed down. . . That might not have been as easy for him to do with me in the usual room, I don't know. [A]

3. Impaired Sense of Rapport

Generally, the participants reported impaired bond with the therapist. They felt that something was lost in the relationship and that it was harder to communicate when they could not see or take in the whole person they were speaking with. It felt harder to reach each other and to meet one another in the dialog, and the feeling of sharing the therapeutic work with their therapist faded.

3.1. Impaired Communication

Typically, the participants experienced the communication was more difficult in online setting and they felt restricted to verbal channels. This made it harder both to convey their message and to perceive what the therapist is communicating. They lacked the capacity to make use of body language and felt that emotions were lost in technologically mediated communication.

> I think about that he can't asses my body language, intonation and facial expressions. . . . That you're very much in the words. And that is one of the things I have been working on a lot, to be less "in the words" and more in something else. . . So it becomes very like verbal. And it's just like one dimension, to me. [A]

> In some way it's like I have to rely more on what he says. Cause I can't catch . . . I can see that he reacts in a way that I KNOW is him expressing empathy . . .But I don't get the same feeling of it when I see it on the screen as if I'm in the same room. [I]

3.2. Increased Relational Distance

Generally, the participants described that the telepsychotherapy made the therapeutic relationship rather feeble and it was harder to be close each other. At times the therapist was perceived as dehumanized and unreal. The moments of here-and-now meeting were compromised and this could also change the relationship in general.

> It is that it's quite [laugh] dehumanizing. That the screen becomes like a. . . threshold or a wall. Like it's not the same contact as when you meet physically. Then it's more like . . . yes you could say it's almost like an avatar. [A]

> And then it becomes like that with the therapist as well. That that person becomes a bit unreal. If you're only a

> voice, or only a little flat. . . But I'm very like. . . I know how someone smells, I know how they move, and then it becomes an entirety . . .. If I can't get the whole it gets tough for me. [A]

4. Being Less Emotionally Available and Open

Generally, the participants experienced that it was more difficult to access the emotional content and to share one's experiences with the therapist. Online sessions became more intellectual and it was easier for the participants to avoid emotionally challenging topics.

4.1. Feeling Less Emotionally Present

Generally, the participants experienced less of emotional presence in the online sessions. They felt less vulnerable and could more easily distract themselves. This resulted in less of emotional content in the therapy and it took more effort to reach one's own susceptibilities.

> I think it's fairly okay. . . I mean it's nice being able to... but it is also a distraction [laugh] in the conversation, me trying to distract myself by doing something else. . . So I guess it feels good at that moment, but I realize that I'm distracting my thoughts and my body from troublesome feelings. [A]

4.2. Being Less Open

Typically, the participants felt less open in online setting than they had felt previously in customary in-person sessions. It was easier to keep in hiding and not to share some of their emotions and aspects of their personality with the therapist: "It might make me restrain myself more. This counteracts the therapeutic work of getting in touch with the feeling. That I try to actively inhibit it, because it doesn't feel as natural to express that emotion." [I]

5. Feeling Freer

Typically, the participants felt less self-conscious and restricted in remote sessions. They became freer in their thoughts and reasoning and they pondered less about the therapist's reactions. It was easier to talk and associate freely using only audio link and not being able to see their therapist. However, it was mostly the intellectual exchanges that became freer.

5.1. The Therapy Became Less Demanding

Typically, the participants felt freer due to the experience of reduced demands in telepsychotherapy. They did not experience the same pressure to deliver and claim their right to be there. The relationship with the therapist became more relaxed and the conversational climate more forgiving.

> Also, I felt less stressed before the meetings, with planning and such. . . that I didn't feel like "now I have to get as much as possible out of this since I took my time getting here" and so forth. So in this way it was a bit less demanding somehow when we had remote therapy. [A]

5.2. Feeling Less Self-Conscious

Typically, participants experienced less self-consciousness in remote sessions. Due to increased difficulty when interpreting the therapist's reactions, the participants felt that they could not adjust to the therapist to the same extent as before. The tools they previously used to check how they were perceived by their therapist were lost, releasing them of being preoccupied with the therapist's reactions and opinions.

> I mean, I could feel that when you're talking over the phone, I didn't have a visual impression and that made my thoughts flow more freely in a way. Because otherwise I tend to read into body language and facial expressions, and the other person's reactions. In a way it was somewhat relieving not having to do that. [A]

6. The Online Setting Was Both Helpful and Hindering

Generally, the participants felt that the technologically mediated communication was both helpful and hindering. The transition influenced first and foremost the therapeutic setting and the practical arrangement, but the very experience of the therapy was also affected.

6.1. It Was More Convenient

The participants generally expressed that the most conspicuous advantage of the remote setting was that the therapy became more accessible and flexible, both in terms of travel time and booking of sessions. The sessions that otherwise would have been canceled could still be fulfilled in the online setting. However, these advantages were generally experienced as not so crucial.

> A session nowadays really takes 45 min, but. . . I mean when I had to get there and so on it would take about one and a half hour or maybe more because I wanted to make sure I was on time. So the biggest thing is. . . regarding time and effort it's better. [A]

6.2. The Technology Was Hindering

Typically, the participants described that the use of communication technology could have a negative impact on the therapy. The need of equipment, technical difficulties and disrupted connection could obstruct the therapeutic work and make the therapy less available.

> I think it could have gotten worse due to, you know, technical disruptions... and I feel like it might be irritating to him, of course. Or like "oh, now FaceTime doesn't work, so we have to take it on the phone!"... so I think it had a negative impact. [A]

7. The Overarching Theme: The Therapy Became Essentially Different

Generally, the participants experienced telepsychotherapy as qualitatively different from customary in-person therapy. They described that the same therapeutic interventions generated completely different feelings when performed at a distance. According to one participant: "I do not get the same feeling when the feedback is *via* Zoom somehow. Even though I know that it is well meant, it doesn't feel as good somehow. . . [Even if] the verbal content is still exactly the same." [I]

This experience was difficult to define and put into words for the participants, and did not necessary imply that telepsychotherapy was inferior or superior to the usual setting,

only that it was a clear but indefinable and elusive difference: "It is something. . . Another tone, or another input. And perhaps mostly different dynamics." [A]

Interconnections Between the Themes

The themes that were identified in the material were connected and influenced each other in different ways (**Figure 1**). All the interconnected themes (1–6) contributed to and constituted the overarching, elusive experience of telepsychotherapy as something essentially different (7). At the same time, this quality of something different was present in all other themes, thus representing the core and distinctive aspect of the experience of transition.

The online setting was both helpful and hindering (6). It was more convenient (6.1) and practical without all the rituals surrounding the therapy sessions (1), but at the same time therapy lost some value when the intermediate space and time between everyday life and the therapeutic room was absent. Online communication and technological difficulties (6.2) contributed to an impaired sense of rapport (3) and disturbed the therapeutic work (2). This included therapists losing their therapeutic stance, the participants' feeling of being less in focus, and blurred therapeutic boundaries and methods. On the other hand, being less in focus could create a feeling of being freer (5). The therapy became less demanding and the participant felt less self-conscious. The diminished asymmetry in the relationship could be liberating as it created more relaxed atmosphere. Another aspect that contributed to the experience of less demands was the loss of therapeutic rituals (1). However, frame alternations implied that the therapy felt less valuable and there was less space for emotional presence and for reflection (4). Being less open and emotionally available (4) also made the therapeutic work more difficult and changed the patient-therapist dynamics (2), at the same time as the changed dynamics further reduced the emotional availability. As a result of the impaired sense of rapport (3) it was also more difficult to reach consensus regarding the therapeutic work, which could arose an uncertainty about the goals and means of therapy (2). Blurred therapeutic boundaries and methods made the work less therapeutic, which also reduced the feeling of the therapy as something important ongoing in a sheltered time and space (1).

Overall View of the Transition

The consensus judgments of the participants' overall views of the transition to telepsychotherapy, based on the interview material, showed that only one of them presented mainly positive experience, three had mixed, and further three had mainly negative experience. None of the participants expressed a solely positive or negative experience, but the participants assessed as mixed had more explicitly conflicting feelings toward the transition.

Self-Ratings

The overall results from the participants' self-ratings are located close to the middle of the 7-point Likert scales and show mixed experiences of the transition to telepsychotherapy. On the group level, the participants were slightly more dissatisfied than satisfied (M = 3.86; SD = 0.9; range 3–5), they experienced the transition as somewhat more hindering than helpful (M = 3.71; SD = 1.25; range 3–6), at the same time as they felt rather safe after the transition to the online setting (M = 4.29; SD = 1.25; range 3–6).

Personality Orientation and Experiences of the Transition

The self-assessments of personality orientation (PMAI) resulted in six participants categorized as predominantly anaclitic and one participant as predominantly introjective. Due to the skew distribution, no comparisons could be made with regard to personality orientation and the participants' overall positive-negative view of the transition as well as their self-rated satisfaction, helpful-hindering experiences and feeling safe-unsafe with the transition. However, we can note that the only one introjective participant is represented in most themes and subthemes, inclusive of the overarching, elusive experience of telepsychotherapy as something essentially different, but not in the theme *Feeling freer* (**Table 1**).

DISCUSSION

The Experience of Transitioning to Telepsychotherapy

Previous research could demonstrate that patients generally have a positive attitude toward psychotherapy online (Simpson, 2001; Simpson et al., 2005; Bennett et al., 2020; Watts et al., 2020). However, most of the relevant studies are based on treatments that from start were designed as online psychotherapy. Our study, focusing on the transition from the usual therapeutic frame to telepsychotherapy, partly shows the contrary. On the most general level, the participants' experiences of transition from the usual therapy setting to telepsychotherapy were marked by the diffuse and elusive feeling that it is something essentially different. This overarching feeling colored all the other interconnected themes that can be seen as embodied and more substantial concretizations of the issue "different how?" The frame alternation and online setting entailed multiple losses for the participants, such as loss of rituals surrounding therapy and of both the sheltered therapy room and the intermediate space and time between the borders of psychotherapy and the everyday life, making telepsychotherapy less cathected and valuable. When several communication channels, accessible with two bodies co-present in the same room, shrank to the screen and/or voice, the contact with the therapist was impaired, the distance in the relationship increased, and the participants felt less emotionally present and open. Less of therapeutic work could be done when the participants felt less in focus for the therapist and especially when the therapist lost their therapeutic stance. The participants' narratives include sometimes drastic descriptions of the therapist's boundary crossing, such as "hearing a spray and rubbing. . . hearing the therapist doing chores at home" and "getting a feeling that she was in several places at the same time." On the other hand, the participants could feel freer, meeting less demands and being less self-conscious. Attending

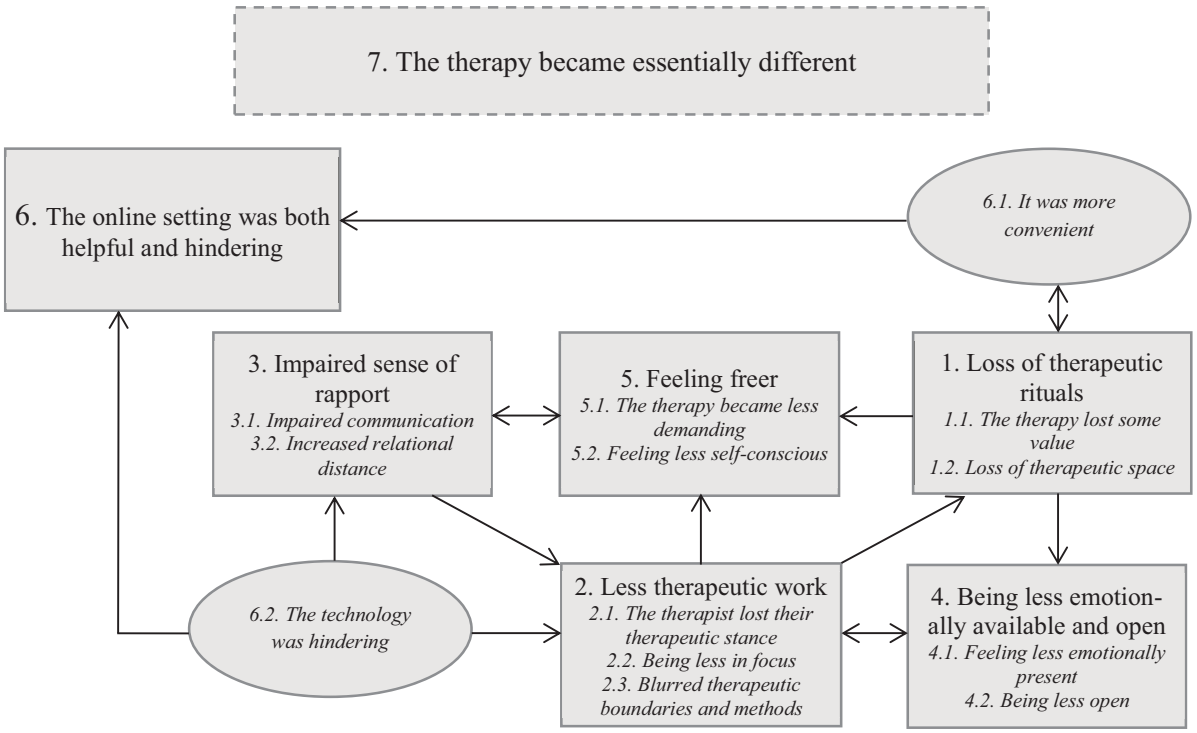

FIGURE 1 | A tentative model of interconnections between themes of transition.

therapy sessions *via* communication technology could be more convenient but impaired the sense of rapport with the therapist and made both parties more exposed for disturbances.

It is striking that several of the losses experienced by the participants in our study were also reported by therapists in several previous studies (cf. Dores et al., 2020; Rizq, 2020; Essig and Isaacs Russell, 2021; Isaacs Russell, 2021; Weinstein, 2021). In a parallel study (Ahlström et al., 2022), therapists experienced that the loss of the therapy room and of access to non-verbal nuances contributed to impaired contact with the patients and flatter conversations. For some of therapists, at least initially, remote therapy was simply a different therapy (cf. Migone, 2013). Telepsychotherapy could give a therapist unwanted access to their patients' private space—and give patients access to the therapist's location when not in their usual office—consequently alternating the patient-therapist dynamic (Isaacs Russell, 2021; Mitchell, 2021). Therapists could admit not being dressed appropriately while seeing their patients out of office (Weinstein, 2021) and report patients abandoning dress code (Sayers, 2021). Furthermore, therapists reported their patients' difficulties in protecting safe therapeutic boundaries (Isaacs Russell, 2021) and their own insecurity about the patient's actual presence (Chalker, 2021; Lichtenstein, 2021). In informal discussions and case presentations, therapists often refer to episodes of patients driving car, taking a stroll, or even answering text messages while in session. All the parallel losses experienced by patients and therapists can be seen as corollaries of the impossibility of co-presence of two bodies in the same therapy room and of restricted channels for implicit communication (Brahnam, 2017; Lemma, 2017; Roesler, 2017; Nebbiosi and Federici, 2021). Furthermore, these similarities can be linked to the patients and the therapists sharing the same reality, uncertainties, and fears (Escardó, 2021), the "shared trauma" of pandemic (Nuttman-Shwartz and Shaul, 2021; Tosone, 2021).

In the present study, the participants' self-ratings showed that they were only marginally dissatisfied with the transition and experienced the transition as slightly hindering, whereas they felt rather safe after the transition. In contrast, thematic analysis revealed several difficulties following the transition. Furthermore, the consensus judgments of the participants' overall view of the transition, based on the interviews, showed that only one of them had a mostly positive experience. This discrepancy between self-ratings and the interview material might be due to the nature of the data, where the interviews enable a more detailed and nuanced description of subjective experiences, whereas rating scales call for more global assessments expressed in numbers. This might suggest that frame alternations due to the transition did not alter the therapeutic experience as a whole, possibly due to the already established relationship to the therapist acting as a buffer. Nevertheless, the participants expressed their elusive feeling that it is something different with the telepsychotherapy. Likewise, the therapists seem to show a more positive attitude to telepsychotherapy in surveys and rating scales, even when reporting their short-term experiences (Békés and Aafjes-van Doorn, 2020; Dores et al., 2020), than in self-reports and interviews (cf. commentary on 18

papers on therapists' experiences and reflections from the first year of pandemic by Ellman and Vorus, 2021). The low concordance between qualitative and quantitative evaluations has also attracted attention in outcome studies (Desmet et al., 2021).

With regard to the therapeutic alliance in telepsychotherapy, previous research is not unanimous. A study of client perception of counseling from start designed as online treatment (Leibert et al., 2006) showed that they were generally satisfied and established good working alliance, however, not as satisfied and not as strong alliance as clients in face-to-face counseling. Similarly to our study of transitions to remote therapy, the main disadvantage was the loss of non-verbal cues and personal warmth, whereas the anonymity when disclosing shameful issues was the greatest advantage. In a study of cognitive behavioral therapy for generalized anxiety disorder delivered in videoconference (Watts et al., 2020) patients reported therapeutic alliance as stronger in telepsychotherapy than in conventional psychotherapy. In contrast, Kingsley and Henning (2015) hypothesized that a lack of face-to-face communication may limit the establishment of a strong therapeutic alliance and be a reason as to why telepsychotherapy does not always work. In our material, participants experienced blurred therapeutic frames, as there in many cases were no plain agreements about the goals and means of therapy after the transition. Furthermore, all participants reported increased emotional distance. Deficient agreement about the goals and means of telepsychotherapy, together with the impaired bond with the therapist, is actually impairing the working alliance, as defined by Bordin (1979). Sometimes, the increased relational distance could evoke an experience of the therapist as surreal or dehumanized. On the other hand, some participants perceived themselves as being closer to their therapist when having sessions over the phone. However, this closeness bore a stamp of unclear patient and therapist roles and of blurred boundaries, thus potentially obstructing effective therapeutic work. Still, for some patients the use of communication technology can facilitate being more open and emotionally accessible. As also observed by Chen et al. (2021), patients can feel freer keeping a safe distance in telepsychotherapy, and for some of them remote work can facilitate avoiding dangers of proximity of bodily co-presence. Accordingly, Isaacs Russell (2021, p. 365) described "the online disinhibition effect which leads some patients to become more emotionally forthcoming when treatments are moved onto screens or phones."

According to Lemma (2017), the online setting in itself is a rupture of alliance; therefore it is of great importance that the therapeutic frames are redefined in accordance with the new situation. The blurred frames in our study might be a result of the frames not being renegotiated and reformulated. One conclusion from our study is the necessity of the therapist's and the patient's joint work on the content and meaning of frame alternations due to transitions to telepsychotherapy (and back to the office). Such therapeutic work can be in itself a productive contribution to more effective therapeutic processes.

The participants in our study perceived their therapists as being more distant and less focused on the therapeutic work. They experienced that the therapists could lose their therapeutic stance, the therapeutic boundaries were blurred and the working methods unclear. Accordingly, in a recent study (Probst et al., 2021) patients reported psychodynamic, process-experiential and cognitive interventions as more typical for in-person therapy than for telepsychotherapy, whereas therapists perceived this difference for all examined therapeutic interventions. Dolev-Amit et al. (2021) emphasized that the frame alternation and distance in telepsychotherapy creates new opportunities for enactment and disappointment, thus necessitating development of adjusted supportive techniques for repairing ruptures in the therapeutic alliance. Furthermore, our study demonstrates that the patients experiencing transition to remote therapy pay close attention to the therapists and their behaviors, as well as to subtle changes in the therapeutic collaboration. It is possible that this relational focus is not representative of all patient groups, but the patients focusing on relational factors and boundary crossing might in itself be a consequence of the modified therapeutic setting. Thus, another conclusion from our study is that transitions to remote therapy, for different reasons, make it necessary for the therapists to be especially observant to what happens around borders for the therapy session and to fluctuations in the mutual emotional contact.

Although the self-ratings indicated the participants' mostly neutral attitude toward the transition to telepsychotherapy, the qualitative analysis clearly revealed that they experienced loss of something essential in therapy, namely the physical presence in the shared therapeutic space and the closeness to the therapist. The positive aspects of the transition seemed to be marginal as the participants consistently expressed their longing back to in-person therapy. The motivation of participants in transitioning to telepsychotherapy was not explored in the present study. However, the general impression from the interviews was that both the patients and their therapists experienced the transitioning as a forced frame alternation. This is also confirmed by the participants' ratings: they were slightly more dissatisfied than satisfied with the transition and they experienced the transition as somewhat more hindering than helpful, even if they felt rather safe after the transition. For therapists shifting to telepsychotherapy, it can therefore be especially important to reflect on how the sense of emotional presence and attentiveness can be conveyed in telepsychotherapy.

Personality Orientation and the Transition to Telepsychotherapy

The present study does not allow us to draw any conclusions regarding differences between anaclitic and introjective patients' experiences, as only one participant was classified as introjective. We can, however, reflect upon the anaclitic patients' experiences of transition, since the other six participants identified themselves as such. A striking finding is the strong relational focus in the participants' accounts, which might be understood from the fact that anaclitic patients are more preoccupied with the therapeutic relationship (Blatt and Ford, 1994; Blatt, 2008). A general and prominent theme in our study is the impaired sense of rapport in telepsychotherapy, accompanied by the typical theme of being less in focus and a sense of being uninteresting,

replaceable and deprioritized. These worries correspond well to the anaclitic patients' yearning for warmth, attention, and care in psychotherapy, as well as their fear of abandonment and feelings of loneliness (Blatt and Shahar, 2004b; Levander and Werbart, 2012; Hennissen et al., 2020). Previous research indicated that anaclitic patients, when generally dissatisfied with their therapy, tend to refer to the therapeutic boundaries as an obstacle rather than criticizing their therapist (Levander and Werbart, 2012; Werbart and Levander, 2016). However, the participants in our study attributed shortcomings to their therapists. At the same time, the participants often diminished their critical statements toward the therapist and excused the therapists by referring to the changed circumstances. To sum up, it is possible that our findings are limited to the anaclitic patients' experiences and new studies are needed to explore the introjective patients' experiences of the transition.

Limitations

However, the main limitation is the small sample size, skewed with regard to personality orientation. The recruitment process was more difficult than expected. Even though the recruitment advertisement reached 25,000 Facebook users, only fifteen signed up, of which only seven met the inclusion criteria, and only one of them was classified as introjective. This restricted and skewed self-selection of participants may be due to our narrow inclusion criteria (experiences of transition from in-person to online therapy), but also differences in the anaclitic and the introjective persons' willingness to talk about their therapy. Relationship oriented anaclitic persons might have a larger need to share their experiences with interested others, whereas introjective persons' tendency to keep others at a distance might constrain their willingness to participate in a study of their therapeutic experiences (Blatt, 1974; Blatt et al., 2001; Blatt and Shahar, 2004a,b; Blatt and Luyten, 2009; Levander and Werbart, 2012; Hennissen et al., 2020). Moreover, anaclitic persons might have been more dissatisfied with the transition to telepsychotherapy, and their dissatisfaction could be an incentive to share their experiences with a committed interviewer.

A further limitation is the use of prototype matching and self-ratings to classify participants' personality orientation. The prototype descriptions contain several aspects of one's personality and it is possible to recognize yourself in some aspects but not others within the same prototype. Furthermore, the concept of personality orientation refers to implicit, deep psychological dimensions that might require clinical expert judgments rather than self-assessments.

Conclusion and Further Directions

The major strength of this study is the in-depth focus on the patients' own accounts of their subjective experiences of the transition from in-person to remote psychotherapy, rather than relying on the therapists' reports about their patients' reactions. Furthermore, the results are anchored in experiences of patients in both cognitive-behavioral and psychodynamic psychotherapy. The forced transition, due to the COVID-19 pandemic, is an exceptional setting, highlighting the differences between in-person and remote psychotherapy. On the other hand, it is possible that the participants' experiences of the transition were colored by all changes to the everyday life, caused by the pandemic, thus rendering it more difficult to delimit the phenomenon in focus for this study.

It is our conviction, further supported by our ongoing studies, that the transition strengthened the contrast between in-person and remote psychotherapy, illuminating the relative importance of the therapeutic boundaries and the consequences of frame alternations. For clinicians, learning about the relevance and role of rituals, boundaries and relationship in the therapeutic process, as seen from the patient perspective, will be relevant long time after the pandemic.

A further strength is the strict application of the step-by-step procedure of thematic analysis of qualitative interview data (Braun and Clarke, 2006, 2013) by the two interviewers, blinded with regards to the participants' personality orientation. The interviewers could approach the material from different points of view and discuss their understanding of the emerging themes. Additionally, the qualitative analysis was continuously audited by the last author.

The data were collected in spring 2021, approximately 1 year after the Public Health Agency of Sweden (Folkhälsomyndigheten [The Public Health Agency of Sweden], 2020) recommended teleworking when possible. Thus our results reflect the patients' relatively short-term experiences of transition to telepsychotherapy and their ongoing mourning of the loss of the ordinary psychotherapy setting. It is highly likely that both patients and their therapist adjust to the new therapeutic environment and the use of communication technology, both among the patients and among their therapists. It is also probable that the willingness to return to the therapist's office differ between patients with anaclitic and with introjective personality orientation. Accordingly, the long-term effects of the transition to telepsychotherapy and the different ways back to the customary therapy setting deserve future studies.

Another relevant question for further research is the patients' (and the therapists') preferences and experiences of use of audio or video channels in in telepsychotherapy in relation to their personality orientation. Among therapists, perhaps especially among psychoanalytically oriented therapists, telephone seems to be the preferred treatment format for remote psychotherapy (cf. Essig and Isaacs Russell, 2021; Probst et al., 2021). Most patients who experienced transition to telepsychotherapy seem to have explicit preferences for the telephone or video contact, and it might be important for the therapists to follow their patients' preferences (Ehrlich, 2021; Isaacs Russell, 2021). Different patients might have different needs and the therapists are in need of different competences for video therapy vs. telephone therapy (British Association for Counselling and Psychotherapy, 2021). In our study most participants had experiences of both video and telephone sessions and one of them (anaclitic patient) initiated shift to telephone after initial use of video link. Our sample was too restricted to examine the potential differences in approach.

Further and larger studies, based on both interviews and surveys, are needed for systematic comparisons of anaclitic and introjective patients' both positive and negative experiences of transition to telepsychotherapy—and back to the therapy room.

The patients' and the therapists' experiences within the same therapeutic dyads can be related to each other in order to explore the consequences of their convergent or complementary views on the therapeutic process in relation to their convergent or complementary personality orientation (cf. Werbart et al., 2018). However, such a study would demand large number of participants in the different subgroups. An essential topic is also to collect evidence and to test how the impaired sense of rapport when using communication technology can be remedied by adequate, patient-tailored interventions, a topic that has to be included in psychotherapy education and training.

DATA AVAILABILITY STATEMENT

The raw data supporting the conclusions of this article will be made available by the authors, without undue reservation.

ETHICS STATEMENT

The studies involving human participants were reviewed and approved by the Swedish Ethical Review Authority (registration numbers 2020-06819 and 2021-01188). The patients/participants provided their written informed consent to participate in this study.

AUTHOR CONTRIBUTIONS

AW planned and designed the present study, continuously scrutinized the progress of the study, and was responsible for the final version to be submitted. LB and TJ participated in designing data collection and were responsible for recruiting the participants, acquisition of all the data included, primary analysis and interpretation of the data for the work, early drafting, and critical revision in the later stages of the work. BP participated in the research group on transitions to telepsychotherapy and in planning and designing of the present study, continuously scrutinized data analysis, interpretation of results, and early drafting, and contributed with critical revision in the later stages of the work. All authors have given final approval of the version to be published and agreed to be accountable for all aspects of the work.

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It turned into something else: patients' long-term experiences of transitions to or from telepsychotherapy during the COVID-19 pandemic

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Introduction: The shift from in-person therapy to telepsychotherapy during the COVID-19 pandemic was unprepared for, sudden, and inevitable. This study explored patients' long-term experiences of transitions to telepsychotherapy and back to the office.

Methods: Data were collected approximately two years after the declaration of COVID-19 as a pandemic. Eleven patients were interviewed (nine women and two men, aged 28 to 56, six in psychodynamic psychotherapy, five in CBT). Treatments switched between in-person and video/telephone sessions. Interview transcripts were analyzed applying the qualitative methodology of inductive thematic analysis.

Results: (1) The patients experienced the process in telepsychotherapy as impeded. Interventions were difficult to understand and lost impact. Routines surrounding the therapy sessions were lost. Conversations were less serious and lost direction. (2) Understanding was made more difficult when the nuances of non-verbal communication were lost. (3) The emotional relationship was altered. Remote therapy was perceived as something different from regular therapy, and once back in the therapy room, the patients felt that therapy started anew. The emotional presence was experienced as weakened, but some of the patients found expressing their feelings easier in the absence of bodily co-presence. According to the patients, in-person presence contributed to their security and trust, whereas they felt that the therapists were different when working remotely, behaving in a more easygoing and familiar way, as well as more solution-focused, supportive and unprofessional, less understanding and less therapeutic. Despite this, (4) telepsychotherapy also gave the patients an opportunity to take therapy with them into their everyday lives.

Discussion: The results suggest that in the long run, remote psychotherapy was seen as a good enough alternative when needed. The present study indicates that format alternations have an impact on which interventions can be implemented, which can have important implications for psychotherapy training and supervision in an era when telepsychotherapy is becoming increasingly common.

KEYWORDS

remote psychotherapy, online therapy, communication technology, patient experiences, therapeutic boundaries, therapeutic relationship, thematic analysis

Introduction

Telepsychotherapy enabled patients to continue to access psychotherapy during the COVID-19 pandemic. However, neither patients nor therapists were prepared for or expected such a forced change of format from sessions in the room to video or telephone sessions, and research into the effects of the shift has accumulated in the wake of the pandemic. Nevertheless, different forms of remote psychotherapeutic treatments have been used for a long time and have been increasingly considered to be an acceptable alternative to conventional settings, often working equally well for different types of psychological problems and of treatments (see below). These can be designed as guided self-help with minimal and asynchronous communication with the therapist (Cuijpers et al., 2010), or as video-mediated treatment, based on synchronous online communication, sometimes called 'videoconferencing' (Simpson et al., 2005; Connolly et al., 2020; Fisher et al., 2021). Nowadays, remote psychotherapeutic treatments are included under such umbrella terms as 'telemedicine' or 'telemental health' (Hilty et al., 2013; Connolly et al., 2020), 'telepsychology' (American Psychological Association, 2013) or 'telepsychotherapy' (McMullin et al., 2020; Poletti et al., 2021), and there is a lack of consensus on terminology (Smoktunowicz et al., 2020). 'Hybrid therapy' is a treatment in which the setting alters between in-person and teletherapy. In the present study, we use the terms 'remote therapy' or 'telepsychotherapy'; however, when referring to other studies, we follow the terms used by the respective authors.

The use of communication technology has been discussed in the psychoanalytic tradition since the aftermath of World War II, when Saul (1951) drew attention to the use of the telephone as a technical aid helpful in psychoanalysis with some patients. Following rapid technological developments, this discourse expanded significantly. Carlino (2011) argued for the evolution of psychoanalytic theory and practice in the digital era, when teleanalysis may be the treatment of choice for many people. However, relationships and communication in cyberspace are seen as fundamentally different from those happening in a shared physical space (Sabbadini, 2014). A specific concern among psychoanalysts is the fate of the body in the virtual space (Carlino, 2011; Lemma, 2015). The cross-modal interaction between the senses gets lost without physical proximity (Bayles, 2012). The lack of the concrete presence of people's bodies in a room makes it necessary to create an illusion of presence, i.e., to establish 'telepresence', which is possible when communication technology works (Essig and Russell, 2021). Furthermore, there is a need to adapt interventions to remote treatments (Scharff, 2012; Fisher et al., 2021).

Comparing the remote and in-person settings, it is important to notice the difference between deliberate teleclinical practice and rapid, unprepared transitions to telepsychotherapy due to restrictions following the outbreak of the COVID-19 pandemic. A meta-analysis of the efficacy of in-person and video-delivered psychotherapy (Fernandez et al., 2021) showed negligible differences between the two formats. However, improvements in video-delivered psychotherapy were most manifest in cognitive behavioral therapy (CBT) addressing anxiety, depression, or post-traumatic stress disorder (PTSD). In a study applying the 'Multitheoretical List of Therapeutic Interventions' (MULTI-30; Probst et al., 2021), therapists rated all interventions as more typical for in-person therapy than remote therapy, whereas patients regarded psychodynamic, process-experiential, and cognitive interventions as more typical for in-person therapy, indicating that therapeutic interventions differ between in-person and remote therapy. Poletti et al. (2021) concluded in a review of 18 studies that telepsychotherapy is as effective for depression, anxiety and PTSD as in-person therapy of different orientations, although therapists and patients might experience initial skepticism and technical difficulties. Previously, a systematic literature review (Backhaus et al., 2012) had found that video-mediated remote therapy had similar clinical outcomes as in-person therapy for anxiety and depression, PTSD, obsessive–compulsive disorder, panic disorder, and social phobia. However, psychotherapy for patients with pain seemed to be more efficient in person (Chavooshi et al., 2017). A systematic review of 24 studies (Margherita et al., 2022) showed that online group interventions during the COVID-19 pandemic were effective in reducing psychological distress and increasing psychological interpersonal resources. An online survey of 281 Italian licensed psychotherapists in the early phase of the pandemic (Mancinelli et al., 2021) showed that the therapists forced to shift to online work were able to preserve their positive professional self-perception. However, they reported being much more conversational and directive in remote sessions, possibly trying to compensate for the physical distance. Furthermore, they felt more fatigued not having access to non-verbal cues in remote sessions. In another online survey among 507 Italian psychotherapists with different orientations (Cantone et al., 2021), the participants reported critical issues with remote work, such as the need for greater flexibility, greater attention, and greater concentration, resulting in greater fatigue. Furthermore, most of them discovered that remote work, while more suitable for some patients, may be inappropriate for others. The authors concluded that the psychotherapists seemed to have difficulty adjusting their technical repertoire to the shift to a remote setting. A qualitative study of 15 psychologists' experiences of telepsychotherapy within the Irish Mental Health System (Reilly et al., 2022) revealed that the participants experienced loss of control over therapeutic boundaries and of non-verbal cues, had to work much harder to establish a bond with their clients, and lacked professional support in the transition. In a critical commentary, Smith et al. (2022) concluded that despite studies demonstrating the effectiveness of video-mediated therapy, the current evidence base is still limited, and that this therapy setting might not suit all patients and all therapeutic orientations. Further research might conclude that telepsychotherapy can be more suitable for patients with certain non-diagnostic characteristics and personality factors. Accordingly, recent studies (Aafjes-Van Doorn et al., 2021a,b; Békés and Aafjes-van Doorn, 2022) found that patients with attachment anxiety experienced more distress in remote therapy during the COVID-19 pandemic. The researchers concluded that the working alliance and therapeutic agency may differ in importance for patients depending on their attachment style, since the therapeutic relationship and emotional closeness is of greater importance for patients with anxious attachment.

The research focusing on the psychotherapists' experiences of the rapid and unprepared shift from in-person therapy to telepsychotherapy during the COVID-19 pandemic, shows that the the new format proved challenging. The pandemic in itself can be viewed as a shared traumatic experience that put patients and therapists in the same uncertain and health-threatening position as the virus itself (Nuttman-Shwartz and Shaul, 2021), thus changing the therapist role. Important features of therapy, such as non-verbal communication and body language, as well as the finely-tuned

adjustments that therapists make in turn-taking and sensitivity to create a therapeutic alliance, were lost with video and phone or had to be modified. The assessment of patient difficulties was also more difficult to do remotely (Feijt et al., 2020; Békés et al., 2021; Fisher et al., 2021; Lin et al., 2021; James et al., 2022; Khan et al., 2022). The technological solutions were unfamiliar to many therapists and thus made them feel uncertain to begin with (Békés et al., 2021). The therapy room's safe space and confidentiality did not come across as easily on screen or telephone when patients had to find their own room for their remote therapy sessions (Ahlström et al., 2022). In therapists' experience, this had a negative effect on the therapeutic alliance and on patient adherence to the treatment (Lin et al., 2021). The sudden change of format has led therapists to modify their interventions.

The current study

Research into how patients experience the change of format and the adjustment to interventions is not yet fully developed (Farber and Ort, 2022). Even less research has been done on the experience of changing to telepsychotherapy and then back again to in-person-therapy, which will probably be more common after the pandemic, when patients and therapists are used to the remote format and need it from time to time. However, there are some studies indicating that both patients and therapists may experience an advantage with hybrid settings, i.e., that sessions within the same therapy can be either remote or in-person (Sperandeo et al., 2021; Leuchtenberg et al., 2022).

Patients might differ in their ability to adapt over time to telepsychotherapy and to benefit from the altered format, as well as in how they experience transitions to and from telepsychotherapy. In a previous study (Werbart et al., 2022), we explored patient experiences of the transition to telepsychotherapy shortly after the onset of the COVID-19 pandemic. The present study was aimed at investigating patients' long-term experiences of transitions to telepsychotherapy and eventually back to the office. The research questions were: What factors are perceived by patients as contributing to their both positive and negative long-term experiences of transitions to remote therapy? What are the positive and negative aspects experienced by patients in relation to a possible return to in-person setting?

Materials and methods

Procedure and participants

Inclusion criteria for the present study were: experience in undergoing psychotherapy with a licensed psychologist or licensed psychotherapist with a frequency of at least once a week and a duration of no less than 4 weeks before transition to or from telepsychotherapy due to the COVID-19 pandemic. Eleven participants were included. One of them had previously taken part in a study focusing on short-term experiences of the transition from in-person sessions to telepsychotherapy (Werbart et al., 2022), which the present study was intended to follow up. Additional participants were recruited *via* social media, and 28 people registered an interest in participating. Contact was made with all of them, and 10 could be included. Of the remaining 18, the majority did not respond to further contact and in two cases their therapies did not meet the inclusion criteria.

All the 11 participants met the inclusion criteria and gave their informed consent to participate in the study. The platform Survey and Report, provided by Stockholm University, was used to collect the consent. The age of the participants ranged from 28 to 56 years ($M = 39.8$). Nine of the participants were women and two were men. No questions were asked about the participants' presenting complaints, but the interview responses indicated different levels of severity of psychological difficulties (such as depression and anxiety). Time in therapy prior to the first transition varied between two and 120 months, and the therapy duration was between 2.5 and 27 months. Five participants were in cognitive-behavioral therapy, a further five in psychodynamic therapy, and one participant was not sure of the therapeutic orientation. All but one of the participants had started their therapy in a conventional in-person setting, except one who had begun therapy remotely on video. Three of the participants had their remote sessions over the telephone, seven of them had their remote session mostly on video but with occasional sessions on the phone, whereas one participant had had a period of 4 months on the phone before switching to video and then transitioning back to in-person sessions. Eight of the participants had experience of two transitions, from the conventional in-person setting to telepsychotherapy and back again to the in-person setting; three of the participants had experience of one transition; in two cases to telepsychotherapy and in one case from remote sessions to an in-person setting (See Table 1).

Data collection

Data were collected in spring 2022 through semi-structured interviews conducted online. The interviews lasted for about 45 min and were audio-recorded using the Zoom platform's audio. The interviewers were the second and the third author, who at the time of the study were students in the final semester of the Swedish three-year advanced psychotherapy training program leading to a Swedish psychotherapist license. Both interviewers conducted five or six interviews, and they had previous clinical experience working with psychotherapy patients switching from conventional in-person settings to remote sessions.

The interview protocol was aimed at collecting narratives around long-term, both positive and negative, experiences of transitions to telepsychotherapy or in the opposite direction. The questions were open and encouraged participants to express themselves freely. The participants were asked how the transitions had affected the patient-therapist relationship, the therapy process, and the experienced outcome of therapy. The interview questions covered the more hindering and more helpful aspects of the transitions and how the experiences had changed over time. Participants were encouraged to elaborate on their answers and give concrete examples. Key questions included: How did you and your therapist decide to switch to remote therapy or to therapy at the therapist's clinic? How did you experience this transition (positive and negative experiences, concrete examples)? How did the transition affect the therapy? How open did you feel in the therapy? How well were you able to profit from the therapy? What were your feelings about the therapy? How was your relationship with the therapist? What is your view of the therapist? What were your feelings concerning trust toward the therapist? How did these

TABLE 1 Participant characteristics: therapy type (PDT=psychodynamic psychotherapy and CBT=cognitive-behavioral therapy), time in therapy before the first transition, length of therapy, communication technology, and number of transitions.

Participant #	Therapy type	Time before the first transition	Length of therapy	Communication technology	Number of transitions
1	PDT	5 months	18 months	Video	2
2	PDT	5 months	12 months	Video	2
3	PDT	2 months	4 months	Telephone	1
4	CBT	2 months	27 months	Telephone/video	3
5	PDT	5 months	26 months	Telephone	2
6	PDT	15 months	24 months	Video	2
7	CBT	2 months	2.5 months	Video	1
8	CBT	18 months	NS	Video	2
9	NS	120 months	Ongoing	Telephone	1
10	CBT	6 months	18 months	Telephone	2
11*	CBT	5 months	7 months	Video	2

NS, Not specified.*Therapy started remotely. Time in therapy prior to the first transition to remote setting.

TABLE 2 Themes and sub-themes in the participants' long-term experiences of transitions between telepsychotherapy and the in-person setting.

Theme	Frequency (n=11)	Label
1. Impeded process	10	General
°1.1. Availability at the expense of efficiency	10	General
°1.2. Lost accuracy and impact of interventions	7	Typical
°1.3. Lost routines and rituals	7	Typical
2. Restricted understanding	8	Typical
3. Altered emotional relationship	11	General
°3.1. Distance for better or worse	11	General
°3.2. In-person presence contributes to security and trust	9	Typical
°3.3. The therapist seems different at a distance	8	Typical
4. New opportunities	8	Typical

Frequencies of participants in each theme and sub-theme (labeled following Hill et al., 2005): General = 10–11; Typical = 6–9; Variant = 2–5.

experiences affect you? How did your experience of remote therapy and therapy at the therapist's clinic change over time?

Analysis

The interview data were analyzed by the second and third author, with supervision from the first author, following Braun and Clarke's (2006, 2013, 2022) six steps of inductive thematic analysis. Step one included familiarizing themselves with the data when transcribing the interviews, reading through the material, and noting down their own thoughts and ideas. Step two was initial coding of the interview transcripts. To ensure an inductive stance, the initial coding was made by the person who had not conducted the interview, i.e., author two or three. In step three, the second and third authors worked jointly to group codes into preliminary themes and discussed these. Together, they gathered the preliminary themes into three main themes. In step four, the main themes were examined in relation to associated codes and relevant sections of the transcripts, and the relationship between themes was explored. Sub-themes were merged and delineated. Moving back and forth between the whole data set, the coded extracts, and the emerging thematic structure, represented in mind-maps, resulted in the fourth main theme. In step five the themes were defined and described, capturing the essence and what was specific for each theme. The themes were given final headings, and a last review was done to ensure that the thematic structure represented the overall experiences of the participants. Steps three to five were audited by and conducted in collaboration with the first and fifth author.

Frequency of participants contributing to each theme was examined and reported following the guidelines of Hill et al. (2005). Themes represented by 10–11 participants were labeled *general*, those by 6–9 participants were labeled *typical, and those by* 2–5 participants were labeled *variant.*

Results

Thematic analysis resulted in four main themes and six sub-themes (Table 2). All themes are presented below and illustrated by verbatim quotations from the interviews. The main themes (1) *Impeded Process* and (2) *Altered Emotional Relationship* were categorized as general, whereas the main themes (3) *Restricted Understanding* and (4) *New Opportunities* were categorized as typical. Implicit in all the themes is the predominant, shared experience that the content of the therapeutic encounters and the therapeutic work were perceived as different, less efficient, even if telepsychotherapy also opened new prospects. Accordingly, the core, overarching theme is formulated as *It Turned into Something Else*, also explicitly expressed in the following quotes:

> … but then it's different to sit alone at home and think out loud than to meet someone in a room.

> … experience that we are people who talk on the phone … and that is something else for me [laughs] than going to therapy, like that.

1. Impeded process

This general theme captures the participants' experience of an inhibited or stalled process during remote sessions. The purpose, aim and quality of therapy were affected and hence negatively influenced the experienced efficiency.

1.1. Availability at the expense of efficiency

Generally, the participants mentioned the availability of remote therapy as a positive aspect. Even if they lived at a distance or could not travel, the continuity could still be intact. According to one participant: "Otherwise it would not be possible. Without that technology we would have had to cancel and that would have made me feel worse." Another participant caught two sides of the same coin:

> Mostly remote therapy was negative but at the same time I'm really grateful for this opportunity. Otherwise, I would not have had any therapy at all… and this is better, it is better than nothing.

However, the participants experienced that this availability came with a cost. They experienced therapy as less serious and more superficial: "Somehow, for me, it felt like everything we said became less rooted in me." The purpose and aim of the treatment were perceived as vague and less effective, more like an ordinary conversation than psychotherapy: "It was like the therapeutic process became more difficult and it became more difficult to reach and to get into such a state and not just a conversation about what has happened…" Something seemed to be lacking: "This [back to the therapist's office] feels like therapy, and what was before was a kind of trudging along at best, more like support." The participants also found it more difficult to maintain focus and to concentrate in remote sessions: "It took a lot of concentration and I felt fatigued by it." Fatigue and passivity made therapy less intense: "It wasn't as effective. It was hard to understand what we were doing. It wasn't clear for me what the purpose of our sessions was, not as clear as it is now when we are back in the room." Once back to the therapy room, the participants felt that therapy started from the beginning again: "It felt like I had to find a way to relate to him the first time I got there IRL."

1.2. Lost accuracy and impact of interventions

Typically, the participants reported that some therapeutic interventions were no longer possible or became more difficult to receive in remote sessions. They felt that some essential parts of the therapeutic work could not be done remotely as it would mean too much anxiety without sufficient support: "I feel I cannot let it out, as I am afraid to lose it, so to speak." The assistance of a therapist present in the same room was experienced as necessary for working with trauma, dissociation, and close relationships: "In therapy, it's in the relationship with the therapist that the work is done and … yes … I think that was more difficult…" Even when the participant tried to engage with the therapist as much as in therapy in the room, it became difficult:

> When it is remote, it feels a bit unreal and does not matter if it is this or that, if I cry, whatever… but in the room it feels more important because it is a real person… so I want to share and I want to be myself, but it is more difficult on screen.

Furthermore, the use of therapeutic aids, such as a whiteboard or handouts, was more difficult when presented on screen. Homework was not as easy: "Homework got harder, harder to let it take time, you did not work through the feelings as much when they came up, without direction, no clear themes and no depth." Therapeutic accuracy was lacking in other ways too:

> I felt like he would catch me [in the room] and not let me get away with being vague and just talk on, but he would say that I was avoiding the work, but now [in remote sessions] I felt he chatted on, and we both avoided the work. I would have needed that he caught me and asked kind of, 'why are we here, what do you want to do?'

1.3. Lost routines and rituals

When routines, such as traveling to and from the clinic or sitting in the waiting room, disappeared in remote sessions, the participants typically experienced less time for reflection and processing. They also felt that the working through and thinking that took place in the remote sessions did not have the same quality: "Well, I guess that it felt more difficult to stay in touch with things that had been said. To let it take place in my everyday life …" The start and ending of the sessions became diffuse: "It was like a small ceremony, I guess you could say.… There's also, maybe, a bigger difference before and after." In retrospect, with the experience of both remote sessions and in-person-therapy, this difference became even clearer for the participants:

> Then I think you lose your own ability to reflect, because it becomes much easier to… you schedule your work meetings and then you have an hour of therapy and then 3 min after the therapy ends, you have switched to something else…

2. Restricted understanding

Typically, the participants expressed that such vital aspects of non-verbal communication as body language, eye contact and tone of voice were lost in remote therapy. They found it more difficult to communicate to their therapists how they felt. The participants typically experienced that remote therapy negatively affected the ability to read between the lines: "I would say that there was a lot of misunderstanding, that I did not understand what she meant and that she did not understand what I meant." Thus, remote sessions increased the risk of misunderstanding and misinterpretation. Back in the room it became a challenge to re-relate to body language: "Suddenly there is a lot more than a face on screen; there is body language and kind of… other information that you perceive." Another participant also remarked on the difference in communication in remote sessions and therapy in the clinic: "There is so much communication through your body and voice that disappears in a video session and when you meet again, so to speak, it becomes much more tangible, and it shows itself."

Facial expressions were visible on screen but could be difficult to interpret in the absence of other non-verbal cues and co-presence: "She did not experience what I felt when we were not in the same room… She had no way of understanding how I was reacting and not reacting only seeing my face." On the other hand, lack of eye contact could be experienced as beneficial by participants who found it easier to address matters verbally. One participant said that once back in the room she acknowledged how important eye contact was and how it had been missing in remote therapy: "If I say something [in the room] and I do not know what I feel, I can see how she reacts, I can read in her eyes and see my feelings in hers." According to another participant, remote sessions work better if you were already familiar with your body language and how the therapist works. This participant stressed that remote therapy demands a higher degree of self-awareness to make oneself understood, and that self-awareness is easier attained in the bodily co-presence with the therapist.

3. Altered emotional relationship

The emotional closeness to the therapist was generally described as altered in remote sessions. The participants felt that the therapist was changed by the remote contact in a way that affected the safety and trust that had been created. This in turn seemed to affect the emotional content in the therapy.

3.1 Distance for better or worse

This general theme captures the experience of the importance of maintaining contact and the relationship with the therapist during remote sessions. The emotional closeness and content of therapy were affected. The regulation of distance in remote therapy contributed to a difference in the therapeutic work, which some patients saw as positive and others as negative. Whereas one participant reported that remote therapy made it easier to avoid painful feelings, another reported that the stress increased and self-regulation became necessary to prevent a dissociative state. The quality of the relationship with the therapist seemed more important for the participants than the in-person or remote format of the therapy.

A general experience was that emotional closeness diminished during remote therapy. Some participants saw this as positive, since they sometimes preferred more distance. It could be easier to carry out emotionally demanding tasks and to be open when experiencing closeness in remote contact. The participants could feel less shy and thus find it easier to communicate difficulties, express emotions and avoid feelings of shame. For some, it also contributed to experiencing fewer feelings, which they considered positive. For one participant, the distance gave a feeling of independence and self-confidence, as the therapist seemed to trust the participant's own ability. This participant also experienced it as positive that the remote therapy did not lead to a dependency and helped them to let go when approaching the termination of the sessions. The more distanced remote contact with the therapist was interpreted as something positive by this participant.

It was quite nice being able to just sit behind my screen, and I could choose whether she got to see my face or how close she could approach me. And in some way, I think it was rather nice that you could choose in a way, at the same time as I knew that it would have been a better challenge for me to actually see each other because that challenges me more.

Other participants found it difficult to stay in tune with emotions, acknowledge their feelings and dare to express them in remote sessions. One participant reported not daring to be angry in remote therapy, feeling sad instead. The participants experienced feelings of not being taken seriously or not being validated enough in remote sessions. The relational contact in the remote setting could be experienced as impersonal, anonymous, and less intimate, awakening yearnings to go back to the therapy room. The distance could also lead to a lack of feeling co-presence with the therapist and to a struggle to maintain one's feeling of presence during the sessions.

3.2. In-person presence contributes to security and trust

Typically, the participants considered it important to start the therapeutic process in person. It contributed to feelings of safety and trust, facilitating the transition to remote therapy. One of the participants started therapy remotely and described difficulties in trust and safety before meeting in person. Some participants did not experience any difference in trust and safety in remote therapy, since the trust created in the in-person sessions was carried with them into remote therapy. The participants experienced that the therapist from the therapy room remained real within them, which made the transition to remote sessions safe: "The trust that we have built up, it is still there, it is not the one that is destroyed." For other patients, the safety that had been grounded in the co-presence with the therapist in the room decreased in remote therapy. This affected their ability to be emotional and open: "This energy, who am I talking to, where is he sitting, so what … how is that … does it feel safe?"

3.3. The therapist seems different at a distance

Typically, the participants experienced that the therapist and the therapist role changed in remote sessions. The therapist became more light-hearted, easygoing and casual, the therapist's private life became more visible, the therapist's and patient's roles were loosened, and the relationship was perceived as more friendly. Some experienced this as positive and that self-disclosure became easier when the therapist also was more open: "So, he talked about himself much more when it wasn't exposure therapy. Yes, I think that all these things, they make me feel a little more comfortable and willing." Others experienced this as a loss: "Then it was a bit like "Hello," "Hello," and "Hi," "Hi;" there was a different tone a bit, in his voice and in my voice; we were on a different forum.. more private forum." The therapists seemed more solution-focused, flexible and available in remote sessions, which could be seen as a sign of more caring. In remote contact, the participants could meet their therapist even when the therapist was sick. Some of the participants appreciated that the therapist offered this; others perceived the therapist as less professional when he or she conducted therapy even when ill. Also, learning private things about the therapist was a burden.

4. New opportunities

Typically, the participants felt that remote sessions created new opportunities. Therapy could continue despite isolation, illness or other duties:

> People might have been isolated and did not do much and for me the situation was extreme, as I had been very ill for some time and did not see anyone except those who helped me clean… I had not left my flat for weeks. So for me it was very nice to have a task like this [remote sessions] to do.

The participants could bring the therapist with them in different situations, like on trips, after a move or in especially difficult situations when the need for therapy was increased:

> At that moment my video session had just started, so I got online, and my therapist talked to me until the ambulance arrived, and she would not have been able to do this otherwise … you can meet the person where they are. If I had had a session at the clinic, that would have been cancelled.

Attending remote sessions from home also gave patients the opportunity to create new routines surrounding therapy, such as taking their own therapy notes on the computer. Being able to take therapy into their real lives could give a feeling of freedom: "The feeling of freedom and that maybe.. I mean, that you go far away but you still feel that you can have conversations." The remote format could give access to a wider range of therapies, despite patients living a long way from the therapist's office. Transition to remote sessions could shake up the therapeutic relationship, leading to challenges that could be experienced as new possibilities for personal growth. Remote sessions could be helpful in the process of ending therapy, giving an opportunity to get used to no longer meeting the therapist, and to become more independent.

Discussion

To sum up our main findings: The patients experienced that the remote sessions provided availability at the expense of efficiency. The therapists' interventions were more difficult to receive and lost some of their impact. Interventions including a whiteboard or textual material could not be done as usual, and the therapist's distance hindered focus on trauma. The therapeutic process went more slowly, and the treatments were experienced as less efficient. Several routines and rituals surrounding the therapy sessions were lost. Conversations were less serious, and therapy sessions seemed to lose direction, which made therapy more supportive rather than a tool for change. The reflections and working through that were an essential ingredient in in-person sessions did not take place remotely, and the non-verbal communication was lost. The patients had difficulties in maintaining their concentration and the therapy focus, which made them tired and frustrated. Both the emotional relationship and the working alliance were negatively influenced. The emotional presence was experienced as weakened, but some of the patients could find expressing their feelings easier in the absence of bodily co-presence. According to the patients, in-person presence contributed to their security and trust, whereas they felt that the therapists seemed different when working remotely: more easygoing and familiar, but also more solution-focused, supportive and unprofessional, less understanding and less therapeutic. Despite their persisting, mainly negative longitudinal experiences, the patients also stressed that telepsychotherapy gave them an opportunity to take therapy with them into their everyday lives when they were in their own homes during the sessions. They appreciated the possibility to continue their treatment despite the pandemic. This finding is consistent with previous research (Christensen et al., 2021; Leuchtenberg et al., 2022). Even in the long term, remote therapy turned into something other than therapy had been in the conventional in-person setting, and once back in the therapy room, the patients felt the therapy started anew.

Difficulties in telepsychotherapy

To a large extent, these findings regarding long-term experiences of the transition to telepsychotherapy resemble the results in a previous study on patients' more immediate experiences of the transition during the COVID-19 pandemic in Sweden (Werbart et al., 2022). Like the present study, the previous study showed that respondents experienced a loss of therapeutic rituals, a decrease in productive therapeutic work, impaired contact, and less emotional presence. In both studies, some participants reported aspects of feeling freer and finding it easier to express certain material in telepsychotherapy, as well as thinking that remote therapy had the advantage of being more accessible and adaptable. One difference is that the previous study reported a typical theme of technology as hindering. This was not found in the present study, in which the participants had a slightly more positive view on telepsychotherapy. This difference might be explained by continuous longitudinal adjustment over time to telepsychotherapy, both by the patients and their therapists. With time, increasing experience, and occasionally with several transitions between the in-person and remote therapy setting, the patients and their therapists might have become more familiar and better adapted to the digital format. Furthermore, as the COVID-19 pandemic had been going on for at least 2 years when the present study was conducted, the patients and their therapists might have become more acquainted overall with, and skilled in, digital communication. Accordingly, a study of the therapists' experiences of forced transitions to telepsychotherapy (Ahlström et al., 2022) showed that they initially struggled with technical and safety issues. The loss of the therapy room and of access to non-verbal nuances contributed to impaired contact with the patients and more superficial conversations. The therapists experienced that the very nature of psychodynamic psychotherapy was affected, even if telepsychotherapy could give some new opportunities. One year later many of the difficulties remained, but the therapists had developed better coping strategies and were back to the therapy focus. Likewise, according to a survey among 1,450 psychodynamic and psychoanalytic therapists (Aafjes-van Doorn et al., 2022), in the initial period of transitions most therapists regarded remote therapy as less effective than the traditional in-person setting; they felt more tired, less competent, and less in contact with their patients. This finding can be related to the patients in our study experiencing the therapist as different at a distance. A survey following up the therapists 8 months later (Aafjes-van Doorn et al., 2022) showed that the therapists regarded remote therapy as more similar to the customary setting, whereas the patients in our study still regarded remote therapy 2 years after the outbreak of COVID-19 pandemic as something different from in-person therapy.

Positive aspects of telepsychotherapy

In the present study, the respondents expressed gratitude that psychotherapy could continue during the pandemic, thanks to the digital format. The lockdowns and restrictions during the COVID-19 pandemic resulted in increased isolation for many (Faustino et al., 2020; Hwang et al., 2020; Pai and Vella, 2021), which might explain the thankfulness that the therapeutic relationship could be preserved, although in another form. A new finding in the present study, absent in the study of Werbart and co-workers (2022), was the theme *New opportunities*, which includes the reflections that telepsychotherapy has the advantage of enabling contact with the therapist more frequently and despite geographical distance. However, telepsychotherapy was also described as somewhat more relaxed, less intense, and less effective. These mixed views might reflect an ambivalent attitude toward psychotherapy among patients in our study, with on the one hand a wish to maintain the relationship with the therapist, but on the other hand a wish to avoid the more challenging aspects of closeness and hard therapeutic work. Furthermore, these mixed results might reflect the therapists' experiences with patients with different personality orientations and attachment styles. Some recent studies indicate that patients with personality orientation around issues of relatedness/closeness and patients with attachment anxiety experienced more distress in remote therapy during the COVID-19 pandemic than patients with personality orientation around issues of autonomy/performance and patients with attachment avoidance (Aafjes-Van Doorn et al., 2021a,b; Békés and Aafjes-van Doorn, 2022; Werbart et al., 2022). Thus, the therapists' parallel work with different patients could contribute to the co-occurrence of their more negative and more positive views of remote work. Still another contribution to these inconsistent views might be the therapists' own experiences of therapy, psychotherapy training and longstanding clinical work in conventional in-person settings.

Telepsychotherapy as something else

Some of our findings concern changes in the therapeutic boundaries in connection with the transitions between the standard and remote therapy format. The experiences of the therapy becoming more relaxed, the therapists becoming more self-disclosing, and the therapy starting to blend with everyday life are all examples of boundary crossings. Lemma (2017) claims that the transition of therapy to the digital format can in itself be viewed as a boundary crossing, and therefore it is important that the boundaries are redefined in accordance with the new situation. Some of the rituals in the in-person psychotherapy format that patients find helpful were lost after the transition to the remote format, such as traveling to the therapist's office and back again, which had allowed time to reflect and process. Wiener (2021) points out that the absence of these journeys could be regarded as deficiencies of the therapeutic frame. The respondents in the present study also recounted how they had to find a new safe spot at home where they could sit during therapy, and thus they had to create therapeutic frames and be responsible for them on their own. Descriptions of how therapists started to act differently, with less professionalism, after the transition to telepsychotherapy could be an indication of therapists being struck by beginners' anxiety, previously described by Ehrlich (2021).

Viewed from the perspective of attachment theory, the transition to remote therapy could be described as a challenge to psychotherapy as a secure base aimed at facilitating exploration of mental and relational processes. Indications of this are the findings regarding the decrease in depth in therapy, increased difficulties in approaching emotions, and the therapeutic process becoming inhibited or stalled. According to Talia et al. (2019), the patient's attachment to the therapist is shown in the degree of their openness and autonomy in relation to the therapist. A survey among 719 patients (Békés and Aafjes-van Doorn, 2022) led to the conclusion that patients' attachment avoidance and their perception that the real relationship is of lower quality predict their more negative attitudes toward remote therapy. The findings in the present study indicate decreased openness and autonomy in the patients, which might show that more effort needs to be made to develop security and trust in remote format therapy. This conclusion could have important implications for psychotherapy training and supervision in an era when hybrid psychotherapy formats are beginning to be increasingly common.

In our study, the patients were generally dissatisfied with the transitions to the remote sessions, even if they also saw new opportunities in telepsychotherapy, and they experienced relief returning to the in-person setting. Their typical experience was that the remote format led to increased difficulties in understanding themselves and the other person. Important means of communication such as body language, eye contact, facial expressions and emotional atmosphere diminished or became more difficult to interpret. These results are in line with Knight's (2020) observation that telepsychotherapy suffers from the loss of important sources of interpersonal communication, such as body language, which means that the persons involved lose important information about each other. According to Knight (2020), the unplanned shift to "part-body-on-the-screen relating" from what was once "whole-body relating" can lead to gaps in the relationship between patient and therapist and could contribute to the two parties relating on a more primitive, suspicious level, with more misinterpretations of each other. Respondents in the present study reported thoughts about how remote therapy increased the occurrence of overinterpreting and misunderstanding the therapist in the absence of body language. This could have a negative effect on the therapeutic alliance, as the experiences of not being understood and seen by the therapist to the same extent as before could decrease the emotional bond with the therapist and contribute to the experience of less efficient therapeutic work. The respondents reported that they found it harder to explain their suffering in remote therapy and that both the therapist and the patient ran into more difficulties in detecting increased patient suffering. Accordingly, a single case study of changes in clinical process due to transition to remote therapy (Negri and Christian, 2022) showed that both patient and therapist were working harder to remain connected and communicate that they were present, but with limited emotional engagement. Thematic analysis of open questions in a survey among 133 Norwegian patients (Stänicke et al., 2022) revealed the patients' experience that the remote work brought an emotional distance to therapy, even if transitions to remote sessions were regarded as good enough emergency solutions, providing access to continuing therapy. In line with this, a Danish qualitative study using interviews and focus groups (Christensen et al., 2021) showed that both older patients with depression and their care providers regarded videoconferencing as a technological aid best suited for

shorter follow-up meetings, and both groups stressed the need to establish in-person contact prior to remote sessions.

Thus, a relevant question is the concord or discord between the patients' and therapists' views of the benefits and drawbacks of remote sessions as compared to the in-person setting. In an online survey of patients and therapists in CBT after the first lockdown in Germany (Leuchtenberg et al., 2022), both groups regarded remote work as more flexible regarding the place and time of the sessions, but less helpful regarding the content of the therapeutic work, especially in cases of more complex problems and courses in therapy. The technical challenges of videoconferencing were experienced as more disturbing by the providers with negative expectations than by patients grateful for the possibility of continuing their treatments despite lockdown. Furthermore, patients experienced therapeutic alliance and empathy as comparable in videoconferencing and in face-to-face sessions, whereas therapists indicated advantages of in-person work. In a Danish qualitative study of patients in mental health services (Moeller et al., 2022), the seven participants experienced remote sessions as useful, and they could maintain good therapeutic relationships online when they had initially met their therapists in person. On the other hand, an Italian study of 23 patients and their five therapists in hybrid settings (Sperandeo et al., 2021) showed that the patients rated their therapists as significantly more empathetic and supportive in the remote sessions than in the in-person sessions, whereas the therapists experienced no such differences. In addition, the concordance between patient and therapist ratings was higher in the remote sessions than in the in-person sessions.

Many positive experiences of teletherapy are presented also in our study. However, both patients and therapists seem to show a more negative attitude to telepsychotherapy in in-depth interviews such as our study, even when reporting their long-term-term experiences (Dores et al., 2020; Ehrlich, 2021; Ellman and Vorus, 2021; Essig and Russell, 2021; Isaacs Russell, 2021; Ahlström et al., 2022; Reilly et al., 2022), than in surveys and rating scales (Békés and Aafjes-van Doorn, 2020; Mancinelli et al., 2021; Sperandeo et al., 2021; Aafjes-Van Doorn et al., 2021a,b; Farber and Ort, 2022). Such discrepancies between qualitative and quantitative studies have also been observed in outcome research (Desmet et al., 2021).

Furthermore, the difference between the generally negative long-term patient attitudes toward telepsychotherapy in our study and the positive experiences of therapists' empathy and support in the Italian study (Sperandeo et al., 2021) may be due to differences in handling the COVID-19 pandemic. The Public Health Agency of Sweden (Folkhälsomyndigheten [The Public Health Agency of Sweden], 2020) recommended in March 2020 homework when possible, without such extensive lockdown as for example in Italy. Thus, the contrast between the remote psychotherapy setting and the more open social life was larger in Sweden, which could contribute to the more negative views. On the other hand, several interview studies from countries with more extensive lockdown had shown equal patient and therapist dissatisfaction with remote psychotherapy setting.

Some studies have shown that patients tended to be more satisfied with the transition to the remote setting than therapists, perhaps due to their gratitude for the possibility to continue treatment during the lockdown and to continue their treatment despite the pandemic (Christensen et al., 2021; Leuchtenberg et al., 2022), or to the therapists' worries about preserving the integrity of treatment and about their ability to maintain their therapeutic stance (Thomas et al., 2021; Ahlström et al., 2022). The common features and differences between the patient and the therapist perspective on transitions to and from the remote setting are still underexplored and need further investigation. In our parallel study of therapists' long-term experiences of telepsychotherapy following the COVID-19 pandemic (under review), the therapists still underlined the differences between the remote and in-person setting, and they stressed the need of acquiring new technical and relational skills. A learning from the present study might be that the patients need the therapists to adjust their interventions to the remote setting and to actively address the loss of the intermediate space and time between therapy sessions and the patient's everyday life, as well as to make the altered emotional relationship an explicit therapeutic topic, and to contribute to distance regulation in the remote setting.

Limitations and further directions

As the aim of this study was to increase understanding about how patients experienced the transition to telepsychotherapy during the COVID-19 pandemic, a qualitative approach with inductive thematic analysis was considered an adequate methodological choice. With this explorative aim, we found that semi-structured interviews with open questions, complemented by follow-up questions, was an appropriate form of data collection. We regard the sample size of 11 patients as a compromise between conducting an in-depth exploration of the participants' experiences and striving to include participants with different therapeutic orientations and work conditions, while still allowing us to reach a saturation point when additional data fail to generate new understanding (Hennink et al., 2017; Braun and Clarke, 2022). Furthermore, this sample size is suitable for experiential thematic analysis and a study in a large project (Braun and Clarke, 2013, pp. 45, 49). The participants were in treatment with different theoretical orientations, varying time in therapy prior to the first transition and varying treatment duration, and using different communication aids. Such a heterogeneous sample can be seen as a limitation; however, our aim was to explore different facets of the patients' long-term experiences of shifts between the in-person setting and remote sessions. It is a limitation that only one of the respondents from the previous interview study (Werbart et al., 2022) agreed to participate in the present study, as the original goal of investigating changes from immediate experiences to long-term experiences among patients who had transitioned to telepsychotherapy could not be completely fulfilled. Still another weak spot is that we could not include the patients' therapists and explore similarities and differences of views within the therapeutic dyads. The present study was limited to the participants' subjective perspectives and did not include quantitative measures of patient satisfaction, expectations, working alliances, or experienced outcomes. Furthermore, it might be a limitation that the interviews were conducted in digital format using Zoom, with the cameras turned off. As in telepsychotherapy, important interpersonal information from body language, facial expressions and eye contact became lost in the research interviews, which might have negatively affected the interview relationship.

Psychotherapists have had to adjust their interventions to telepsychotherapy, often in improvised form, since they were forced to switch to remote therapy. An area for further research is how therapists have modified their approach and interventions in order to

overcome difficulties in the therapeutic relationship and intensity of treatment, as well as how patients experience these modifications. Some of the problems of telepsychotherapy that the present study pointed out might be possible to overcome, whereas others will not. This is something that research could find out. A further area of research is the increasingly common use of hybrid approaches, with one question being for which patients, under which circumstances and in which therapeutic modalities hybrid treatments can be justified, and when they are rather an expression of the patient's or the therapist's resistance and defenses.

Conclusion

The present study of the patients' experiences of switching between in-person and remote psychotherapy sessions contributes to several learnings for the therapists and researchers. Our results indicate that format alternations have an impact on which interventions can be implemented remotely or in hybrid treatments. Furthermore, there may be specific risks associated with the remote setting for patients with certain types of difficulties. For example, some patients did not dare to use remote therapy in the same way as in the conventional in-person setting due to their fears of not getting enough support and of increased self-harm and dissociation. On the other hand, for some patients the remote setting could facilitate the regulation of closeness and distance in the therapeutic relationship and the expression of their emotions. Another learning is that the therapists need to actively negotiate the transitions between in-person and remote sessions together with the patient. Exploring and working through patient experiences of format alternations might in itself become an important contribution to the therapeutic process. However, more knowledge is still needed to understand how in remote or hybrid settings the different therapeutic approaches have to be adapted to the patients' problems and their individual needs for distance and closeness in relationships. A further topic for research is the role of the therapist in making the transition as helpful as possible.

Data availability statement

The datasets presented in this article are not readily available because Interviews with participants cannot be shared due to confidentiality. Requests to access the datasets should be directed to camilla.vonbelow@psychology.su.se.

Ethics statement

The studies involving human participants were reviewed and approved by Swedish Ethical Review Authority (registration numbers 2020-06819 and 2021-01188). The patients/participants provided their written informed consent to participate in this study.

Author contributions

CB was responsible for this particular study and article within the larger project and designed the data collection and research questions. She supervised JB and TM in the process of the analysis, wrote early drafts of the article and developed these together with the other authors. JB and TM participated in designing data collection and were responsible for recruiting the participants, acquisition of all the data included, primary analysis and interpretation of the data for the work, early drafting, and critical revision in the later stages of the work. BP was co-researcher in the research project and participated in planning and designing the present study. He drafted some parts of the manuscript and participated in the text revisions leading to the final version to be submitted. AW was project leader and principal investigator in the research project on transitions to telepsychotherapy. He participated in planning and designing the present study, continuously scrutinized the progress of the study, data analysis, interpretation of results, and early drafting, and substantially contributed to the final version to be submitted. All authors have given final approval of the version to be published and agreed to be accountable for all aspects of the work.

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Conflict of interest

The authors declare that the research was conducted in the absence of any commercial or financial relationships that could be construed as a potential conflict of interest.

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Modification of the therapist's facial expressions using virtual reality technology during the treatment of social anxiety disorder: a case series

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Exposure therapy is a mainstream of treatment for social anxiety disorder (SAD). However, effort and time are required to recreate interpersonal situations that produce moderate anxiety. On the other hand, virtual reality exposure therapy can easily control anxiety-inducing conditions and allow for graduated exposure. However, artificial intelligence and animations that speak as naturally as actual humans are not yet practical, adding to the limitations of these treatments. The authors propose the use of a virtual reality technology that can transform facial expressions into smiling or sad faces in real time and display them on a monitor, potentially solving the above-mentioned problems associated with virtual reality animations. This feasibility study was conducted to determine whether this system can be safely applied to the treatment of SAD patients. A total of four SAD patients received 16 exposure therapy sessions led by an experienced therapist over a monitor; throughout the sessions, the facial expressions of the therapist were modified using software to display expressions ranging from smiling to sad on the monitor that was being viewed by the patient. Client satisfaction, treatment alliance, and symptom assessments were then conducted. Although one patient dropped out of the study, treatment satisfaction and treatment alliance were scored high in all the cases. In two of the four cases, the improvement in symptoms was sustained over time. Exposure therapy in which the interviewer's facial expressions are modified to induce appropriate levels of anxiety in the patient can be safely used for the treatment of SAD patients and may be effective for some patients.

KEYWORDS

social anxiety disorder, exposure therapy, facial expressions, virtual reality, fear of negative evaluation

Introduction

Social anxiety disorder (SAD) is characterized by a strong fear of situations involving other people's attention. Its prevalence varies by geographical region; for example, the 12 month prevalence rate in the United States is 6.8%, making it the third most common mental disorder (Kessler et al., 2005). After disease onset, social life becomes disturbed as the patient begins to avoid interpersonal situations, resulting in high social costs (Patel et al., 2002). Since less than 25% of patients achieve remission after 2 years of drug therapy and only 35% achieve remission after 10 years (Yonkers et al., 2001; Keller, 2006), the disease often follows a chronic course. Exposure therapy has been shown to be effective as a major treatment method other than pharmacotherapy (Heimberg et al., 1985; Ponniah and Hollon, 2008). However, when exposure therapy is conducted for SAD patients, a great deal of effort and time are required to recreate interpersonal situations capable of causing adequate anxiety (e.g., exposure to public speaking requires gathering people together and controlling their reactions).

The development of virtual reality (VR) exposure therapy (VRET) for anxiety disorders has recently been attempted (Mishkind et al., 2017). VR enables the artificial creation of various situations and can more easily control the conditions that induce anxiety, compared with *in-vivo* exposure therapy, making gradual exposure possible. Studies have also been conducted to examine the effects of VRET for SAD by reproducing speaking and eating situations. The effect of VRET on SAD has been confirmed in several meta-analysis. In comparison with psychotherapy using *in-vivo* exposure, the results showed non-inferiority of efficacy at post-treatment time points (Chesham et al., 2018; Horigome et al., 2020). However, it is unclear whether VRET or *in-vivo* exposure has superior long-term effects, as there are few reports comparing the effects of two groups longitudinally. While some meta-analysis reported that VRET is also non-inferior to psychotherapy with *in-vivo* exposure in terms of long-term efficacy (Kampmann et al., 2016), a meta-analysis that included more trials indicated that it may be inferior to *in-vivo* exposure in the long term (Horigome et al., 2020).

To increase the effectiveness of VRET, the need to make the sociocultural context of the VR scenario resemble the environment in which the subject is located has been noted (Emmelkamp and Meyerbröker, 2021). However, even with these efforts, it is difficult to eliminate the context of using VR. The lifelikeness of VR animations used in previous studies was insufficient, and the available conversational responses were limited. Artificial intelligence and animations that speak as naturally as actual humans are not yet practical. Therefore, we thought that controlling the facial expressions of actual therapists engaged in natural conversations with their patients might be effective for eliciting anxiety in a step-by-step manner. Functional-brain imaging studies suggest that patients with SAD show more amygdala activation than healthy controls when perceiving negative facial expressions and that amygdala activity is correlated with the severity of SAD (Stein et al., 2002; Straube et al., 2005; Phan et al., 2006). Therefore, it may be possible to control the anxiety level of SAD patients by displaying real-time modifications of the therapist's facial expressions. We have developed software that can transform facial expressions captured by a 3-dimensional camera into smiling or sad faces in real time and display them on a monitor. We hope that in the future, this system can be used to treat patients with SAD, enabling interviews to be conducted with appropriate control of the patient's anxiety, thereby improving the effectiveness of regular psychotherapy, the persistence of treatment effects, and the rate of treatment continuation. The present feasibility study was performed to determine whether this system can be safely used to treat SAD patients. This study was an exploratory investigation that was not performed based on any rigorous scientific or therapeutic guidelines and was also not intended to investigate the effects of the intervention.

Methods

Subjects who met the DSM-5 diagnostic criteria for SAD were included. Subjects with pre-existing medical conditions such as bipolar disorders, schizophrenia spectrum disorders, or substance-related disorders, those with imminent suicidal ideation, and those who had received other structured psychotherapy within 12 months were excluded. Recruitment of the participants was conducted through referrals from their primary psychiatrists.

In this study, the hospital and participants' houses were connected via a web conferencing system for conducting patient interviews over a computer monitor. The interviewer's face was automatically captured by a 3-dimensional camera (BlasterX Senz3D), and the interviewer's facial expressions were virtually transformed into smiles or sad faces in real time by the image processing technique used in the authors' previous work (Suzuki et al., 2017). This technique was used to adjust the intensity of the participants' anxiety by adjusting the interviewer's facial expression appearing on the computer monitor (Figure 1). The same therapist conducted all the exposure therapy sessions in all the cases, and 16 sessions were scheduled once a week for 40 min, in principle. Conversations were not structured, and the conversational themes were set freely during each session. In the first session, participants received an explanation of this study, including its purpose, duration, frequency, and the significance of modifying the interviewer's facial expressions. At the beginning of each session and occasionally during the session, the participants were asked to report their level of anxiety on a scale of 1 to 10, and any changes in their anxiety level were shared with the interviewer. When the participant became less anxious with a particular facial expression, participants and interviewers discussed whether they should change the facial expressions to ones that elicit stronger anxiety.

No restrictions were placed on usual outpatient care, such as medication, which was performed in parallel with the study. The measured outcomes included the Working Alliance Inventory-Short Form (WAI-SF) (Tracey and Kokotovic, 1989; Takasaki et al., 2020) at weeks 1, 8, and 16, the Client Satisfaction Questionnaire (CSQ-8) (Nguyen et al., 1983) at weeks 8 and 16, and the Liebowitz Social Anxiety Scale (LSAS) (Liebowitz, 1987) and the Fear of Negative Evaluation Scale (FNE) (Watson and Friend, 1969) at weeks 0, 8, 16, and 24, respectively; the Japanese versions of these measures were used.

The ethics committee of Shonan Keiiku Hospital approved the study, and all the participants provided written informed consent. The study was registered with the University Hospital Medical Information Network (UMIN 000033878).

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FIGURE 1
Facial expression alterations created using our software.

TABLE 1 Changes in measures.

		Baseline	8w	16w	24w
Case 1	WAI-SF	81	83	80	
	CSQ-8		30	31	
	LSAS	93	93	61	89
	FNE	26	7	11	14
Case 2	WAI-SF	76	74	81	
	CSQ-8		25	24	
	LSAS	126	115	95	94
	FNE	28	29	28	27
Case 3	WAI-SF	77	81	79	
	CSQ-8		29	30	
	LSAS	53	48	40	34
	FNE	24	22	15	16
Case 4	WAI-SF	83	83		
	CSQ-8		25		
	LSAS	52	71		
	FNE	6	12		

WAI-SF, working alliance inventory-short form; CSQ-8, client satisfaction questionnaire; LSAS, Liebowitz social anxiety scale; FNE, fear of negative evaluation scale.

Results

A total of four subjects (1 male, 3 females, mean age, 31.0 ± 9.9 years; mean duration of illness, 17.3 ± 6.8 years) participated in the study. All the participants were being treated with Selective Serotonin Reuptake Inhibitors, and their medications were not changed during the study period. The measure results for each case are shown in Table 1 and Figure 2. The WAI-SF was 79.3 ± 3.3 at week 1, 80.3 ± 4.3 at week 8, and 80.0 ± 1.0 at week 16. The CSQ-8 was 27.3 ± 2.6 at week 8 and 28.3 ± 3.8 at week 16. In all the cases, patients whose primary psychiatrist was the interviewer in this study were recruited; thus, the interviewer in the sessions and the attending psychiatrist were the same person.

One of the patients (Case 4) was affected by a natural disaster and dropped out because the environmental changes made it difficult to continue the study. Therefore, the study outcomes for three cases are presented below.

Case 1

Case 1 was a 25 year-old male with a 13-year illness duration. He had been unemployed for 3 months and had been living confined to his home. He was aware of his difficulty in maintaining free conversation, and the first half of the sessions were spent practicing free conversation. The contents of the conversation were set to trivial themes, such as favorite foods and taste in clothing. During the conversation, ideas on how to make the free conversation livelier were exchanged. When he experienced a change in the therapist's facial expression, he reported being more afraid of a smiling face than of a normal face, and he expressed an even stronger fear of a sad face. Nevertheless, after the third session of exposure to sad faces was performed, his fear gradually decreased, and from the fifth session, the sad face began to be used most of the time. From that point on, he began to talk about increasing the things he could do between sessions, and he discussed what types of challenges would be good for him to take on. He increased his opportunities to go out alone, and by the 8th week, his FNE score had improved. After the 8th week, he became aware of the improvement in his symptoms, and he started going out to eat alone and making appointments to meet with others. In the second half of the sessions, he requested to practice interviewing for a job, and the interviewer conducted a mock job interview, along with free conversation. By the 14th week, he started job hunting; however, he had a very hurtful and depressing experience during the process and was unable to find a new job. His LSAS score improved during the 16th week, but his FNE score worsened. At the 24 week follow-up, he remained unemployed, and both his LSAS and FNE had worsened.

Case 2

Case 2 was a 35 year-old female with a 20 year illness duration. Although she had been working, she wanted to change her job; she mentioned that she wanted to improve her condition so that she could complete a job interview. While she said she was not afraid of the

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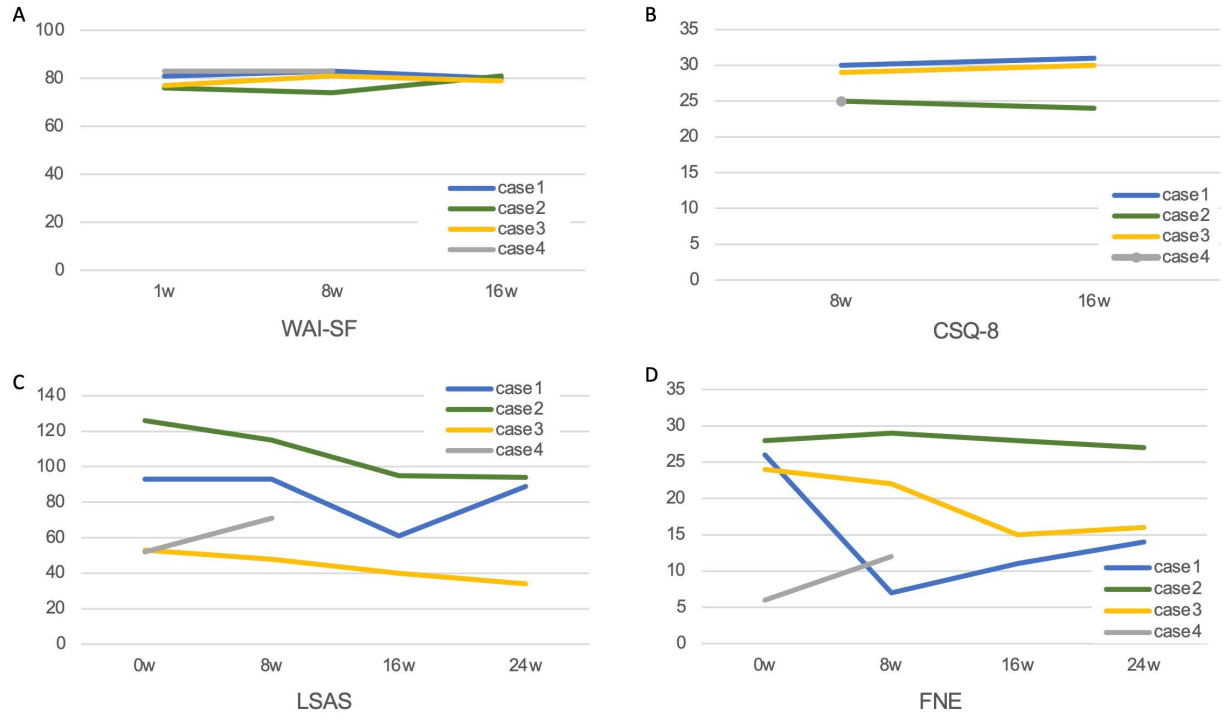

FIGURE 2
Changes in measures. **(A)** WAI-SF (Working Alliance Inventory-Short Form), **(B)** CSQ-9 (Client satisfaction questionnaire), **(C)** LSAS (Liebowitz Social Anxiety Scale), and **(D)** FNE (Fear of Negative Evaluation Scale).

therapist's smiling and normal facial expressions, she was afraid of the sad face. Objectively, when the interviewer's expression changed to sad, the patient's facial expression stiffened and she had difficulty speaking. While engaging in free conversation, exposure to the sad face was started during the third session, and the duration of exposure was gradually increased. The contents of the free conversation were negative memories of the past, such as how she could not do as well as others, how she had made mistakes in important choices in her life, and what kind of bad luck she had suffered. The therapist tried to listen empathetically and to identify what she was doing well and give positive feedback. However, as if to deny such positive feedback, the communication became repetitive, with the patient insisting what she was not doing well. Even when the therapist tried to talk about topics that did not seem to be related to her symptoms, she talked about her own negative episodes that were related to the topics. She also had a fear of eating in front of others and tried to have a free conversation with the interviewer while eating together over a computer monitor. However, the patient reported that she was very fearful, especially when the interviewer told her how she was eating, and she became very concerned about how she was being looked at, with her fear instantly intensifying. The patient began to experience challenges in life situations outside of the sessions, such as communicating within the workplace, which she had been having difficulty with, and going out to eat with friends. She reported that her fear of the therapist's sad expressions did not disappear until the last session. Her LSAS score gradually improved and the improvement had persisted at the 24 week follow-up, but her FNE score did not improve. In addition, the patient was unable to gain the confidence needed to interview for a new job.

Case 3

Case 3 was a 21 year-old female with a 9 year illness duration. The patient's baseline LSAS score was the lowest among the participants, but she expressed a strong fear of sad faces. At her request, she spent most of the interview time viewing the smiling face until the 10th session. Even viewing the smiling face, the patient was highly nervous and sometimes cried, although this gradually ceased during the sessions. At the beginning of the session, the conversation focused on the patient's student life, past memories, and family, and the interviewer listened sympathetically as the patient sometimes talked about things related to her current medical history. The patient began to reflect more on things related to her symptoms and became aware that she was afraid that people might be angry with her. She also said that she had only vaguely recognized feelings of anxiety; however, she was now able to think objectively about why she was anxious and what effects anxiety had on her. From the 11th session, the patient began to choose a normal facial expression most of the time. When the sad face was attempted in two sessions, the patient rarely looked at the monitor and became grim. During the 12th session, the patient noticed that she was not good at asking questions about others during free conversation, and from the 13th session, she began to practice taking on different roles (e.g., she was a senior member of a club, and the interviewer was a junior member), asking questions, and trying to make the free conversation livelier. Both her LSAS and FNE scores improved, and the improvements had persisted at the follow-up.

Discussion

Only Case 4, who showed lower L-SAS and FNE scores on the baseline than the other participants, dropped out of the study. While it is not entirely impossible that the dropout could have been caused by the interventions used in this study, there is a clear reason that a natural disaster made it difficult for Case 4 to continue the study, and we have determined that the software used in this study can be safely applied to the treatment of SAD. A previous study has reported a mean WAI-SF score of 77.9 for patients with anxiety disorders who underwent 16 weeks of video conference-delivered cognitive behavioral therapy intervention (Matsumoto et al., 2018). In addition, another study reported that psychiatric patients treated with telepsychiatry had a mean CSQ-8 score of 21.6 after 4 months (Bishop et al., 2002). Our results are comparable to these previous studies. The WAI-SF and CSQ-8 scores remained high throughout the study in all the cases, suggesting that this system does not affect therapeutic alliance or patient satisfaction. Working alliance is an important variable in psychotherapy (Sharf et al., 2010; Flückiger et al., 2018), and cognitive behavioral therapy for SAD has also shown that working alliance is related to treatment efficacy and study dropout (Haug et al., 2016). Although a few reports have examined how the use of VR affects the working alliance, previous studies of VRET for SAD have reported that VRET did not affect the working alliance, when compared with *in-vivo* exposure (Anderson et al., 2013; Bouchard et al., 2017). In VRET, high presence might reduce the tendency for patients to drop out of treatment, thereby increasing the effectiveness of the therapy (Robillard et al., 2003; Krijn et al., 2004; Price and Anderson, 2007). We thought the software we used is likely to achieve a higher presence than the use of VR animation because it displays the therapist's face with real-time modifications. Future research should verify such things.

All participants reported that changing facial expressions also changed their feelings of fear, suggested that the software used in this study may be used to provide graded exposure therapy to SAD patients. In the future, we will need to confirm scientifically whether patient anxiety can be regulated. The ability to modulate patient anxiety may help to reduce the treatment burden, preventing dropout and increasing treatment satisfaction. In fact, Cases 2 and 3 were anxious about their usual medical visits, and they reported that conducting the interview using the system's smiling face helped to reduce their anxiety. These findings suggest that a smiling face may facilitate the introduction of treatment for SAD.

Although this system required a 3-dimensional camera and a personal computer, it was easy to use and the modified facial expressions appeared natural without any discomfort. Therefore, the system can be easily applied to actual clinical practice. The use of telemedicine has recently become more widespread worldwide because of the COVID-19 pandemic (Kinoshita et al., 2020), and combining telemedicine with technology such as that used in this study may increase the likelihood of treatment for severe SAD patients, including those who are experiencing social withdrawal. Although the course of treatment varied from case to case, some cases showed notable improvement, despite the use of unstructured interviews, free conversations, and non-specific psychotherapy.

Cases 1 and 2 started their exposure to the sad face during the third session and increased the duration of exposure thereafter. Neither of them achieved their goal of getting new employment, but the changes that occurred throughout the sessions were different.

Case 1 was very positive about the study, and gradually became less fearful of sad faces; he seemed to gradually increase his self-efficacy as the sessions progressed. He was willing to increase what he could do outside of the sessions, and from the 5th session, he increased the range of his activities and seemed to become more confident. Unfortunately, his LSAS and FNE scores worsened after a job search that did not go well and a hurtful experience. Nevertheless, he seemed to have been improving steadily up until then.

In contrast, Case 2 continued to talk negatively about herself, asserting her lack of confidence until the end of the study. Her fear of the sad face did not decrease, and while her LSAS score decreased, her FNE score did not improve. Exposure therapy is a treatment method in which extinction learning occurs by experiencing anxious situations in a safe environment. Extinction learning is a new learning modulated by context, rather than erasing the original learning (Bouton, 2004). In Cases 1 and 2, the interviewer gave positive feedback with a sad face, which may have sounded sarcastic in this context, or the patient may have felt that the interviewer was giving a negative evaluation. Case 1 was convinced that the interviewer's sad face was artificially created, and while he felt fear of the sad face, he also felt reassured by the positive evaluation. On the other hand, Case 2 stated that even though the interviewer was giving a positive evaluation, she felt that she was being evaluated negatively inwardly. Thus, she repeatedly denied the interviewer's positive feedback. For Case 2, the positive feedback combined with a sad face led to her experiencing a feeling of being negatively evaluated as a result of talking about herself. Additionally, since the contents of the negative evaluation were unknown, she was unlikely to have any perception that it is safe to be evaluated negatively by the interviewer. Rather, she may have continued to have a vague fear that the evaluation might lead to something bad. Therefore, extinction learning for the FNE was unlikely to have occurred, and her score did not improve. Incidentally, the FNE has been considered a core cognitive bias that causes maladjustment in SAD patients (Weeks et al., 2005). However, in recent years, fear of receiving praise or positive feedback in social situations, that is fear of positive evaluation (FPE), has also come to be considered as an important cognitive component of social anxiety (Wallace and Alden, 1995; Fredrick and Luebbe, 2020). It is possible that the FPE score might have increased in Case 2, although FPE was not measured in this study.

Meanwhile, Case 3 appeared to be sufficiently fearful even when the smiling face was used; only the smiling face was used until the 10th session, and the sad face was rarely used. Nevertheless, she began to deepen her introspection about her medical condition, to think of ways to practice improving her communication skills, and thus to take control of her fear on her own. As a result, both her LSAS and FNE scores improved and the improvements persisted until the end of treatment. Reportedly, highly socially anxious individuals tend to avoid smiling even if they evaluate it positively (Heuer et al., 2007). Even subjects who are unaware of their fear of smiling may be unconsciously or biologically fearful of smiling; thus, smiling may be useful as an exposure stimulus. Furthermore, since SAD patients tend to be more concerned about what others think of them, it seems that even a smile can elicit fear, especially if the facial expression is not consistent with the context of the conversation. Consequently, even if the patient is aware that smiling does not elicit fear, as in Case 2, it may be worthwhile

to continue smiling sessions for a longer period of time, while carefully monitoring the patient's condition. Additionally, previous studies on communication with virtually transformed the facial expressions as used in our system have also shown that the use of smiling improves the smoothness of conversations during web conferencing, enhances creativity during collaborative work, and promotes idea generation (Nakazato et al., 2014; Suzuki et al., 2017). As with Case 3, it may also be effective when used for exposure therapy for SAD patients. Smiling may facilitate the generation of ideas for treatment and enhance working alliances by facilitating collaborative communication, which may ultimately lead to therapeutic benefits.

The present study was a pilot study and was limited to three cases. Since we did not have a therapeutically planned exposure group and there was no control group, whether the observed improvements in symptoms were due to our systems could not be determined. However, the accumulation of examples and further exploration of effective utilization methods may be worthwhile in the future.

Conclusion

Interviews performed by modifying the therapist's facial expressions via a web conferencing system could be conducted without causing treatment dropout or adverse events. During treatment for SAD, changing the therapist's facial expression to a smile over the monitor may increase the effectiveness of the treatment by reducing resistance to the treatment and improving the therapeutic relationship. In addition, changing to a sad facial expression elicited fear in the SAD patients, suggesting that facial expression modification could be used as a graded exposure stimulus.

Data availability statement

The datasets presented in this article are not readily available because our raw data contains personally identifiable information. Requests to access the datasets should be directed to TK, taishiro-k@mti.biglobe.ne.jp.

Ethics statement

The studies involving human participants were reviewed and approved by the ethics committee of Shonan Keiiku Hospital. The patients/participants provided their written informed consent to participate in this study. Written informed consent was obtained from the individual(s) for the publication of any identifiable images or data included in this article.

Author contributions

TH contributed to the design of the study, performed all the interventions, collected the data, and wrote the manuscript. SY and TT developed the system and provided technical assistance. MM and TK contributed to the design of the study and the writing of the manuscript. All authors contributed to the article and approved the submitted version.

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Conflict of interest

SY is employed by OMRON SINIC X Corporation.

The remaining authors declare that the research was conducted in the absence of any commercial or financial relationships that could be construed as a potential conflict of interest.

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Outcome trajectories in a county mental health clinic before and after telemental health: a retrospective COVID-19 cohort study

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Background/objectives: Telemental health (TMH) care has received increased attention, most recently due to the COVID-19 pandemic. Many treatment settings and clinicians were forced to rapidly shift to TMH modalities, including clinicians with limited exposure to and possibly negative attitudes toward alternative treatment delivery formats. With the shift to new modalities, effectiveness research is necessary to understand if patients are receiving the same quality of care as before the pandemic and their receipt of mostly in person services. This study compared the naturalistic treatment outcome trajectories for a cohort of patients who received in-person services prior to the pandemic and a distinct cohort of patients who received TMH services after the onset of the pandemic, in a community mental health setting with limited exposure to TMH prior to the COVID-19 pandemic.

Materials and methods: We adopted a retrospective cohort design to examine treatment modality as a between-group moderator of symptom change trajectory on the self-report Patient Health Questionnaire (PHQ-9) in a sample of N=958 patients in the Northeast United States. Treatment durations differed in the naturalistic treatment setting and we examined patient-reported outcomes up to a maximum of one year.

Results: Statistically significant average decreases in symptom severity were found over the course of up to one year of treatment, yet the average outcome trajectory was not significantly different between two modality cohorts (in person delivery before the pandemic versus TMH delivery after pandemic onset).

Conclusion: These findings suggest that even in a setting with limited exposure to or training in TMH, the average outcome trajectory for patients who received TMH was statistically similar to the outcome trajectory for patients in an earlier cohort who received in-person services prior to the pandemic onset. Overall, the results appear to support continued use of TMH services in community treatment settings.

KEYWORDS

telemental health, community mental health center, outcome, COVID-19, patient characteristics

Introduction

Although there is room for improvement, psychotherapy has demonstrated effectiveness in the treatment of a range of mental health and comorbid conditions in both controlled and naturalistic treatment settings (Barkham and Lambert, 2021). Most psychotherapy outcome studies have involved in-person, face-to-face intervention delivery formats (Barkham et al., 2021). However, telemental health (TMH) interventions have received significant attention in the past two decades (Lamb et al., 2019). Similar to face-to-face psychotherapy, TMH interventions appear to be generally effective (Bashshur et al., 2016; Hubley et al., 2016). When compared directly to more traditional in-person interventions, TMH interventions evidence similar outcomes (Backhaus et al., 2012; Varker et al., 2019).

Several factors have likely motivated increased attention toward the development, testing, and dissemination of TMH. One reason is the promise to mitigate mental health care access problems (Dowling and Rickwood, 2014; Olfson et al., 2019). Unmet treatment needs are especially prominent in elderly populations, those who identify as a racial-ethnic minority, low-income individuals, and those who reside in rural areas (Wang et al., 2005; Olfson et al., 2019). Despite the promise of improving access, in general as well as in specific populations, there are limitations to existing research on TMH outcomes and knowledge gaps remain.

To our knowledge, naturalistic TMH implementation has been examined most extensively in the United States (U.S.) in the context of the Veterans Administration (Offering Veterans VA Care Closer to Home, 2021). A recent cohort study of rural U.S. Veterans found that dissemination of internet-ready tablets for TMH in the context of the COVID-19 pandemic was associated with reduced suicidal behavior and emergency department visits (Gujral et al., 2022), Much of the other evidence regarding TMH effectiveness in the U.S. is derived from controlled studies involving homogenous patient samples (Schwartzman and Boswell, 2020). In addition, and not surprising, TMH efficacy research has mostly relied on clinicians with both interest and at least some degree of credentialed training in delivering interventions in TMH formats (Varker et al., 2019). In contrast to this self-selection, the COVID-19 pandemic required most mental health care systems and professionals to shift to TMH more or less overnight (Pierce et al., 2020; Perle, 2022), and TMH use peaked during the pandemic (Torous et al., 2020).

Pierce et al. (2020) conducted a survey of psychologists who *did not* use TMH prior to the COVID-19 pandemic. Among the most endorsed reasons for not using TMH prior to the pandemic were insufficient training, privacy issues, unclear reimbursement practices, efficacy concerns, and insufficient demand. Interestingly, a different survey of over 400 therapists with diverse training backgrounds indicated that most therapists reported having *some* degree of past TMH training/education (e.g., a workshop), yet less than half reported using TMH prior to the COVID-19 pandemic (Perle, 2022). Similar studies suggest that prior to COVID-19 approximately 20% of psychologists had used TMH at any frequency in their practice (Glueckauf et al., 2018). Low rates of pre-COVID-19 TMH adoption may be partly explained by some clinicians possessing negative, or at least ambivalent, attitudes toward TMH (Adler-Milstein et al., 2014; Wade et al., 2014). Some findings indicate that *patients* of color espouse concerns about the quality of TMH compared with in-person services (George et al., 2012). Recent research on potentially shifting clinician attitudes toward TMH has highlighted that clinicians perceive both advantages (e.g., improvements in access to services) and disadvantages (e.g., concerns about alliance quality) to increasing reliance on TMH (AlRasheed et al., 2022; Lipschitz et al., 2022).

Increasing our knowledge of mental health care stakeholder attitudes and experiences regarding the increased reliance on TMH is important. In addition, there is a need for more research on the *effectiveness* of TMH in routine community mental health settings. Naturalistic outcome studies in this area are lacking and even less is known about outcomes in more diverse community settings. COVID-19 has raised additional interest in understanding potential outcome differences among treatment modalities. Specifically, for many systems that were required to shift rapidly to TMH in the context of COVID-19, it is unclear if patients treated via telehealth after the onset of COVID-19 experienced similar, worse, or better outcomes than patient cohorts that were treated in-person prior to COVID-19. The current study investigated patient reported outcome trajectories in a mental health clinic in the context of their rapid shift to TMH at the start of the COVID-19 pandemic.

The current study is a continuation of a practice-research partnership between a county mental health clinic and psychotherapy researchers in the Northeast United States. The clinical context is a public supported mental health clinic that provides outpatient mental health services to under-resourced individuals in the community, many of whom suffer from a severe and persistent mental illness. Prior to the COVID-19 pandemic, psychotherapy interventions in this setting were universally delivered in-person. Within a few days of the onset of the pandemic, psychotherapy interventions became universally telehealth in modality, including both telephone and videoconferencing formats. Despite a general awareness of the emergence and reported effectiveness of TMH, stakeholders in the setting were skeptical of TMH and did not pursue targeted or rigorous training in TMH prior to COVID-19. Based on personal communications with clinic administrators, the existing concerns were consistent with published survey research (e.g., Connolly et al., 2020; Lipschitz et al., 2022). Given their rapid shift to TMH, administrators were interested in examining their own routinely collected patient reported outcomes for cohorts of patients who were seen before versus after the implementation of TMH. As part of the ongoing practice-research partnership, clinic stakeholders provided permission for researchers to use some of their routinely collected data to investigate potential differences in patient reported outcomes in the context of the pandemic prompted move to TMH.

Based on routinely collected data from this clinic, the present practice-oriented research study aimed to explore trajectories of change in the clinic's primary repeated outcome measure (Patient Health Questionnaire, PHQ-9; Kroenke et al., 2001), with particular attention to in-person vs. TMH services (or pre- versus post-COVID-19 patient cohorts) as a between-group moderator of change trajectory. Using a retrospective cohort analytic design, we explored if group-level outcome trajectories differed as a function of treatment modality.

Given existing research on the effectiveness of TMH, we expected that the overall trajectory of change would be similarly positive between in-person pre-COVID and telehealth post-COVID onset cohorts. Notably, however, the unique features of this setting rendered

this expectation tentative. Prior to COVID-19, anecdotally, attitudes toward TMH in this setting were mixed at best. In addition, exposure to TMH training was extremely limited. Finally, this urban setting serves a relatively higher proportion of economically disadvantaged individuals with severe and persistent mental illness who are less represented in the existing TMH research (Schwartzman and Boswell, 2020).

Materials and methods

Participants

Data were derived from the routine data collection infrastructure of an outpatient community mental health clinic (CMHC) in the Northeastern United States. This CMHC provides treatment to adult county residents with serious mental illness and substance use disorder diagnoses. This setting collects routine data from patients to monitor treatment processes and outcomes and inform quality improvement. Adult patients at the CMHC between September 2017 and August 2021, and who completed the PHQ-9 at baseline and at least one follow-up timepoint ($N = 958$) were included in the current study. Patients were excluded if they were missing any PHQ-9 score or if they had a baseline value yet no follow-up data. Additional demographic information was obtained from records kept by the facility. Demographic information is typically collected in the context of the initial intake appointment and is expected to be entered into an administrative database by the assigned clinician. Although the date of service when a PHQ-9 questionnaire was administered and a baseline PHQ-9 score was available for all patients included in the analyses, other demographic variables had significant missingness. Racial/ethnic identity was not recorded for most of the sample, and among those for whom racial/ethnic identity data were available ($n = 206$), racial/ethnic identity was coded as unknown for 18.4% of cases. Among the remaining ($n = 168$) patients with known racial/ethnic information, 60.7% were recorded as White, 32.2% as Black, 3.0% as another race or mixed races, 2.4% as Hispanic/Latinx, and 1.7% as Asian or Asian-American. Approximately half of those whose sex was available ($n = 268$) were recorded as male (55.2%) and the remainder were recorded as female. Patient age ranged from 19–77 ($n = 263$, $M = 46.22$, $SD = 13.70$).

New patients are expected to be given a clinician-assigned primary diagnosis based on the Diagnostic and Statistical Manual of Mental Disorders-5 (American Psychiatric Association, 2013). Like the demographic information in the administrative database, many patients did not have a recorded primary diagnosis. For those who had an assigned and recorded diagnosis in the database ($n = 236$), the most common primary diagnoses were in the categories of mood disorders (44.5%) or psychotic disorders (42.4%). The remainder of patients had primary diagnoses of trauma-related disorders (8.1%), anxiety disorders (3.0%), substance use disorders (1.3%), or other disorders (0.8%). Notably, a relatively small percentage of patients in the study database were assigned a *primary* diagnosis of a substance use disorder. Patients with more severe and acute substance-related problems typically receive services in a different affiliated clinic.

Measures

This study evaluated whether treatment modality (before versus after the onset of the COVID-19 pandemic cohort/use of TMH), race/ethnicity (White vs. non-White identifying), and/or their interaction moderated cohort trajectories of symptom change during routine outpatient treatment.

Treatment modality/cohort

Treatment modality (in-person services versus TMH) was nested within pre- versus post-COVID-19 pandemic onset, such that each case was coded 1 for pre- and 0 for post-COVID treatment. Patients who initiated and completed a course of treatment prior to 3/1/2020 were categorized and dummy-coded as pre-pandemic onset/in-person service cases ($n = 738$). Patients who began treatment after 3/1/2020 were categorized and dummy-coded as post-pandemic onset/TMH cases ($n = 220$). This time demarcation reflected the full transition to offering psychotherapy via telehealth at the CMHC.

Outcome

The outcome variable was the PHQ-9 (Kroenke et al., 2001), which is a 9-item self-report measure of depression symptom severity widely used as a screening and outcome monitoring measure in primary care and mental health care settings (Kroenke, 2021). Items correspond to the DSM criteria for major depressive disorder. Patients rate the frequency with which they have experienced each of these symptoms during the past two weeks on a scale from 0 ("not at all") to 3 ("nearly every day"). The PHQ-9 has good internal consistency reliability, with *alpha* between 0.80 and 0.90 (Kroenke et al., 2001; Levis et al., 2019). Originally developed as a depression screening tool, the PHQ-9 has been validated in psychiatric settings and shows good sensitivity to change among patients with diverse psychiatric disorders (Beard et al., 2016). The PHQ-9 is widely used as a general measure of mental health status (e.g., Bone et al., 2021). Recent findings show that in general mental health settings the PHQ-9 functions more as a general measure of symptoms/distress than as a disorder-specific scale, and it may be most appropriate as an outcome monitoring tool in settings where diagnoses are less precise and comorbidity is common (Katz et al., 2021).

Procedures

New patients provided written and informed consent for the clinic to collect and use their routine clinical information for administrative review and quality assessment and improvement purposes. This study was approved as an exempt research project by a university institutional review board (IRB). Diagnoses were assigned by clinicians upon patients' first visit to the CMHC, and patients are administered the PHQ-9 at intake and then throughout treatment. Clinicians are expected to readminister the PHQ-9 on an approximately monthly basis; however, it is up to the clinician's discretion regarding whether an assessment will be conducted at a particular visit (e.g., may not be administered in a state of crisis).

Given the naturalistic setting and the varied nature of the psychotherapies implemented, session frequencies and treatment durations vary among patients. Consequently, there was variability in PHQ-9 data collection.

Furthermore, given the level of impairment of some patients in this setting, information can be collected verbally rather than in patient-completed written form, and regardless of format, PHQ-9 total scores are entered by the clinician in the administrative database. The standard in the setting is for patients to complete measures in a self-report format in the waiting area (pre-COVID-19). However, even prior to the pandemic, clinicians were allowed to administer questionnaires or forms verbally and record responses if deemed more appropriate. When the current treatment setting moved to TMH, the PHQ-9 was administered verbally by clinicians and the scores were recorded in the database. However, it was not the case that all pre-TMH PHQ-9 administrations were more "traditional" self-report administrations. Unfortunately, the precise format of each PHQ-9 administration was not recorded, neither before nor after the move to TMH.

Treatment

All patients received individual psychotherapy services from licensed psychotherapists through the CMHC. Patients were eligible to receive additional services including medication management, group psychotherapy, and treatment planning. Prior to COVID-19 onset, individual psychotherapy took place via in-person sessions and the clinic did not offer telepsychotherapy. In March of 2020, the clinic transitioned to TMH following public health guidance. Although details about the particular treatments delivered were not collected or available, setting staff describe the approach as largely supportive and problem-focused. In the current participant sample, all therapy providers were licensed Masters-level clinical social workers. Although information regarding a particular therapist's theoretical orientation is/was not collected, the predominant orientation is best characterized as integrative, as staff are described as drawing from a mix of supportive, trauma-informed, solution-focused, and third-wave cognitive behavioral therapy approaches.

Data analysis

Analyses were conducted using SPSS version 25. Multivariate normality was inspected within groups of interest. The PHQ-9 total score was the longitudinal outcome variable of interest, and all included patients had a baseline and follow-up PHQ-9 score. Given the naturalistic variability in treatment duration and PHQ-9 observations, we examined these features and observed a large range in both domains. Based on this and input from setting administrators, we applied an additional inclusion/exclusion criterion: for cases with treatment courses that went beyond one year, we excluded PHQ-9 *observations* past the one-year mark. This affected $n = 348$ cases. Notably, no *cases* were removed from the analysis; rather, we elected to remove outlying time points. This increased the consistency between the groups. As expected, cases with trimmed observations (due to a course of treatment exceeding one year) had significantly longer treatment durations than cases with untrimmed observations ($p = 0.00$). The average number of PHQ-9 observations in the post-COVID onset/TMH cohort was slightly higher ($M = 3.18$, $SD = 2.62$; range = 2–26; *Median* = 2.00; 25% = 2.00, 75% = 3.75) than the pre-COVID/in-person cohort ($M = 3.12$, $SD = 1.77$, range = 2 to 20; *Median* = 2.00 25% = 2.00, 75% = 4.00).

Given the multilevel data structure with PHQ-9 scores nested within patients, multilevel models (MLM; Raudenbush and Bryk, 2002) were used to test the primary research question. MLMs are suited for longitudinal data analysis as they are robust to the data dependency. MLMs are efficient in handling missing and unevenly spaced data by using all available data for a given participant to estimate group trends at each time point, making this a particularly suitable approach in this context. Maximum likelihood and an unstructured covariance were used as the estimation method, as well as random intercepts and slopes centered at baseline. Our primary analysis involved one multiple predictor model focused on the pre- versus post-COVID onset (in-person versus TMH cohort) predictor and moderator. Prior to testing this model, we explored the best fitting base model for time coded as the occasion of observation and centered at baseline. The difference between the linear and linear plus quadratic time models exceeded the critical value, so the non-linear time effect was retained in the model. The primary multilevel model included the main effect of treatment modality (pre- versus post-pandemic/TMH onset), linear time, quadratic time, the interaction between treatment modality and linear time, and the interaction between treatment modality and quadratic time. In addition, we tested pattern mixture models to examine if missing value pattern significantly influenced the association between treatment modality and PHQ-9 trajectories (Hedeker and Gibbons, 1997). In each case, the addition of the missing value effects did not result in significantly improved model fit. In addition, the fixed effect interaction with missing pattern was not statistically significant.

Results

Treatment modality cohort descriptives

We explored available demographic and clinical information in both modality cohorts. Group-level descriptives are reported in Table 1, along with inferential test results where applicable (e.g., some non-binary race/ethnicity and diagnostic categories had too few cases). The average baseline PHQ-9 scores in both cohorts were in the mild-to-moderate severity range (Kroenke et al., 2001); the pre-COVID cohort evidenced higher baseline scores. In addition, even with capping treatment duration at one year, we observed a statistically significant difference in treatment length between pre-COVID and post-COVID onset cohorts, with pre-COVID cases averaging many more days in treatment (values represent time in treatment and not number of treatment sessions). In addition, the pre-COVID onset cohort was older in age. We did not observe a difference on dichotomized racial/ethnic minority status between cohorts. Based on comparisons between cases with trimmed and untrimmed observations and the modality cohorts, we included grand mean centered baseline PHQ-9 score, age, and treatment duration as covariates in the primary model.

TABLE 1 Pre- and post-COVID onset cohort demographic information.

Variable	Pre-COVID (total n=738)	Post-COVID (total n=220)		
Category	M (SD)	M (SD)	t-test	p
	n (%)	n (%)	χ^2/Fisher's exact test	
Baseline PHQ-9	7.96 (6.89)	7.02 (6.15)	$t(956) = -1.83$	0.068
Minimum	0	0		
Maximum	27	24		
Gender				
Male	130 (53.9%)	18 (66.7%)	X^2 (1, $n = 268$) = 1.59	0.207
Female	111 (46.1%)	9 (33.3%)		
Minority Status				
White	94 (61.0%)	8 (57.1%)	X^2 (1, $n = 168$) = 0.08	0.775
Non-White	60 (39.0%)	6 (42.9%)		
Diagnosis				
Anxiety	6 (2.8%)	1 (4.2%)		NA
Mood	92 (12.5%)	13 (54.2%)		
Trauma	18 (2.4%)	1 (4.2%)		
Psychotic	93 (12.6%)	7 (29.2%)		
Substance Use	2 (0.3%)	2 (8.3%)		
Other	1 (0.1%)	0 (0.0%)		
Age (Years)	46.79 (13.73)	41.26 (12.63)	$t(261) = -2.00$	0.047
Treatment Duration (Days)	126.31 (129.97)	47.15 (78.55)	$t(956) = -8.58$	0

Means and standard deviations reported for continuous variables. T-values and p-values of independent samples t-tests are reported for continuous variables. Sample sizes and percentages are reported for categorical variables. χ^2-values and p-values of Chi-squared tests and p-values of Fisher's exact tests are reported for categorical variables.

Pre-post COVID-19 onset/telemental health modality cohort model

Model results are reported in Table 2. For the primary predictors of interest, the linear time effect was statistically significant, indicating that, on average, patients experienced improvements in their symptoms over the course of treatment. However, the main effect of quadratic time was not statistically significant. The main effect of treatment modality (in-person versus TMH cohort) was not statistically significant ($p = 0.868$). In addition, the interaction effect between linear time and modality cohort was not statistically significant ($p = 0.346$), and the interaction between quadratic time and modality cohort was not statistically significant ($p = 0.412$).

Discussion

Although evidence for the effectiveness of TMH is encouraging, and controlled research often demonstrates similar outcomes between in-person and TMH interventions, previous studies have typically involved trained and motivated telehealth clinicians and homogenous patient samples. Furthermore, quantitative and qualitative research demonstrates that many patients, therapists, and administrators remain skeptical of TMH. However, attitudes toward TMH may be shifting out of necessity, in the context of the COVID-19 pandemic that forced most service providers to rapidly adjust from in-person to TMH services. Some research has examined the experiences and "lessons learned" of stakeholders, yet less has been published on patient outcomes in routine service settings in the context of COVID-prompted practice changes.

The current study explored the potential impact of the rapid shift to TMH in a CMHC setting that did not offer TMH services prior to the onset of the COVID-19 pandemic, with a comparison of average outcome trajectories between pre- and post-COVID-19 onset patient cohorts. On average, patients receiving psychotherapy in this CMHC demonstrated significant symptom improvement regardless of treatment modality. Average outcome trajectories were positive and did not systematically differ between modality cohorts in this context. The absence of a statistically significant difference is consistent with prior research demonstrating that TMH often yields similar effects to in-person mental health services (Backhaus et al., 2012; Varker et al., 2019).

Although analyses examining the effect of treatment modality did not indicate a statistically significant difference in average symptom *trajectories* between the modality cohorts up to one year in treatment, patients in the pre-COVID cohort presented with somewhat higher baseline severity on the PHQ-9 relative to the post-COVID-19 onset cohort ($d = 0.13$). This result is somewhat counterintuitive given other reports of increasing levels of anxiety and depression in the context of the pandemic (e.g., Bueno-Notivol et al., 2021). Several factors may have contributed to this observed difference, including potential differences between surveys involving broader community samples versus assessments of treatment-seeking clinical samples. Offering psychotherapy via TMH may have improved access to treatment due to the ability of TMH to lessen barriers to and increase reliability of accessing care. This may be especially true among under-resourced individuals in the community such as those served by the clinic. By having access to one's therapist at the "push of a button," barriers such as cost or travel are likely reduced. Without having to leave home, there may be reduced stress associated with needing to find childcare or take extra time away from work, both of which otherwise add to the hardships that may already be experienced by marginalized communities (Hilty et al., 2007; Pruitt et al., 2014).[1] Overall, these findings provide further support for the generalizability of the effectiveness of TMH as part of routine care in CMHC settings.

1 We conducted an exploratory model that examined the effect of racial/ethnic minority status on PHQ-9 outcomes. We failed to find a significant main or interacting effect of this variable. Given the very small sample with available demographic information in the post-COVID onset group, these results must be interpreted cautiously. Please see the Online Supplement for full model results.

TABLE 2 COVID-19 onset/treatment modality effects on cohort outcome trajectories.

Parameter	Coefficient	*df*	*t*	*p*	95% CI
Intercept	7.47	706.83	9.53	0.000	5.93, 9.00
Age	−0.41	253.48	−2.27	0.024	−0.76, −0.06
Treatment Duration	0.08	267.54	0.37	0.712	−0.33, 0.48
Baseline PHQ-9	4.06	253.24	23.65	0.000	3.73, 4.40
Time	−2.11	687.86	−2.61	0.009	−3.69, −0.52
QuadTime	0.24	714.73	1.58	0.114	−0.06, 0.54
COVID/Modality	−0.14	702.05	−0.17	0.868	−1.78, 1.49
Time*COVID/Modality	0.80	688.18	0.94	0.346	−0.87, 2.48
QuadTime*COVID/Modality	−0.13	720.40	−0.82	0.412	−0.45, 0.19

Modality, binary predictor indicating pre- versus post-COVID-19/telemental health modality cohort; PHQ, Patient Health Questionnaire; Time, Linear time effect; QuadTime, Quadratic time effect.

Strengths and limitations

The present study had several strengths. This study used naturalistic clinical data from the delivery of psychotherapy as part of routine care and had a large overall sample. It also had broad inclusion criteria, with diverse diagnoses and ethnicities observed in the patient sample. These factors likely enhance the ecological validity of the study and findings, supporting the generalizability of the findings to patients in similar CMHCs. Findings also have potential to inform decisions regarding services moving forward at this clinic, such as continuing or possibly expanding TMH.

However, the current study also had several limitations. First, we cannot draw conclusions about the precise nature of the interventions delivered, beyond involving psychotherapy in different modalities. Second, there was a substantial amount of missing data, particularly for patient characteristic variables. Data may be missing due to administrative error or oversight; in addition, there may have been some data loss when the setting changed electronic records systems. Third, we do not know the precise method of assessment for each case or time point when services were previously provided in-person. Fourth, this study did not involve random assignment to in-person or TMH. We were, however, able to take advantage of the clear demarcation of TMH implementation, akin to an interrupted time series. Fifth, we did not have access to therapist data, which prevented us from including therapists in our model and testing potential therapist effects. Sixth, given the naturalistic setting, there was a large range in treatment duration and assessment frequency, so we applied a cutoff to reduce some degree of heterogeneity across the sample and groups of interest. The findings are limited to what was observed through up to one year of treatment (see plot of raw scores in Online Supplementary Figure S1). Finally, it is important to note that the current study examined differences at the between group/cohort level and focused on group level-average trajectories. This masks meaningful heterogeneity in response trajectories among different groups of patients.

Conclusion

To our knowledge, this is one of a limited number of studies on the impact of the COVID-19 pandemic and the rapid move to TMH focused on pre- versus post-COVID-19 onset outcomes in routine mental health treatment. Findings add to the growing empirical support for TMH. Results suggest that TMH is a generally effective treatment modality for providing psychotherapy to a range of patients. Future research should focus on unpacking the heterogeneity of modality effects in naturalistic samples. Assuredly some patients in each cohort declined in status over the course of treatment while others improved more substantially. In turn, there may be patients who have a similar likelihood of responding to either modality. It will be important to disentangle this variability and to identify patients for whom in person services (or telehealth) are likely to be of most benefit.

Data availability statement

The raw data supporting the conclusions of this article will be made available by the authors upon reasonable request.

Ethics statement

The studies involving human participants were reviewed and approved by University at Albany Institutional Review Board. Written informed consent for participation was not required for this study in accordance with the national legislation and the institutional requirements.

Author contributions

BH assisted with data collection and management, conducted the data analysis, and assisted in all aspects of the writing process. AS and SA participated in the writing process and contributed as experts. SA also assisted with data analysis. JB facilitated data collection, sharing,

developed study objectives, and participated in the writing process. All authors contributed to the article and approved the submitted version.

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Conflict of interest

The authors declare that the research was conducted in the absence of any commercial or financial relationships that could be construed as a potential conflict of interest.

Publisher's note

Supplementary material

The Supplementary material for this article can be found online at: https://www.frontiersin.org/articles/10.3389/fpsyg.2023.1095217/full#supplementary-material

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Cultural accommodation of internet-based interventions for substance use and related disorders: a proposed comprehensive framework based on a pilot study and a literature review

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Despite the low utilization rates of substance use and related disorders services, and the ability of internet-based interventions for substance use and related disorders (IBIS) to address challenges related to service engagement, limited attention has been placed on the processes for the accommodation of these interventions to diverse cultural settings. This study aimed to develop a framework for the cultural accommodation of IBIS across populations based on a pilot study and a literature review. A pilot study of cultural accommodation of an existing internet intervention for alcohol use was carried out in Israel, which involved focus groups and daily online surveys of prospective consumers (N = 24) as well as interviews with experts (N = 7) in the substance abuse treatment field. Thematic analysis revealed a range of themes that relate to the general Israeli culture and the specific Israeli drinking subculture, identified as needing to be addressed in the process of intervention accommodation. A comprehensive framework for cultural accommodation of IBIS is suggested, consisting of five stages: Technical and cultural feasibility; Engagement of target group; Identification of accommodation variables, Accommodation, and evaluation of the accommodated intervention. In addition, the framework consists of four dimensions of accommodation: Barriers and facilitators; Audio-visual materials and language; Mechanisms of change; Intersectional factors. We suggest that the proposed framework may serve as a guide for the cultural accommodation of existing internet-based interventions for substance use and related disorders across a range of cultural and geographical settings, thus augmenting the ecological validity of internet-based interventions for substance use and related disorders, expanding cross-cultural intervention research, and reducing health disparities worldwide.

KEYWORDS

substance use and related disorders, cultural accommodation, internet-delivered treatment, intersectionality, remote psychotherapy

Introduction

Extensive international research has shown that, despite the numerous benefits of treatment centers for substance use and related disorders (SURD, e.g., smoking, problematic alcohol use, and gambling) in Western countries, utilization rates are low. Only one-fifth of those with signs of an SURD sought treatment in 2019 despite its efficacy (Substance Abuse and Mental Health Services Administration, 2020). Worldwide, it has been estimated that fewer than one in six individuals with a SURD problem, receives treatment each year (World Drug Report, 2018).[1] This treatment gap is due to numerous individual (e.g., shame), social (e.g., fear of stigmatization), structural (e.g., geographical remoteness), organizational (lack of gender sensitive interventions), and economic barriers (e.g., inability to pay for treatment) (Gueta and Addad, 2014; Chebli et al., 2016; Gueta, 2017, 2020). Those barriers are intensified among minorities such as latino adolescents (Burrow-Sanchez et al., 2011), and in geographically remote locations (Arjadi et al., 2015).

Internet-based interventions for substance use and related disorders (IBIS), meaning, the delivery of treatment programs in the form of web sites or mobile applications are well suited to the management of the above barriers given the effectiveness and flexibility associated with internet interventions (Ferreri et al., 2018). In the last decade, varied IBIS has been developed to increase reach, provide real-time monitoring, and offer personalized delivery intervention to tackle a range of SURD (Chebli et al., 2016). IBIS, are part of an umbrella term called E-mental health that encompasses a variety of technological approaches of self-guided interventions to mental health treatment as well as synchronous and asynchronous methods to connect providers to those who need support. Furthermore, the value of IBIS and other digital mental health interventions was recognized during the COVID-19 pandemic for assisting those who do not have access to or do not want traditional face-to-face care (Mark et al., 2022). This issue was particularly relevant to minority groups such as Black, Indigenous, and people of color, since the COVID-19 pandemic intensified the need for culturally responsive mental health services due to higher economic, physical, and mental health effects resulting from the pandemic on those populations (Alvarez et al., 2022). However, despite the need for IBIS during the COVID-19 pandemic, those interventions are less provided by SURD treatment institutions compared to other mental health institutions (Tauscher et al., 2023). This gap is notable since the internet penetration rate, defined as the percentage of the total population who use the Internet has grown globally and can reach up to 67.9% (Internet World Stats, 2022).

Despite the above need and ability of internet-based interventions to reach people around the globe, these interventions are not within reach of many individuals who could benefit from them (Chebli et al., 2016; Muñoz et al., 2018; Salamanca-Sanabria et al., 2018). A systematic review of systematic reviews (Marcolino et al., 2018) which aimed to assess the impact or effectiveness of mobile health interventions in different health conditions, indicated that most studies were performed in high-income countries. The authors concluded, therefore, that there is a necessity to develop and implement computerized interventions in developing countries. For reasons of financial efficiency and validity, this can be facilitated through the adoption of programs that have already been developed elsewhere, for use across cultural and geographical boundaries reducing health disparities worldwide (Gainsbury and Blaszczynski, 2011; Alvarez et al., 2022).

Given the understanding in the cross-cultural psychotherapy literature that culture impacts the content and process of psychotherapy, accommodation of empirically-supported treatment may be best achieved by a standard cultural accommodation (Koç and Kafa, 2019). In this study, cultural accommodation of psychotherapy refers to 'the systematic modification of an evidence-based treatment or intervention protocol to consider language, culture, and context in such a way that it is compatible with the client's cultural patterns, meanings, and values' (Bernal et al., 2009, p.362). Specifically, cultural accommodation of internet-based intervention refers to a systematic, and collaborative process of making changes to a digital health innovation to increase its relevance and acceptability for a local community (Lal et al., 2018). This can increase the acceptability and effectiveness of an intervention for a local population and/or enable the transfer of interventions across cultural and geographical boundaries (Shehadeh et al., 2016; Sundell et al., 2016; Lal et al., 2018; Salamanca-Sanabria et al., 2018). However, little is known about the best methods for cultural accommodation of internet-based intervention given the lack of standardization in the adaptation process in terms of guidelines, procedures, and processes for adaptation as well as the scant documentation of the adaptations made by researchers (Lal et al., 2018; Rathod et al., 2018). This gap is notable in the SURD literature, as the current literature lacks clear guidelines for culturally modifying existing *internet-based interventions*, for substance abuse treatments (Ferreri et al., 2018).

To address this gap in the literature, we sought to develop a comprehensive framework using a mixed emic–etic approach and a multistage procedure (Millward, 2012), synthesizing a literature review (Peters et al., 2015) together with a qualitative pilot study carried out in Israel, on the cultural accommodation of an empirically-supported cognitive-behavioral web-based intervention "Down Your Drink," (DYD) developed in the U.K for young alcohol-users.

IBIS: a critical tool in SURD intervention

Across the world, misuse of substances, and problematic behaviors such as gambling remain serious public health concerns (Fowler et al., 2016). Varied IBIS in terms of treatment goals and methods have been developed to tackle these concerns (Chebli et al., 2016). For example, many existing alcohol applications include self-monitoring wherein users are encouraged to regularly monitor their alcohol consumption, while other programs are intended to prevent relapse by incorporating individualized coping strategies (Garnett et al., 2015). Various methods are used, such as multimedia formats, interactive exercises and quizzes, automated tailored feedback, behavioral tools, chat features, and motivational interviewing (Rooke et al., 2013). IBIS varies concerning guidance,

1 www.unodc.org/wdr2018

as some programs have no interaction between consumer and therapist, and others include regular contact with a therapist through various channels such as email, live chat, or online video-conferencing (Gainsbury and Blaszczynski, 2011), while others combine online peer support group sessions (Cooper, 2004).

Internet-based interventions for substance use and related disorders are available to the general population, for both adults and adolescents, as an alternative to, or as complementing, more formal interventions (Fowler et al., 2016). IBIS have been found to enhance the effects of established treatments among both clinical and subclinical users and to increase the likelihood of users seeking professional help (Fowler et al., 2016). Systematic literature reviews of the effectiveness and treatment outcomes of internet-based interventions for smoking cessation, problematic alcohol use, substance abuse, and gambling, have concluded that internet-based interventions are effective in achieving positive behavioral change (Ferreri et al., 2018; Boumparis et al., 2019; Lin et al., 2019; Kruse et al., 2020; Sagoe et al., 2021). Furthermore, evidence indicates that benefits are associated even with partial program completion (Gainsbury and Blaszczynski, 2011). A recent review of studies also suggests high patient satisfaction with IBIS (Lin et al., 2019; Mark et al., 2022).

Advantages of IBIS for minority cultures and non-western countries

Internet interventions provide a promising avenue for the widespread and cost-effective delivery of treatment that is accessible, affordable, dependable, individualized, and destigmatized (Fowler et al., 2016). This has particular advantages for minority cultures and members of non-Western countries (Marcolino et al., 2018). IBIS can facilitate access in cases of geographical remoteness, transport problems, physical disabilities, work commitments, or childcare problems that have all been described as barriers to substance use treatment (Gainsbury and Blaszczynski, 2011). The ability of internet interventions to monitor and store electronically user's client interactions, feedback, drop-out, traffic, and tool utilization data regarding baseline and follow-up data provides a useful platform for evidence-based practice, allowing results across studies to be replicated, extended, and compared with greater ease and clarity (Gainsbury and Blaszczynski, 2011).

Another advantage of IBIS relates to its' capacity for reducing internal barriers for help-seekers such as stigma, shame, and denial that are intensified among minority populations (Chebli et al., 2016). The perceived anonymity[2] enabled in IBIS has been found to facilitate self-disclosure, openness, and disinhibition of participants within therapy (Blankers et al., 2012). Studies have also highlighted the benefits of confidentiality (Ferreri et al., 2018), visual appeal, accessibility, interactivity, and the flexibility of treatment mode regarding contact with therapists (Hester et al., 2013), and peer-based social support (Blankers et al., 2012; Kruse et al., 2020).

However, despite the benefits, the therapeutic content offered via IBIS may have limitations when applied to certain racial/ethnic minority clients and across a diverse range of cultural and geographical settings, due to their lack of culturally sensitive accommodation. Several recent meta-analyses show that conventional (i.e., non-internet) forms of treatment effectiveness improve if they are modified or adapted to include cultural variables that relate to the particular cultural needs of various racial/ethnic minorities (Shehadeh et al., 2016; Sundell et al., 2016). For example, a meta-analysis of cultural adaptation of minimally guided interventions for common mental disorders (Shehadeh et al., 2016), indicated that higher cultural adaptation scores were significantly associated with greater effect sizes ($P = 0.04$). Conclusions were the need to create frameworks and to provide information on the methods used to allow comprehensive adaptation to other settings and contexts while keeping fidelity with the original intervention (Shehadeh et al., 2016). Yet, despite the evidence regarding the accommodation of common mental disorders interventions, the particular advantages for racial/ethnic minority cultures and non-westerns countries (Marcolino et al., 2018), and the increasing availability of smartphones in low and middle-income countries,[3] cultural adaptation in the area of IBIS has not been thoroughly addressed.

Culturally adapted of internet and non-internet-based interventions

The importance of culturally sensitive or competent therapy has been well theorized, and literature suggests a need for taking into account issues of accessibility and modality as well as the incorporation of culturally-specific elements into the therapeutic process (Rogler et al., 1987; Bernal and Sáez-Santiago, 2006). In line with a culturally competent perspective, cultural adaptation models for *non-internet* interventions have been well-acknowledged as some of them point to specific dimensions of face-to-face interventions that should be modified (Resnicow et al., 1999; Helms, 2015), while other frameworks outline the phases of cultural accommodation (Barrera and Castro, 2006; Hwang, 2009). Regarding the dimensions, one of the first and most widely cited models in the psychosocial intervention literature pertaining to (non-internet) cultural adaptation is the ecological validity model (Bernal et al., 1995). This model, which was originally conceptualized for Latino populations, consists of eight dimensions of interventions (language, persons, metaphors, content, concepts, goals, methods, and context) that can serve as a guide for developing culturally sensitive treatments and adapting existing psychotherapies to specific minority groups. Another cited framework is the Cultural Sensitivity Framework (CSF), which Resnicow et al. (2000) suggested. This framework distinguishes between surface structure and deep structure cultural accommodation to intervention which may be implemented with cultural sensitivity. Surface structure changes aim to improving feasibility by matching materials and messages to outwardly visible characteristics of the target population, such as language, expressions, images, or cultural metaphors. In contrast, deep structure changes target the program's impact on participants

2 In most cases IBIS sites store site user details and not personal identity-related details.

3 http://www.internetworldstats.com/stats.htm

taking into consideration the intersection of social, cultural, and historical variables and core cultural values of a certain population that are relevant to the target behavior.

Additionally, other frameworks propose the phases of cultural accommodation which are needed (Barrera and Castro, 2006; Hwang, 2009). For example, The Cultural Adaptation Process model is a three-phase model (i.e., setting the stage, initial adaptation, and adaptation iterations) which includes research to assess the conceptual fit, determine the needs unique to the community, test adaptations in pilot settings, and make changes using feedback (Bernal et al., 2009). In addition, the Formative Method for Adapting Psychotherapy framework highlights a community-based bottom-up approach for culturally adapting psychotherapy by including stakeholders such as mainstream health and mental health care providers (Hwang, 2009).

However, despite the growing understanding of the need for cultural accommodation of psychological treatment, few models exist which offer guidelines for program adaptation of substance abuse treatment (Burrow-Sanchez et al., 2011). Similar to other psychotherapy interventions (Koç and Kafa, 2019), the efficacy of empirically supported treatments for substance abuse disorders has largely been established in randomized clinical trials with predominantly white samples, which has been criticized from theoretical, ethical, and practice-based viewpoints (Burrow-Sánchez et al., 2015). Such interventions, in use with racial/ethnic minority groups, may impose worldviews of the Western dominant society onto vulnerable populations and be ineffective for minority groups. According to Bernal and Adames (2017), clinicians that strive to employ culturally competent practice to match treatment approaches to their clients' characteristics and needs, may accidentally risk altering effective components of treatment. As such, they suggest cultural adaptation procedures as a way to balance the tension between maintaining fidelity to evidence-best-practice and the need for psychosocial culturally adapted interventions.

Furthermore, there is a need for more information and research attention on the phases as well as the modification of the dimensions involved in cultural accommodation of internet-based interventions, especially since many of the adaptation frameworks that have been developed were originally meant for face-to-face interventions (Sundell et al., 2016; Lal et al., 2018; Alvarez et al., 2022). Specifically, regarding substance abuse treatment, the Cultural Accommodation Model for Substance Abuse Treatment (CAM-SAT) (Burrow-Sanchez et al., 2011) was developed as a framework for guiding the development and testing of culturally accommodated versions of (face-to-face) treatment content and delivery to increase cultural relevance for Latino adolescents. The model includes the possibility of adding additional, culturally specific, modules to the existing program (e.g., on the issue of ethnic identity and adjustment). A recent meta-analysis indicated that culturally sensitive substance use treatments for racial/ethnic minority youth had greater reductions of post-treatment substance use levels (g = 0.37) compared to other conditions (Steinka-Fry et al., 2017).

However, the introduction of web–based interventions demands consideration of additional aspects of cultural accommodation since it applies to the needs and expectations of potential users about the digital medium itself and not only the intervention's content (Burchert et al., 2019). Relying on face-to-face accommodation frameworks may not be valid for the accommodation of internet-based interventions given the characteristics of internet-based interventions (Lal et al., 2018; Alvarez et al., 2022). Many previous cultural adaptations neglected to consider user satisfaction, technical literacy, and educational level (Shehadeh et al., 2016). A recent review identified four distinct types of adaptations for culturally adapted internet-based interventions for mental disorders (Spanhel et al., 2021): alterations to an intervention's structure (e.g., shortening modules), functionality (e.g., accounting for poor internet access), design and aesthetics (e.g., changing graphics to be culturally relevant), and human guidance (e.g., identifying the optimal level of human guidance). Specifically, Lal et al. (2018) in their eHealth adaptation framework for adolescent psychosis identified items that help evaluate users' experiences of a Web-based platform, for example, motivation, aesthetics, accessibility, interaction, quality, and credibility of information, and usability. They raise technical issues (e.g., internet accessibility), as well as the need for exploring issues such as motivation for internet use, desired level of interaction, and how they prefer to see their community depicted in the intervention. Another study (Burchert et al., 2019) found that Syrian refugees face challenges utilizing mental health apps due to low technical literacy, inadequate language proficiency, a lack of acceptance, and a lack of trust in the app.

Furthermore, internet-based interventions, compared to face-to-face interventions, rely heavily on user engagement (i.e., how actively people are using the program), because they cannot rely on a client-practitioner relationship to establish compliance and adherence (Burchert et al., 2019). Thus, usability in internet-based interventions has become a significant factor in successful intervention development and cultural accommodation (Alqahtani and Orji, 2020). High dropout rates and erratic usage patterns threaten the statistical power and validity of the results of trials, as well as their safety. Thus, exploring usability features can increase adherence and may have a significant effect on the acceptance and accommodation of online mental health interventions (Burchert et al., 2019; Balci et al., 2022).

In addition, an important part of any face-to-face cultural accommodation relates to the client-practitioner relationship such as addressing cultural similarities and differences between them (Bernal et al., 1995) or using treatment staff from the target group (Resnicow et al., 2000). Furthermore, a crucial therapeutic element that also needs to be addressed in face-to-face cultural accommodation relates to professional biases and ethnocultural transference meaning the client's unconscious diversion of emotions from someone in his life to the therapist (Hwang, 2009). However, those issues may be non-relevant to IBIS as some of the online interventions are self-guided or include only minimal contact from therapists. Instead, those client-practitioner relationship issues in the internet arena may take other forms or may introduce other issues. Moreover, a recent meta-analysis (Balci et al., 2022) of culturally adapting internet-and mobile-based health promotion interventions indicated a limited impact of culturally adapted interventions. This limited impact is attributed to a lack of detailed phases of the adaption process, the limited surface structure of interventions, and the lack of theory and framework of those cultural accommodations.

Thus, given the limited systematics in the cultural accommodation process of internet-based interventions, including

IBIS, and the reliance on face-to-face accommodation that may be not valid, there is a need to develop specific internet intervention accommodation frameworks for IBIS that will include both the phases and the dimension of this process (Shehadeh et al., 2016; Abi Ramia et al., 2018; Ferreri et al., 2018). Yet, we were unable to find any models designed specifically for the cultural accommodation of IBIS. Due to the inherent differences between face-to-face and internet- based contexts this lack is notable. The current study aimed to develop an initial framework for cultural adaptation of IBIS, with the help of a pilot study using a well-validated existing IBIS, Down Your Drink (DYD), an online intervention developed in the U.K which we sought to adapt to the Israeli context. Specifically, we aimed to conduct a bottom-up, community-driven qualitative study with a multi-stakeholder perspective of Israeli prospective consumers and experts, to inform the cultural adaptation of an internet-delivered intervention to explore the feasibility, acceptance, and users' experience of DYD.

Cultural adaptation of the down your drink (DYD) intervention in Israel: a pilot study

Down Your Drink is an online problem-drinking intervention, originally developed in the U.K. by Linke et al. (2004). DYD includes three phases that assist participants in increasing motivation for change, and provide support during early phases of desistance and assistance in maintaining changes and avoiding relapse (Linke et al., 2008). The original program was designed for use for 6 weeks in a 1-week entry format and is based on the trans-theoretical model of change, the motivational interview, and cognitive-behavioral therapy. Given this therapeutic orientation, DYD is characterized by an enabling and non-confrontational manner reflected both in the style of writing (tone) in the text and the construction of tools aimed at encouraging self-reliance and individual choice (Linke et al., 2008). DYD was developed by researchers and clinicians and has been well-validated and shown good treatment effectiveness. Over the years, the content and presentation of the site have changed according to feedback, advances in the field of short-term interventions, and literature relating to the requirements of interactive sites (Wallace et al., 2011). The program has already been culturally accommodated in additional countries such as Spain (Caballeria et al., 2021). Given the evidence of DYD's effectiveness and the accommodation to other countries, we aimed to accommodate DYD for delivery in Israel, yet we found a lack of a guiding framework as to how to effectively conduct such cultural adaptation.

The Israeli social-cultural context

The need for DYD delivery in Israel is rooted, firstly, in the concerning levels of alcohol use among adolescents and young adults. A survey conducted among 348 16–35-year-olds who visited the general emergency departments in Israel during a week indicated that one fifth of those interviewed were in the habit of consuming more than four units of alcohol per drinking session, indicating a high rate of binge drinking among emergency department patients and a need for intervention (Levinson et al., 2017). Statistics from the Israeli Health Behaviors of School-aged Children 2018–19 study found that 21% of Jewish and 12% of Arab 16–18 year olds reported at least one incidence of heavy episodic drinking (more than 5 units) in the past month (Harel-Fisch et al., 2019).

The Israeli social-cultural context offers a compelling case for the exploration of cultural accommodation of IBIS. On the one hand, some characteristics of Israeli culture have been found to serve as a barrier for accessibility to *face-to-face* SURD treatment. Israeli society has been characterized by its strongly masculine and patriarchal nature, in light of the central role of religion in the daily life and the country's continuous state of war and compulsory army services for all Jewish and some Arab citizens aged 18 (Levy and Sasson-Levy, 2008). This context has been found to serve as a barrier to engagement in face-to-face substance abuse treatment, due to the desire to conceal treatment-related-vulnerability (Gueta et al., 2019). Israel is also a multicultural society composed of diverse ethnic cultures, some of whom experience mistrust in treatment services, creating barriers to face-to-face substance use treatment services (Gueta, 2017). On the other hand, some Israeli social characteristics increase the likelihood of using IBIS and particularly DYD. Israel is characterized by high use of technology: according to the Central Bureau of Statistics, State of Israel (2019), internet penetration in Israel has reached 90% of the population. In addition, the modern Israeli capitalistic lifestyle that treats people in individualistic terms and emphasizes autonomy and self-reliance may be a facilitator to engagement in self-change processes of reducing substance use (Chen et al., 2020). Interestingly, at the same time, Israeli society is also a family-centered society in which family values can serve as a key motivation to drive Israelis to engage in substance use treatment services (Gueta, 2017).

As such, as clinicians and researchers, we believed that Israel is an excellent turf for IBIS. However, we also saw a need for accommodation to the particular social-cultural context. As a first stage, before embarking on a costly process of cultural accommodation, we undertook a pilot study in Israel which included three stages: (1) a week in which study participants were asked to do daily guided use of the English DYD site or, in the case of a control group, daily reading of online self-help literature; (2) Focus groups conducted with the study participants around the experience of their use of DYD or their reading; (3) Seven interviews with experts in the substance abuse treatment field. The findings from the study, together with previous literature, enabled us to map out the dimensions needed for cultural accommodation in Israel, which we believe to have relevance and benefit in additional cultural contexts.

Methods

Research paradigm

This qualitative project used a critical realist paradigm (Maxwell, 2012). Ontologically, critical realism claims that a "real world" exists while acknowledging the mediating power of ideology and social and cultural context in producing these realities

(Maxwell, 2012). Accordingly, the issue at stake – the cultural accommodation of DYD to the Israeli population manifests in and is shaped by a complex interplay between personal history and experience, interpersonal connections, material conditions, and interactions with social institutions. As this study aimed to create a framework of cultural accommodation for IBIS with a particular focus on practice, a critical realist approach, that can inform policy and practice, provided the appropriate lens to develop this framework. Methodologically, this paradigm influenced the development of the research question, interviews, and data analysis (Maxwell, 2012). Specifically, this paradigm emphasizes comparing and triangulating sources and data types (Maxwell, 2012). Accordingly, this qualitative exploratory research design, including source triangulation features (Patton, 2002), was utilized to explore the feasibility of DYD cultural accommodation from prospective users' and experts' perspectives. This triangulation of sources constituted a highly interpretative methodological framework, allowing pragmatic adjustment to an applied setting such as online intervention for substance abuse (Bjelland et al., 2017) Also, following this paradigm affects how data is evaluated and interviews are done (Maxwell, 2012). For instance, under this approach, the interviewer and the interviewee are viewed as active participants in a relationship of mutual learning.

Procedure and participants

User participants were recruited through social media. A strategy was developed and employed for the recruitment of a non- clinical sample (Chen et al., 2020). We posted an announcement through social media (e.g., Facebook groups of students and groups aimed at research participation). The bold headline read: "Do you want to reduce your drinking on your own?" followed by some information about the project. Phone conversations were held with potential candidates for preliminary selection, based on four eligibility criteria: participants should be aged 18–65 years old, own a computer, currently reside in Israel, and have a high level of English (so they could use the site). In addition, participants were screened with the Alcohol Use Disorders Identification Test (AUDIT), and those with scores lower than 8 or greater than 19 were excluded because DYD is focused on intervention for those drinking hazardously or harmfully, who are likely to be experiencing short-term consequences of their drinking, yet unlikely to be seeking any treatment for this misuse. As a result of the adverts, 35 respondents were found; their screening resulted in a total of 28 participants that began the study. Four participants dropped out of the study due to time constraints, which did not enable them to complete the tasks. There were no notable differences between these participants to those that remained in the study in terms of drinking levels or other socio-economic demographics (e.g., age, gender, education). The final current study comprised 24 problematic alcohol users, 9 women and 15 men, aged 22–30 ($M = 25$). Almost all of them had higher education, were employed, and were single.

Following the screening process, 24 participants were randomly assigned to one of two group- (1) those using DYD (16 participants) and (2) a group assigned to on-line self-help literature (eight participants). The first group was given detailed daily instructions for structured use of the DYD site, to ensure the use of a wide range of tools and interventions within the site. These instructions were developed by the research team following intensive acquaintance with the site, and together with the collaboration of the DYD developers in the UK (details of these tasks are available from the authors). The participants were requested to spend 45 min a day over 1 week on the site, from a personal computer. Participants were requested to provide feedback through an online survey before and after every daily session, to validate the use and gain feedback on the day's experience. This survey solicited their comments about each specific module of DYD and allowed us to identify on-line directed feedback on three components: general impressions (likes, dislikes, e.g., "What did you like in the program/unit"); usefulness ("What was most helpful/unhelpful?") and suggestions for modifications to Israeli context and language ("How can we make the program helpful to Israelis?").

In parallel, the second group was sent daily readings from on-line self-help sites, on issues that also appear on the DYD site, for example, personal stories of recovering addicts, the medical and psychological impact of alcohol use, alcohol norms, etc. They were asked to spend 45 min each day reading the literature and similarly filled out feedback forms each day. They were not informed of the existence of the DYD group. Since only the DYD users were familiar with the DYD website, this group provided feedback only regarding their experience of daily readings from on-line self-help sites and suggestions for cultural accommodation for the Israeli populations based on thus experience.

Next, three focus groups were conducted for the two groups. All groups were audio-taped, lasted about 1.5 h, and followed a written protocol of open-ended questions. The focus group protocol had three main sections (general impressions of experience, perceived usefulness of the different aspects of the site, and suggestions for modifications to the Israeli context). Each session was held in a research room at the university, led by the first and the third authors, who are qualified clinicians (a clinical psychologist and a clinical criminologist) as well as researchers. To compensate for their time, each participant was offered $214 for participation in the week and focus groups. Finally, interviews with seven experts in the substance use field were carried out by the first and the third authors. Interviews with subject matter experts are acknowledged as a primary method in culturally modifying both face-to-face (Resnicow et al., 2000; Hwang, 2009) and internet-based interventions (Alvarez et al., 2022) for gathering input regarding what a community needs from an intervention. The interview started with a presentation of the DYD intervention and the international context of IBIS and was followed by an interview that solicited their comments about DYD and the cultural accommodation of IBIS. The expert participants were a purposive sample, recruited through acquaintances and personal contacts. These were experts in SURDs (i.e., from outpatient counseling and treatment facilities, and rehabilitation), who have long-standing professional experience with the SURD population ranging between 7 to 21 years. The experts, specialists in both psychotherapy and cultural-sensitive treatment, included 2 high-level specialists in relevant government ministries, 4 directors of substance use programs, and an expert in internet intervention. The authors developed the focus group protocol and the interview guide, by carefully considering existing literature on cultural accommodation of SURD interventions and brainstorming ideas

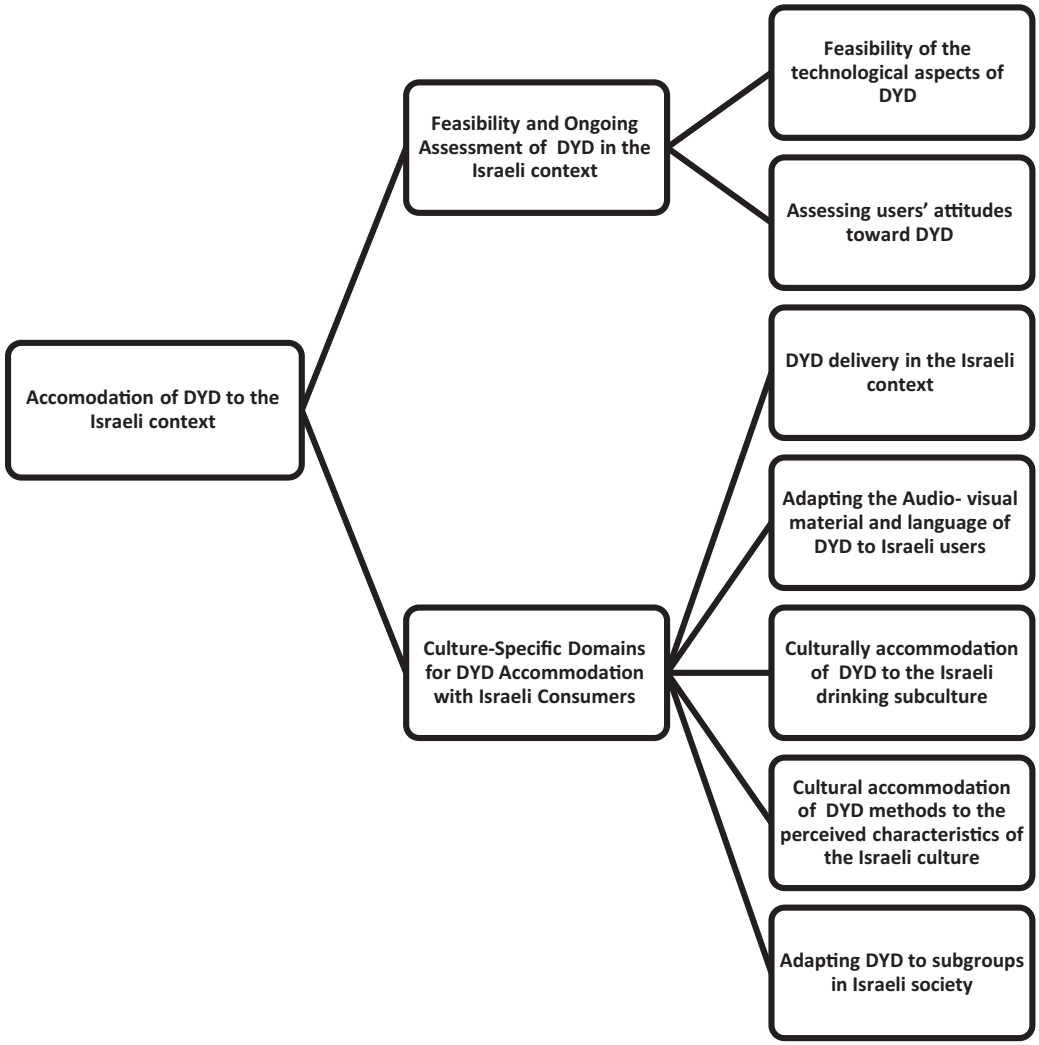

FIGURE 1
Thematic map of themes and sub-themes.

to enrich understanding and practice of the topic. In addition, the interview guide was guided by both researchers' clinical and academic experiences.

Data analysis

A coding team of the first and the third authors, both involved in research and treatment in the field of SURD, conducted a reflexive thematic analysis of the data using a combination of inductive and deductive approaches (Braun and Clarke, 2012). This methodology was chosen due to its flexibility and variability in theoretical and analytical scope (Braun and Clarke, 2022). Specifically, we drew on the explicit content of the data as this approach is more rooted in the data and therefore is more congruent with a critical realist perspective. We chose to privilege semantic content over latent content, as our goal was to construct a pragmatic framework of IBIS that could inform practice. The choice to conduct an inductive thematic analysis was informed by the understanding that the analysis remains grounded in the data (Braun and Clarke, 2022). Also, this method of study acknowledges the participants' distinctive DYD experiences in the end and thus continues our earlier ontological and epistemological viewpoint.

The themes were actively constructed via the following analytic process. First, using an inductive approach to thematic analysis, the transcribed audio recordings of the focus group and interviews were read and re-read independently by the first and the third authors, to gain greater familiarity with the data and identify initial codes for each participant's experience of using or perspective of DYD. This was done by writing familiarization notes that reflected the semantic answers and were related to issues such as preferred methods and barriers to using the DYD. Then the research team grouped these notes resulting in systematic data coding. In this phase, codes were created relating to various aspects of the cultural accommodation of the DYD in terms of process and content of the accommodation. Next, the codes s were refined and labeled, and interrelationships between them were proposed resulting in sub-themes according to their topical proximity and conceptual similarity. For example, sub-themes were related to accommodation considering Israeli alcohol use culture (i.e., where

drinking occurred, brands of alcohol) or the general Israeli culture (e.g., "Israeli purposefulness"). In the fourth phase, the sub-themes were aggregated under main themes as we developed and reviewed themes. Initially, four preliminary themes were generated, which were then merged and reduced to two themes in the refinement stage. Fifth, our interpretations were theoretically informed, and personal accounts were merged to understand shared meanings (Braun and Clarke, 2019), as we refined and defined the themes. Our reflexive thematic analysis resulted in two related themes, each with several subthemes (see **Figure 1**). Lastly, "a coherent story about particular patterns of shared meaning across the dataset" (Braun and Clarke, 2019, 592) was developed by the research team. The results which we present involve a synthesis of the themes which came up in the focus groups and the expert interviews together.

Ethical considerations

The study gained ethical approval from the authors' university research ethics committee. All participants signed informed consent forms. Following each interview and focus group, the audio recordings were anonymized; a pseudonym was assigned to each participant to protect their identity, and a range of details (such as roles) were deliberately omitted to help protect participant anonymity.

Reflexivity and quality criteria

Qualitative research, and particularly reflexive thematic analysis, is understood as a subjective process where the researcher brings their "own histories, values, assumptions, perspectives, politics, and mannerisms into the research" (Braun and Clarke, 2013, p. 36). During this study, a thorough audit trail and a reflexive journal were used to critically reflect upon how the authors shaped the research process and impacted theme development (e.g., The third author has personal experience with immigration, having clinical experience working with racial/ethnic minority groups coping with substance abuse problems). Reflection was a continuous process that helped identify and keep track of personal thoughts, feelings, and emotions and shed light on unconscious and changing preconceptions resulting from the emerging study (Sparkes and Smith, 2014). Specifically, we were mindful of our motivations to accommodate the DYD intervention to Israeli society and our values and ethical position regarding the importance of culturally sensitive intervention. Accordingly, we acknowledge the role that our pragmatic position may play in data construction. Thus, the decisions made during data analysis (e.g., reducing the master list of codes) were explicitly outlined to make the study as transparent as possible.

Results

The analysis of the pilot research participants (both prospective consumers and experts) revealed a high acceptance and perceived efficacy of DYD (see Gueta and Walsh, 2018), but also revealed a wide range of themes identified as targets of DYD accommodation. First, our experience and the pilot study findings indicated a need for ongoing collaboration with the community and stakeholders involved starting with understanding culturally relevant issues relevant to feasibility before starting accommodation and continuing through the process. Second, the participants indicated multiple technical and content recommendations for cultural accommodation of DYD, which interplayed between them. Furthermore, participants indicated that these technical and content issues are shaped by both the general Israeli culture as well as by the specific Israeli drinking subculture.

Feasibility and ongoing assessment of DYD in the Israeli context

Participants (both prospective consumers but mainly experts) indicated a need for examining technical and cultural feasibility as an essential stage before investing resources in adaptation. In addition, they indicated the need for ongoing evaluation of the accommodation specifically after the implementation. This finding indicated the need for systematic guidelines for the accommodation process, but also for gathering significant knowledge of the community before the accommodation process.

Feasibility of the technological aspects of DYD

First, issues that relate to the technological aspects of DYD were suggested by experts for the pre-accommodation process to examine cultural accommodation feasibility to Israeli society and within groups in Israeli society. For example, one treatment expert indicated that the ultraorthodox community in Israel prohibit, based on religious reasoning, the use of smartphones, and limit access to internet sites, thus making IBIS for this community not feasible.

Assessing users' attitudes toward DYD

Second, other within-group relevant cultural variables that the experts identified, related to the need for authorization from a religious figure such as a rabbi or the need for understandings around family relationships and involvement. Specifically, experts highlighted the need to address the target group's hypersensitivity to labeling, and fear of the criminal justice system. For example, one of the experts advised: "if this program were to be adapted to Israeli Ethiopian immigrants, you should pay attention to the issue of distrust of the formal authorities, such as the police." Similarly, the consumer participants described a general feeling of mistrust of the "system" (formal institutions such as the police, government offices and national insurance) and said that the site was experienced as a stigmatizing object based on the quantity of alcohol consumption. For example, Amir a 25-year-old described: "the site is pretty tagging like you're alcoholic and I personally do not feel like I have any kind of drinking problem, I don't drink as much." However, other participants, such as Galit pointed to the site as a non-persecutive object characterized by a lack of judgment which takes a respectful approach toward the user: "I really liked the part where the (site) would not always accuse me of. . . like "you with your drinking habits."" This variety of reactions toward the

DYD site may reflect an internal representation of an object on which various characteristics are cast, based on other internalized relationships of the DYD user and may also relate to cultural perspectives or attitudes toward authority.

Furthermore, regarding the issue of the perceived characteristics of the DYD site and the "relationship" with the DYD site, it was possible to identify a component of a face-to-face therapeutic process, but with unique implications for IBIS, which we conceptualized as "transfer to an internet site." In this transference process, the website's users personified the website and referred to it with singular and plural nouns. This is how Ilai, for example, described the site: "The site is very polite." In addition, it seems that a sort of quasi-therapeutic relationship was formed in which the website was seen as an object from which alcohol consumption must be hidden, as is evident from Adina's description regarding one of the DYD tools, the diary of documenting alcohol consumption: "The diary stopped me (from drinking) sometimes because somewhere I didn't want to report any more about it. I wouldn't say I liked it. . .There were beers that I almost did not report."

Lastly, experts also indicated the need for ongoing adjustment and involvement of the consumers and stakeholders in the accommodation process to provide usability needs to increase engagement.

Culture-specific domains for DYD accommodation with Israeli consumers

The participants (both prospective consumers and experts) discussed the need for accommodation of different aspects of the DYD intervention in order to accommodate it to the Israeli context. Analysis of the interviews and focus groups identified five domains of accommodation: DYD delivery, audio-visual material and language, culturally specific references to alcohol use, cultural preference for type of messages and communication of behavioral change, and sub-groups in Israeli society.

DYD delivery in the Israeli context

Delivery relates to the way in which participants gain access to the IBIS and the messages they receive about it prior to use. Participants indicated that in order to accommodate DYD to the Israeli context, barriers and facilitators to DYD related to the intervention *delivery*, rather than to the intervention *content* need to be identified and addressed. For example, according to expert participants, a barrier in the Israeli context for DYD may be related to its use only through a website on a computer and not as an application since Israelis have high levels of mobile phone use. In contrast, in order to facilitate the use of DYD by Israeli consumers, it was suggested by one of the consumers to use social media advertising that highlights the self-change elements of the DYD intervention, given the perceived characteristics of "Israeli roughness" and the need for a sense of control. One of the experts added that "you would need to place the site on a server which is acceptable to the community, . . . not a site which is seen as stigmatized and unacceptable."

Adapting the audio- visual material and language of the DYD to Israeli users

Another sub theme that was identified by the participants relates to audio- visual material and language. First, the participants related to audio-visual material and language that relates to the general Israeli culture. The site's users pointed to the need to incorporate pictures in the site, in which the protagonists are Israeli. For example, Gia- a 26-year-old described his recommendations for changes to the site in order to fit the Israeli context: "Totally (pictures) of Israelis, Israeli people, like the first grade English booklets." Furthermore, participants pointed out various perceived characteristics of the Israeli culture that the accommodation of images needs to address. For example, participants believed there was a need for intense and shocking images, given the high level of emotional intensity among Israelis, to induce behavioral change. They attributed the emotional intensity to threats of terror to Israeli society and Israel's location in the Middle East with violent conflicts, leading to some emotional numbness among Israelis:

> We are a little more immune or more indifferent to what we read and receive through the media because of the place where we live. It's as if 100 kilometers from here could be a terrorist attack, every moment people explode into pieces. . .. .So you're developing some kind of defense mechanism that even if you're reading some kind of news then yes, it does not bother me (Shahar, 27-year-old).

In addition, the level of the language was another factor to consider. For example, in our pilot study, we identified a sensitivity to the level of the language used by the (English) DYD that may be interpreted as politeness and condescension from an Israeli standpoint. They suggested that cultural accommodation in Israel would require the writing of verbal content in a simple manner, which would be perceived as writing less formally. For example, Uri, a 27-year-old suggested: "If you translate the site into Hebrew according to the language which is written, for Israelis it will seem patronizing. . . .The UK is very polite, and the site's language is too polite for Israelis so use simple and friendly language."

Cultural accommodation of DYD to the Israeli drinking subculture

The pilot participants highlighted various elements of DYD which needed to be adapted *based on the Israeli drinking subculture*. Accordingly, the participants pointed out the need to consider substance use related jargon and sayings such as the word "Satla": to express idiomatic expressions of the state of being under the influence of drugs (e.g., getting high or feeling drunk). In addition, recommendations for accommodation were related to the need to specify the quantities of alcohol and local alcohol brands, as Ben 24-year-old suggested when referring to the DYD task of creating a drinking diary: "The tables should introduce Israeli drinks. I also really wanted to put the names of the beers on the first day. a little dumb but it makes it a little personal because it's your beer." Participants also pointed out the differences in the accepted time and the social circumstances of drinking alcohol in Israel, as opposed to those presented on the DYD. For example, a participant wrote in the online survey about the necessary adjustments to the section on the site where drinking is shown in the morning. "In

Israel it is not usual to drink in the morning/lunch, as opposed to Europe." Another participant, Liran, a 25-year-old emphasized in the focus group the need to present the unique circumstances of Israeli drinking culture: "It is necessary to adapt to situations when we drink in Israel. that it is on Friday nights, events (like weddings)."

In addition, the location of drinking alcohol, such as in home settings and less in pubs, was noted in the online survey as another recommended accommodation of the site: "Examples of social drinking in 'yeshivas' (Argo-meaning gathering for drinking) and not necessarily in pubs, I think most of the intensive drinking (in Israel) is done in houses." There may also be unique areas of recreation and enjoyment for a particular community/culture, such as Eilat (the "holiday city of Israel") where participants say there is large consumption of alcohol. For example, Galit, a 25-year-old described the unique culture of drinking in Eilat: "Eilat is a kind of bubble, get drunk there no matter how old you are, you need to concentrate on areas in Israel or places where they drink."

Lastly, participants identified the need to accommodate the site to the special circumstances related to Israeli developmental tasks such as the army service in Israel that may impact drinking habits. For example, during vacation/time off from army service, soldiers may drink excessively and dangerously, as Adina 26-year-old described: "Once you go out for the weekend. . . you will drink non-stop because you see your friends."

Cultural accommodation of DYD methods to the perceived characteristics of the Israeli general culture

The participants indicated various methods of DYD aimed to induce change, which needed to be addressed, based on perceived characteristics of the Israeli culture. Participants related to high levels of self-efficacy among Israelis and "Israeli roughness" which require emphasizing elements of self-change in the process, increasing the user's sense of control and emphasizing positive motivation. One participant indicated this as an advantage of DYD for the Israeli population and suggested to enhance it:

> We're competitive, with a high ego. . .. It may be that ego or machoism that everyone sits in a bar and drinks. you don't want anyone to tell you that you are an alcoholic and you have to change it, . . .something I really liked on the site the part of taking control yourself . . .do it even stronger (Tzahi, 34- year-old).

"Israeli purposefulness" (i.e., the need to get straight to the point, not to waste time) was another perceived Israeli characteristic that was highlighted by participants as having implications for types of messages and communication accommodation. This feature was considered to be essential in adapting the site and was reflected in proposals by the participants to reduce the text. For example, referring to "cutting down," the site's users wrote that the lengthy wording was less suitable for the Israeli population because "Israelis love 't'chless' (getting straight to the point) and not 'digging' (providing unnecessary elaboration as in an archeological excavation (." In addition, according to the site's users, adapting to the Israeli characteristics of purposefulness refers to the addition of images, videos and much factual information: "I think that there should be less written and more videos" (Maya, 29-year-old).

Another issue that the participants pointed out regarding the characteristics of the general Israeli society characteristic relates to the interpersonal relationships of the Israeli peer group as having unique implications for the perceived efficiency of techniques on the site. The Israeli peer group was presented by many participants both as a source of pressure but also as a positive influence. Accordingly, an idea was proposed to create an anonymous forum for social comparison of drinking:

> The aspect of competitiveness will suit the Israeli population very well. Maybe to integrate social networks. do like a certain forum that is anonymous and where you do not need to be identified and where you see the quantities (of alcohol use) of other people (Zohar, 30-years-old).

The study participants also indicated the need to attend to specific motivations for alcohol use and consumption change in the Israeli context. For example, Oria, 27-year-old related to the use of alcohol in Israel as a means of coping with post-trauma: ". . . many Israelis drink as a means to cope with their post-traumatic stress disorder, from their military service." As such, the site would need to relate to the role of alcohol as coping with post trauma and also suggest alternatives, such as therapy for coping. Another issue of motivation for alcohol use and consumption change relates to unique structural issues. For example, participants pointed out the need to present the high costs of alcohol consumption in Israel, compared to Europe, as a motive to reduce alcohol consumption, as Sharona-24-year-old noted: "You can add the money section. It's really one of the big reasons. I think it's agreed by most Israelis why you should stop because it really wastes money." The participants also added the need to sharpen the connection between alcohol consumption and driving, which is of great significance in Israel, due to the lack of comprehensive public transportation, as indicated by Sharona:

> The entire issue of drinking in Israel, . . .is driving. And it does not appear at all on the site, as if in England they are traveling by public transport and that's it. So, you can put it in as well. Because I was often asked what would prevent you from drinking? So, I straight away said driving, because if my girlfriend decides I'm driving, I cannot drink.

In addition, motivation to change addictive behavior may be related to specific Israeli sets of values, as Yael 25-year-old described the importance of family members in motivating her to reduce her alcohol consumption:

> I liked (in the site) that there was the part that you can attach people who are close to you and register not only. your habits, but also it shows the effect on other others. So there was the bit you add a circle with a relative and that, so I added my sister and brother, and suddenly it makes me realize that if I drink then why should my little brother not drink?

Lastly, participants also indicated the need to consider that the perceived effect of DYD may also be influenced by Israeli characteristics and thus demand accommodation. For example, the above-mentioned Israeli numbness and need for a high level of emotional intensity to induce change also shape the long-term effect of the intervention (in comparison to the British need for subtlety or more restrained messages). Accordingly, the underlying reasons which participants thought would lead to attrition were attributed to the absence of internalization of the alcohol damage because the alcohol damage was not shocking enough to resonate in consciousness. For example, Limor 26-year-old noted this issue and her recommendation for addressing this:

> I felt that it (the site) gave me tools, but in the end, I did not have anything in my head that echoed for me, which prevented me from drinking. I mean, I was looking for such a shock, like in AHA!! videos. . ., reminding me, "AHA!!, wait, I saw this no way am I going to drink anymore. . .you should put horror pictures and stories.

Adapting DYD to subgroups in Israeli society

The participants indicated the need to consider subpopulations in Israeli society, that are affected differently by the context of religion and stigmatization that may impact DYD acceptability. For example, one of the experts indicated that for some targeted groups in Israeli society, such as religious Muslims, the DYD goal of moderate drinking may not be relevant since there is a religious prohibition for alcohol use, thus he suggested: "if you accommodate the DYD to Israel, you will need a section in Arabic that its' goal is not to reduce but rather to stop drinking." In another example, one of the expert participants pointed out the need to address the gender elevated shame among religious girls: "Girls are more stigmatized because of drinking, particularly girls from religious background maybe you can develop gender-sensitive module."

Discussion

The pilot study described here took place within a specific cultural context, in Israel. However, while the specifics of the Israeli-related examples may not apply to other contexts, they may be generalized to the level of overall principles and domains, the content of which may vary from culture to culture. Thus, we wish to use our Israeli pilot study as a prototype to extract and identify key principles and domains of IBIS accommodation that go beyond a specific population or culture. In the discussion, informed as well by the literature review, we present these principles and domains as an initial framework. Thus our framework builds on previous face-to-face cultural adaptation (e.g., Bernal et al., 2009), but also contains the particular considerations feature of designing and implementing interventions for IBIS. Furthermore, the framework that we propose for cultural accommodation is comprehensive as it involves two elements: (1) chronological stages involved in cultural accommodation of IBIS; and (2) dimensions of cultural accommodation.

TABLE 1 Stages of accommodation.

Stage	Aim	Example issues
Technical and cultural feasibility	To find out if using IBIS is feasible in a specific community	Do they have internet access? Is internet use acceptable to the community?
Engagement	To find out whether the community is motivated to use IBIS	Do potential users feel the site is relevant? Would they want to use it?
Identification of accommodation variables	To identify the culturally specific variables which will need to be translated	What needs to be changed in the existing site? e.g., language, audio visual materials, motivational messages, etc.
Accommodation	To make the actual changes	Translation, changing characters, developing new modules
Evaluation	To assess the effectiveness of the accommodated site	Can potential users navigate the site? Is it user friendly? Do they continue use?

Comprehensive framework for the cultural adaptation of ibis

Stages of cultural accommodation of IBIS

From our analysis of the pilot study, we were able to identify five recommended stages for cultural accommodation for IBIS (see Table 1). Specifically, those stages were developed based on the pilot study's first theme, which stresses the need for a feasibility and ongoing assessment of DYD in the Israeli context. We start by saying that, as the participants and experts pointed out repeatedly, and which was clear from the comments they made, all of these stages need to take place hand in hand with the targeted community and stakeholders. For example, only those who drink know the names of the drinks, the time they drink, and what messages will speak to them. Only members of a targeted community will know what stigmatizes, what language is needed, and whether the medium is relevant to their community. As such, the findings, and our own experience in interviewing the participants (i.e., our awareness of what we did not know) emphasized how any cultural accommodation demands close collaboration with the target community (Murry and Brody, 2004).

From our readings and analysis of the data, we were able to construct a chronological timeline for carrying out accommodation. The first stage of the model, technical and cultural feasibility (acceptance) relates to assessing the appropriateness of specific interventions to the target group, to ensure that both the content and the delivery of the intervention are acceptable to the target group. According to the relevant literature, this stage can increase the likelihood of uptake and ultimately affect its effectiveness (Escoffery et al., 2018; Lal et al., 2018). This stage, which is unique to IBIS in terms of usability includes exploring technical issues such as internet usage since appropriate internet access (e.g., geographical accessibility, adequate speed) must be widely available to access IBIS. For example, as pointed out by the experts, for some of the Israeli population, DYD may not be relevant due to technology prohibition. Thus, we suggest that this stage needs to involve understanding relevant cultural variables such as attitudes toward technology that may contradict the delivery of IBIS.

Given the numerous themes and ideas for accommodation that were identified by the study pilot and based on the literature (Escoffery et al., 2019), we suggest that the second stage, engagement, will involve the target group (users and stakeholders) in assessing levels of motivation for use of IBIS. This stage aims to further examine the feasibility (acceptance) and appropriateness of specific interventions before the investment of resources in accommodation. In line with the literature, (Shehadeh et al., 2016; Sundell et al., 2016) the current results suggested that working in a researcher–community partnership to develop services is vital as it will increase ownership of the intervention by the local setting and improve its sustainability especially if conducted in a collaborative and shared decision-making process (Lal et al., 2018). Specifically, given the enhanced importance of engagement for internet-based interventions, compared to face-to-face interventions, there is a need to study the usability and the users' experience by exploring how the IBIS is perceived in terms of engagement and trust and other features of what we have termed "transference to site" to establish compliance and adherence. This issue of stigmatization has been mentioned in cultural accommodation of internet based intervention, but given the intensified stigmatization of people with SURD, comparable to people with mental illness (Corrigan et al., 2009), this issue is critical in IBIS accommodation.

In addition, the study's findings illustrated that despite the high acceptance and perceived efficacy of DYD to Israeli society and Israeli social characteristics (e.g., high internet use) numerous accommodation domains were identified. Thus we suggest that the third stage of IBIS, the identification of accommodation variables, will identify the most relevant cultural variables, that should be considered in accommodation that will be needed to be integrated into an empirically-supported treatment program (Burrow-Sanchez et al., 2011; Escoffery et al., 2018). This stage can include the identification of cultural values, beliefs, or experiences such as Israeli "roughness" or "purposefulness" or the emphasis on self-control. This can be achieved by identifying and soliciting knowledge from relevant community key stakeholders such as users, families and caregivers, local substance abuse treatment providers, and policymakers. Qualitative methods can allow the stakeholders to express their concerns and suggestions directly to the researcher. This stage also involves a review of the current theoretical and empirical literature regarding the target group. The next stage of the model, accommodation involves the actual changes to the original program, along four dimensions which we describe in the section below. Based on existing literature (Bernal et al., 2009; Escoffery et al., 2019), and face-to-face accommodation and echoed by the experts, we suggest that the fifth stage of the model relates to the evaluation of the accommodated IBIS, in terms of efficacy by randomized clinical trials.

Dimensions of cultural accommodation of IBIS

The four dimensions which we outline below are the actual elements of the IBIS that we suggest demand accommodation which was derived from thematic analysis of the pilot study interviews and linked to existing literature (see **Table 2**). Specifically, those dimensions were developed based on the pilot study's second theme, which stresses the need for culture-specific domains for DYD accommodation with Israeli consumers.

Barriers and facilitators to IBIS

This first dimension involves identifying already existing elements of the IBIS, which may be obstacles (barriers) to the use of IBIS, or in contrast, existing or new elements which may be needed to be introduced to facilitate use in the specific community. In other words, what will prevent or enhance community members' use of IBIS? In our study, these were seen, for example, by the emphasis on mobile phone use (as opposed to computers) or the need to place the IBIS on a platform (e.g., a website) acceptable to the community. The aim of accommodation in this dimension is to find effective ways to get the target population to find and access IBIS. This domain focuses on the process of intervention delivery rather than on intervention content. It can relate to the initial interface with the IBIS, for example, our pilot, in line with a previous study regarding face-to-face interventions (Gueta, 2017) indicated the need to tackle barriers related to the intensified fear of stigmatization and mistrust in treatment services among racial/ethnic minorities (in the current study, Israeli Ethiopian immigrants) to enhance treatment engagement. Addressing this issue in the context of IBIS can be done by providing details on the technological platform of the intervention, the financing agency, linking the intervention to reputable organizations of the targeted group, and details about online confidentiality to increase the credibility and acceptability of programs by the specific group.

Secondly, the results also indicated a need to identify facilitators for IBIS use, such as enhancing familiarity with the IBIS among the target group. The experts in our study suggested a systematic search for media groups and community web pages for promoting programs. Other methods that were mentioned in the literature can include recruiting and training people with lived experience of the problems (e.g., alcohol users) who receive peer-support training to provide support and foster engagement (Lal et al., 2018). Inherent to this process is the need to involve stakeholders to raise awareness of treatment availability (Barrera and Castro, 2006) and to enhance technological literacy. Moreover, in contrast to face-to-face accommodation, delivery considerations such as a preference for programs that run on a smartphone or tablet over ones that need access to a personal computer due to different rates of technology ownership among minorities (e.g., Black, Indigenous, and people of color) is important to address (Alvarez et al., 2022).

Audio-visual materials, language, and metaphors

Internet-based interventions for substance use and related disorders, compared to face-to-face interventions, depend on the user connecting to and feeling comfortable with how the site looks and the messages the site is giving. Thus, design and aesthetic components are highly important for the cultural accommodation of IBIS since it promotes user-centered solutions that are based on an evaluation of the demands and living conditions of the target group. Findings from the current study indicated the need

TABLE 2 Dimensions of cultural accommodation.

Dimension	Aim	Example
1. Barriers and facilitators to IBIS	Find effective ways to get the target user to find and access IBIS.	Using religious figures, community web sites
2. Audio-visual materials	To make the site attractive and relevant to target users, to enable them to identify.	Changing protagonist names, adding new pictures.
Language and metaphors	Identify relevant cultural expressions and sayings, idioms to increase identification	Identify the unique products and time, age, location and circumstance of substance use.
Cultural context of use	Identify the unique products and time, age, location and circumstance of substance use.	Specify the quantities of alcohol and local alcohol brands, adapt examples to involve appropriate locations and times.
3. Mechanisms of change	Identify the unique cultural motivations and functions of substance abuse for this group.	Substance abuse as "self-medication" with post- traumatic stress, substance use as a response to weakening of family bonds.
The goal of intervention	Identification of cultural values to define goals of the intervention.	Goal of intervention redefined to strengthening family bonds, to reduce alcohol use, to find alternative coping strategies.
Methods	Tasks and procedures employed by the intervention to be acceptable to the client's culture.	Inclusion of social network or social community features; connection to offline therapists
4. Intersectional factors	Identifying increased vulnerability of multiple marginalized, oppressed or racial/ethnic minority groups.	Role-plays and problem-solving in the context of a racist environment.

to change audio-visual materials (e.g., pictures), language, and metaphors, to amplify and enhance change. This demands a knowledge of which images and graphics are needed to make use of the site attractive to members of a particular population. In prior face-to-face accommodations, videos, and personal stories were revised to include names of the target population (Burrow-Sanchez et al., 2011), typical situations and stereotypes for the targeted group with protagonists such as Colombian actors and Latin American college stories (e.g., economic problems) (Salamanca-Sanabria et al., 2018). However, given the heavy reliance on audiovisual material and the absence of verbal cues in IBIS, there is a need to explore the meaning of such accommodation. For example, as suggested by one of the current study experts and echoed in the literature, the use of images of people from the community may be counterproductive since they may perceive targeted interventions as casting an unfavorable light on their community (Resnicow et al., 2000).

Second, in line with the literature on both face-to-face and internet accommodation, the current study indicated the importance of accommodating surface structures (Resnicow et al., 2000) such as the language, metaphors, cultural expressions and sayings, and idioms, with which the service users may personally identify (Bernal et al., 1995) as well as the level of the language. Furthermore, the current findings also stressed the importance of including substance-use-related jargon and idiomatic expressions related to substance use. Another finding indicated identifying the subculture of substance use in the particular population in terms of the unique products (brands), units, time, location, and circumstance of substance use for the target population, age, and context.

Third, participants in the study related to the centrality of social media in Israel young people's lives and the idea of including "competition" or comparison. In contrast to face-to-face interventions, many IBIS include the ability to monitor substance use and to compare use with those of a large normative peer sample. Such tailored feedback has been shown to outperform traditional, static health information strategies and is more likely to be read, remembered, and viewed as personally relevant (Bennett and Glasgow, 2009). Studies suggest that incorporating social norms information in feedback helps decrease problematic behavior, such as alcohol consumption, given that individuals often differentially underestimate their own and overestimate the behavior of others (Wood and Williams, 2011). Yet, general peer norms may be seen as lacking credibility for cultural minority members who may seek to compare their use with those of peers within their community (Leightley et al., 2018). This issue suggests the need for a culturally adjusted assessment of SURD symptoms (i.e., what is considered problematic use in a particular culture) since large diagnostic systems have to deal with the tension between universality and cultural specificity since they rely on lists of mostly behavioral criteria (e.g., DSM 5) shaped by social norms about what constitutes heavy drinking or loss of control, that differed considerably between and within cultures and will impact on behavior, as well as on the reporting of behavior (Rehm and Room, 2017).

Mechanisms of change

Mechanisms of change relate to the active ingredients in existing intervention treatments that account for change (Burrow-Sanchez et al., 2011). Those issues relate to deep structure modification that aimed to enhance the efficacy of the intervention for the target group (Resnicow et al., 2000). Echoing face-to-face accommodation, from the participants' comments, we saw that this involves identifying the unique cultural motivations and the function of substance abuse for the target group. For example, in the current study, the issue of drinking alcohol as self-medication for war and terror trauma was raised by participants. This is in line with findings regarding the prevalence of past-year and past-month alcohol use among Israeli combatant veterans which was more than 2 times higher among Israeli war veterans than among the general population (Feingold et al., 2019). However, identification of motivations can involve both adding elements to the site which address these motivations and also suggesting alternatives to drinking for fulfilling the needs behind the motivation. Cultural motivations also relate to cultural norms around thinking and approaching tasks such as independence versus interdependence

in achieving goals (Burrow-Sanchez et al., 2011). For example, the encouraging self-reliant characteristic of the DYD methods (Linke et al., 2008) was identified in the current study as appealing to the Israeli population in line with the cultural importance of self-change (Chen et al., 2020), but may be less appropriate in cultures which encourage greater levels of interdependence or a sense of self in relation.

Another issue of motivation that was identified, relates to the presentation of the health consequences of SURD (e.g., one of the participants said the health messages were not "shocking" enough). This issue may be related to the well-documented habituation pattern among Israeli citizens in response to chronic terrorism threats that were described through emotional numbness and indifference (Cohen-Louck and Saka, 2017). Thus, we suggest that the accommodation of IBIS should also take into consideration the cultural meaning of SURD health consequences as a motivational factor. For example, the time-orientation preference of the local group which may emphasize long-term health consequences or short-term detrimental consequences to encourage individuals to reduce their alcohol consumption (Burrow-Sanchez et al., 2011). There are also unique structural issues such as the one identified in the current study regarding the cost of alcohol in Israel, compared to Europe, that may enhance alcohol reduction and thus were recommended by participants to be incorporated into DYD.

Secondly, mechanisms of change relate to the goals of IBIS that include the cultural values and customs of the targeted group which are considered as deep structure changes (Resnicow et al., 2000). For example, according to current study findings, and in line with research regarding the Latina population (Bernal et al., 1995), and other Israeli studies (Gueta, 2017), the importance of family values can serve as a main motivation to change alcohol consumption. Thus we suggest that this domain may involve the identification of cultural values that can induce change which may take a very different form in cultures and re-frame the goal of the intervention (Bernal et al., 1995).

Third, Bernal et al. (1995) indicate the need for the methods, tasks, and procedures for problem-solving employed by the intervention to be compatible or acceptable to the client's culture. For example, studies suggest cultural differences in the extent to which members of a particular ethnic group expect and desire connection with professionals or other users of the intervention site (Fu et al., 2013). This issue is more dominant in IBIS since it relies heavily on those therapeutic methods. Our pilot findings, for example, indicated the desire of users to connect with other users and compare the change in alcohol consumption given the perceived Israeli competitiveness. In other cultures, where anonymity may be more sensitive, this may be highly problematic. Thus, in contrast to face-to-face cultural accommodation that there is a more limited option for delivering the intervention in terms of guidance, we suggest that the accommodation of IBIS should also take into consideration whether the treatment program has the flexibility to consider the needs and the amount of guidance given to the user (e.g., minimal, contact on request or no guidance) which may be more suited in cultural contexts. For example, for certain users, "e-helpers" are used to provide structured guidance which covers a review of the previous session, a review of the user's experience, and providing support in using the program (Carswell et al., 2018). In addition, compared to face-to-face accommodation that pertains to the relationship with the therapist, the current findings indicated that given the self-guided nature of the intervention, this form of accommodation is not relevant. However, as mentioned above, another process that we termed "transference to site," relating to internalized relations of a particular cultural group with authority and formal institutions, may be relevant and need to be addressed.

Lastly, another finding of the current study regarding cultural preference for the type of messages and communication relates to the preferred amount of text, images, and emotional intensity that is unique to internet-based intervention (Lal et al., 2018). Specifically, the Israeli preference for minimal words and more images, as well as greater intensity, was attributed to the continual state of war and compulsory army services (Levy and Sasson-Levy, 2008).

Intersectional and vulnerability factors

In line with previous Israeli findings (Gueta, 2017), the current findings indicated that in addition to accommodation of DYD to the Israeli context, there is a need for addressing within-group differences in Israeli society, such as religious affiliation. This is because users of the site may belong to multiple groups, related to ethnic/racial/migrant groups, gender, sexuality, and social economic class may impact the feasibility of IBIS for them. This is in line with recent evidence from a meta-analysis (Riper et al., 2018) evaluating the effectiveness and moderators of internet interventions for adult drinkers which indicates that stronger effects of digital interventions on alcohol intake were moderated by gender, level of education, and age. Thus, we suggest the need to incorporate an intersectionality lens (Collins, 2015; Gueta, 2020) that can shed light on the dynamics of the intersections among problematic substance use, social identities, and different forms of oppression associated with structural contexts, thus elucidating the complexities of help-seeking behavior of SURD treatment (Gueta, 2017). This is in line with the call of Gonzàlez Castro and Garfinkle (2003) regarding face-to-face cultural accommodation to point out other variables that are critical in the development of culturally relevant substance abuse treatments for specific minority groups such as addressing the within-group differences, regarding different beliefs, attitudes, values, and expectations about treatment that may be reflected in two motivational orientations of modernization and traditionalism.

Specifically, according to the current findings, IBIS accommodation also needs to take into consideration gender roles within the culture and the intersection between substance use and gender such as intense shame. This can mean tailoring toward characteristics of the individual (e.g., clothing) to ensure it is suitable for women or men, and even creating four versions of the main character with users selecting the one they prefer (Carswell et al., 2018). However, this modification may carry the risk of losing the intervention's internal validity and needs further study.

Limitations

Limitations of the current study include a relatively small sample size within the participant group categories and sampling

including mainly educated students (this was mainly due to the need for participants to have good English to use the UK site). However, although most of the examples provided herein relate to this group of people that are limited in terms of age and education, nonetheless, since we have also based our framework on a literature review of face-to-face and internet-based intervention accommodation, we believe that the principles discussed should apply to other racial/ethnic and sociodemographic subpopulations. Yet, larger samples from other geographical regions and cultures may produce different results or additional dimensions, due to regional and cultural differences and should be a focus of future research. Future research should include focus groups of adolescent participants at different points of the IBIS continuum such as before treatment, during treatment, and post-treatment. This will help to further develop the current preliminary framework of accommodation of IBIS.

Conclusion

Worldwide, as a growing proportion of the population has easy and affordable access to the internet, and given its' effectiveness, IBIS represents an innovative cultural accommodation model which can be offered across a range of cultural, geographical, and health system contexts (Shehadeh et al., 2016; Ferreri et al., 2018). The results of the pilot study together with a literature review enabled us to develop a preliminary framework of accommodation of IBIS introducing the stages and dimensions with public health and clinical relevance. Specifically, the novelty and heuristic power of the IBIS framework is twofold. First, in contrast to previous face-to-face accommodation, the current framework stresses usability features given the intensified need to enhance engagement and adherence in IBIS and includes specific features that are relevant only to IBIS such as user experience and engagement, aesthetics, and the intensified substance abuse stigma compared to other mental illness. Second, in contrast to the previous framework that delineates either the phases or the dimensions of cultural accommodation, the current framework is useful as an integrated framework that includes both the phases and dimensions that need to consider in the cultural accommodation of IBIS. This comprehensive perspective is significant as the cultural adaptation processes of internet-based interventions are rarely well-defined or detailed resulting in limiting the efficacy of the accommodations (Balci et al., 2022). In addition, this framework includes both surfaces for improving feasibility as well as deep structural changes to enhance the effect of the intervention (Resnicow et al., 2000) thus addressing previous limitations (Balci et al., 2022). This fills an important gap in the literature and addresses policymakers' and funding bodies' need for IBIS accommodation. This is important since accommodation increases the client's self-management and motivation (Gainsbury and Blaszczynski, 2011), ecological validity, as well as the overall external validity of the intervention (Bernal et al., 1995). Cultural accommodation should ultimately culminate in the conduct of randomized treatment outcome studies that will also contribute to the original interventions. Standardization in cultural adaptations will advance cross-cultural psychotherapy research and practice by enabling us to explore the methodical and efficacy aspects of this process (Koç and Kafa, 2019).

Author contributions

KG was involved in conceptualizing this work, drafting a major part of the manuscript, revising, and agreeing to be accountable for all aspects of the work. SW was involved in conceptualizing this work, drafting some sections, revising, and agreeing to be accountable for all aspects of the work. YH-F was involved in conceptualizing this work and agreeing to be accountable for all aspects of the work. All authors contributed to the article and approved the submitted version.

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Conflict of interest

The authors declare that the research was conducted in the absence of any commercial or financial relationships that could be construed as a potential conflict of interest.

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Understanding psychoanalytic work online and back to the couch in the wake of the COVID-19 pandemic: an investigation among Italian psychoanalysts

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Background: Worldwide, psychotherapists' clinical experience went through rapid developments with transition to teletherapy during the COVID-19 pandemic. Literature on the use of remote psychoanalysis was not conclusive, leaving the issue of the consequences of the necessary setting alternation open. This study aimed to investigate the psychoanalysts' experiences of shifting to remote work and then returning to in-person setting, considering the effect of the patients' attachment styles and personality configurations.

Method: Seventy-one analysts of the Italian Psychoanalytic Society were asked to fill out an online survey about patients who found the transition easier and patients who found it more difficult. General questions on therapeutic work, ISTS (Interpretive and Supportive Technique Scale) for interpretive and supportive aspects of technique, WAI-S-TR (Working Alliance Inventory-Short Revised-Therapist) for therapeutic alliance, RQ (Relationship Questionnaire) for attachment style, and PMAI (Prototype Matching of Anaclitic-Introjective Personality Configuration) for personality configurations were administered.

Results: All of the analysts chose to continue the treatment using audio-visual tools. Patients with difficult transitions had a significantly higher frequency of insecure attachment and a higher score on RQ Dismissing scale than patients with easy transitions. No significant differences were found between the two groups in personality configurations, psychotherapeutic alliance, and psychotherapeutic technique. Moreover, a higher level of therapeutic alliance was positively correlated to RQ Secure scale and was negatively correlated to RQ Dismissing scale. Patients with easy transition both to remote work and back to in-person setting had higher scores of therapeutic alliances than those with difficult transition both to remote work and back to in-person setting.

Conclusion: Online psychoanalytic therapy was widely used during the COVID-19 pandemic. Patients with insecure attachment styles had greater difficulties in adapting to setting alternations, thus confirming that insecure attachment is a vulnerability factor not only for psychopathological problems but also for a well-functioning therapeutic collaboration. Patient's personality configuration did not influence their adaptation to the setting alternation. The supportive and

interpretive styles did not undergo significant changes in the transition from in-person setting to remote setting and vice versa, thus suggesting a continuity in the analysts' "internal setting."

KEYWORDS

remote psychoanalysis, COVID-19, attachment style, personality configuration, therapeutic alliance, therapeutic process

1. Introduction

The severe pandemic, which to different extent spread across the world in 2019, produced a change in human relations. The medical and social measures applied did manage to lead painstakingly to a gradual decrease of the public health danger, although it was not fully resolved. This achievement however did have some severe consequences, which affected everyone's practical and relational life and, inevitably, individual experience. In general, especially in Italy, one of the first countries that were severely and most harshly hit by the pandemic, there was an almost complete restriction of human contact, limiting it to the strictest necessities for extended periods of time. This and other mandatory behaviors to counteract COVID-19 took on a weight that could give rise to potentially stressful situations, with gradually more severe consequences up to potential traumatic impact (Kumar et al., 2020; Gullo et al., 2021; Preti et al., 2021; Rossi et al., 2022; Cavalera et al., 2023; De Salve et al., 2023). We are still experiencing the repercussions of the pandemic, despite its increasing remission. Only recently did the World Health Organization declare the pandemic over and ease restrictions. In the 2020-23th a series of consequences have affected the psychotherapeutic and psychoanalytic work, called both to collect the sometimes-painful responses of individuals and to deal with new forms of distress that developed in response to the exceptional nature of the pandemic-related situation and the consequences of the restrictions (Gabbard, 2020). The change concerned above all the modes of communication, in particular, the extensive use of synchronous remote communication, which reduces the different ways of contact and enhances the exchange through other perceptual, visual, and acoustic channels – a factor often not too considered. It was necessary to modify first temporarily, then for long periods, the physical co-presence of therapist and patient, previously regulated by a specific setting, as a habitual vehicle of human exchange, essential for the therapeutic process to take place. The majority of analysts and psychotherapists had to resort to a set-up that would allow the continuation of the therapeutic work even remotely, revising the usual methods. The inevitable choice was the use of audio-visual devices, currently quite advanced, already partially in use, without however having systematically tested the consequences in the therapeutic field. Most of the previous experiences in the psychoanalytic area concerned training, with significant results (Fonda, 2011), following a mixed method of alternating between remote and in-person therapy. Other experiences have had unsystematic character, bringing to the fore the question of compatibility with the development of the therapeutic process.

Indeed, it was necessary to resort to remote synchronous activity to accompany patients during a critical time and in order to safeguard the therapeutic continuity in front of the new situation, without the support of previous systematic studies in the psychoanalytic and psychotherapeutic field. In the first period the therapeutic activity was carried out like in an emergency situation, both for the analyst and the patient. It is not by chance that Bolognini (2020) used the image of the use of tents in the event of an earthquake until some understanding of the situation takes place and recovery operations start. We can find an attempt at understanding – initiated by a group of psychoanalysts living and working in Italy – in *Funzione Gamma,* monographic issue that was published a year after Bolognini's (2020) intervention and focused entirely on this topic (Goisis and Merciai, 2021) by pointing out some risks. In general, there is some agreement that narcissistic and dissociative aspects are most implicated in online use. In the former case we can usefully frame the issue from a sociological point of view, with the now widespread need to have one's own narcissistic space – on Facebook, Instagram and other social media – in which the identification of the Other is irrelevant (Han, 2015) or more in the background. In the latter we can refer more usefully to the clinical standpoint, where the online can become a "psychic retreat" (Steiner, 2003) of a mind that would otherwise be prey to a sense of inadequacy, anxiety and so on, but can also give rise to actual addiction (Caretti, 2000). Here the importance of the therapeutic relationship comes into play, as a tool that can prevent this kind of risk in the use of online.

In fact, some studies already examined the use of new technologies both in response to increasing social mobility and the extension of psychotherapeutic techniques (Fonda, 2011) and as a reinforcement of therapies in psychiatric settings with patients who find it difficult to tolerate distance (Grenyer, 2013; Jorm et al., 2013). We find two different areas of application: one related to the training of future psychoanalysts in countries without training institutes; the other to specific social or clinical situations. In the former case it is a historical issue, of which the history of psychoanalysis has even some illustrious examples – think of part of Ferenczi's psychoanalytic treatment with the father of psychoanalysis, Freud, in Vienna – and about which there are, on the whole, rather tolerant stances from International Psychoanalytical Association (IPA) (International Psychoanalytic Association, 2017, 2018). In the latter, the situation is more nuanced, with more and more studies, albeit of an exploratory nature, concerning different psychotherapeutic methods, with inevitable evolutions from the point of view of psychoanalytic technique that are not shared by all clinicians in the field (Marzi, 2021; Nicolò, 2021). Beyond some issues relating to confidence, the question, in the modified setting, concerns the formation and evolution of the therapeutic relationship and the therapeutic alliance, essential for the development of the associative process and therapeutic elaboration (Freud, 1915–1917; Sandler, 1983).

From a more strictly psychoanalytic point of view, the heart of the matter is to answer the following question: does psychoanalysis retain its specificity in relying on online exchange or not? The answers, are not unequivocal. On the one hand, based on established effectiveness,

some authors (e.g., Scharff, 2013) have not only come out in favor of online psychoanalysis, but have even gone so far as to argue, despite the inevitable "adjustments" required – that psychoanalysis still retains its specificity even online; "Psychoanalysis is the encounter with an understanding mind in whatever setting that may occur" (Scharff, 2013, p. 8). On the other hand, mainly by considering it unacceptable that the analytical relationship can be "disembodied," like all virtual relationships, other authors have strongly contested the possibility of teleanalysis (e.g., Argentieri and Mehler, 2003). It seems to be more of a generational conflict than a real conceptual opposition, even if the debate focuses on some aspects that should not be overlooked. For instance, Roesler, a Jungian analyst, warns of the risk of not grasping the non-verbal cues of the relationship, bearers of emotional aspects on which analytic work is often based. From another point of view, Migone (2013) considers it a futile effort to hold together two situations that are different by their nature; online psychoanalysis should not be considered as a mere imitation or simulation of in-person psychoanalysis but should rather be viewed in its specific characteristics. The ever-increasing though exploratory studies have had the merit of testing the appropriateness of adapting the analytical method to remote mode, as well as assessing its possible clinical consequences. The debate did not rule out the possibility of remote use, but indicated the opportunity to explore aspects that could prove decisive: the subjective characteristics of the patient, the development of the alliance and of the therapeutic process; on the technical front, what is lost (non-verbal communications; the transitional aspects studied for example by Werbart et al., 2022a; Aafjes-van Doorn et al., 2022) and what is acquired (repair versus distance; greater knowledge of personal and behavioral aspects in the case of video tools; no discontinuation of therapy) Prompted by all this, the European Psychoanalytical Federation (EPF), which gathers European psychoanalysts and is an integral part of IPA, formed a working group to focus on the issues related to the use of remote treatment, which has given rise to some studies (Marzi, 2021).

The COVID-19 pandemic, under the pressure of the emergency, has caused an intensification of studies on remote therapy, to investigate its practicability and effectiveness. We find two orders of investigation that have taken place in the literature: in the psychoanalytic field an intense study has been developed on the changes that setting modification brought about in the therapeutic relationship, and on the many application fields of the clinical method; the main psychoanalytic concepts and their applications have been revisited in numerous national and international Webinars, which have partly resulted in publications and inspired the theme of the 2023 IPA International Congress. A second order of studies regards the broader field of psychotherapy, with the development of numerous empirical studies aimed at investigating the new situation, with attention to the effects of online therapy and its effectiveness.

Among the relevant observations in the psychoanalytic field, Altman (2020) underlines the physical change that occurs in online therapy as for the physical distance/co-presence of the dyad focusing on the effect on the patient's attachment system, the analyst's reflexive function, and, in the change, the role of the body with its instinctual components. Werbart et al. (2022a) have also been investigating on the influence of the attachment system on online transition. With regards to the emergency situation, from different perspectives, Roussillon (2020) and Guignard and Diatkine (2021) focused on the potential regression-provoking effects of the traumatic situation that can enhance dependency, but also on the containing function of the therapeutic relationship regarding the inevitable regressive instances. Erlich's observation, on the other hand, turned to the distinction between traumatic event and traumatic experience (2021) potentially activated by the pandemic, emphasizing the dual aspect, active and passive, which characterizes the experience, which must be taken into account in the clinical experience. On the one hand, he refers to Freud's observation, according to which an event can become traumatic in the absence of social containment, and to the anxiety containment function offered by the therapeutic relationship. On the other hand, we also find here a reference to the anaclitic/introjective modality of experience described by Blatt (2008), with whom Erlich also worked (Erlich and Blatt, 1985). In an analogous line of thought, he develops the distinction between 'internal analytic setting' and 'external analytic setting', supported also by Gampel (2020) and Ehrlich (2021), thus leading to distinguish between setting as a rule and setting as a tool.

We are here introduced to one of the central concepts that have guided our research, the attention paid to personality characteristics, in terms of dependency/autonomy polarity (of relational significance), following Blatt (2008), and their impact on the therapeutic relationship, to assess their influence on the acceptance/lack of acceptance of transitions (transition to teletherapy and return to sessions in person). At the center of our study, and also of all this debate, we place the concept of the therapeutic relationship, essential tool for the development of the therapeutic process, and the related concept of therapeutic alliance, definitely introduced in psychoanalysis by Zetzel (1956; see also Meissner, 1996; Ponsi, 2000), transversely recognized as a variable linked to the outcome (Ackerman and Hilsenroth, 2003; Ardito and Rabellino, 2011). Indeed, we can better speak of a common factor, variously modulated according to the situation.

The debate on online and therapeutic alliance is therefore still very much open: as evidence of this, one can consider the four volumes edited by Scharff (2013, 2015, 2017, 2019) with contributions from psychoanalysts belonging to societies in different parts of the world and about various aspects of teletherapy: from the clinical to the educational realms, from the technical dimension to the transmission of psychoanalytic knowledge. Similarly, some questions on telepsychoanalysis prompted by the pandemic remain unanswered: Are setting modifications compatible with the unfolding of the psychoanalytic process, which considers the relationship essential by using a specific setting to foster the working-through in a relational context (Foresti, 2020; Gabbard, 2020, who emphasized the fragility of the analyst, in a two-person dimension; Gampel, 2020; Puget, 2020)? How did the transition and the subsequent return to in-person setting (due to a decrease in confinement measures) alter the therapeutic relationship and collaboration, and which mechanisms are particularly involved (Kristeva et al., 2020; Levy, 2020)? One further question remains open: For which patients did setting alternation have hindering impacts, and for which it rather facilitated the joint therapeutic work?

The large literature on empirical research that has developed in the wider psychotherapeutic field over the past 3 years, after the onset of the pandemic, has also aimed to answer some of these questions; previous empirical studies are instead quite rare (Cantelmi et al., 2000; Backhaus et al., 2012; Sucala et al., 2012).

Empirical studies during the early stages of the pandemic critical period were delving into the direct experiences of both patients and analysts with regard to remote therapy. Confirming a large recourse to distance therapy, a loss has been described with regard to the

framework accompanying treatment (Werbart et al., 2022a), as well as undermined security (Ahlström et al., 2022; Békés and Aafjes-van Doorn, 2022). However, a change has been observed over time; studies after a longer period of time have revealed a greater familiarity with the IT tool and remote work on the part of the therapist, and a decrease in anxiety which also accompanied the patient's processing work, less burdened by the emergency (*ibidem*).

Our research is placed in this order of reflections and aims to investigate, at a distance of time from the onset and therefore with somewhat consolidated results, the extension of recourse to remote therapy in the Italian psychoanalytic community in the most critical periods of the lockdown, despite the concerns expressed in earlier psychoanalytic literature. The study aims to answer the doubts raised on the development of the therapeutic process in tele-analysis; in particular we wanted to know the vicissitudes of the therapeutic alliance in transition; if the use of online therapy could contain the possible regressive tendencies and the elaboration process has been able to evolve; if the personological characteristics and the attachment system appear to have an effect on the transition, as the literature seems to suggest; whether there have been alterations in interpretive technique; whether or not online therapy ultimately alters the development of the analytic process and how it responds to emergency situations. We wanted to verify these findings on a specific sample and within a longer time frame, to see how they evolved.

1.1. Approach to our study

The study aimed at collecting information about both the phase of transition to remote therapy and the phase of return, partially or totally, to in-person setting during the COVID-19 pandemic. The first purpose was to collect information, at a descriptive level, on the analysts' evaluation of the patients' experience regarding both the phase of transition and of return, partially or totally, to in-person settings. A second exploratory objective was to test differences between patients with difficult or easy transition to setting changes. Differences concerning variables related to socio-demographic characteristics, duration of treatment, type of problems of the patient, and with respect to attachment style, psychotherapeutic alliance, personality configuration, and psychotherapeutic technique were analyzed. In addition, possible differences between the two groups and types of setting (remote work and return to in-person setting) in terms of psychotherapeutic alliance and psychotherapeutic technique were assessed at an exploratory level.

2. Materials and methods

2.1. Participants

Approximately one thousand analysts from the thirteen centers of the Italian Psychoanalytic Society were involved with some preparatory meetings and *ad hoc* questionnaires. The data collection was performed entirely online through the Qualtrics platform, after the acquisition of written informed consent, and analysts who voluntarily decided to participate filled in a battery of questionnaires divided into two sections. Eighty-six analysts of the Italian Psychoanalytic Society were involved, 71 completed the questionnaire in the full first section, and 20 completed it in the full second section.

The first section of the survey includes a series of general questions on the development of therapeutic work in different phases of transitions to and from remote work; the second section evaluates specific aspects related to patients in treatment who experienced the transition positively or with difficulty. More specifically, in this section each analyst was asked to answer with two types of patients in mind: those with an easy transition to setting changes, patient A; those with a difficult transition, patient B.

All analysts have an established analytic practice and have completed training at the Italian Psychoanalytic Society.

2.2. Procedures

All the study participants gave their informed consent after being properly informed.

The research was authorized by the President of the Italian Psychoanalytic Society within which it was performed and followed the principles of the Declaration of Helsinki.

The research was carried out during the first semester 2022, in a fairly generalized resumption to the sessions in person.

2.3. Measures

The analysts completed two different sections.

2.3.1. First section: *ad-hoc* constructed questionnaire

A special form was constructed with questions for analysts concerning the transition to remote therapy and the return to in-person therapy. The questionnaire covered the following areas: use of remote treatment; analysts' acceptance; patients' compliance; appropriateness of the therapeutic relationship and any difficulties encountered; effects on the therapeutic process; effects on the treatment also in relation to the disorder and type of patient; responses to return to in-person setting; subjective findings.

The questionnaire can be found in Appendix A.

2.3.2. Second section: short *ad-hoc* survey

The form was constructed to collect information on the patient's age, gender, type of problem, and duration of treatment. In addition, questions were formulated on a 5-point Likert scale concerning the patient's family structure, work, and relational life.

2.3.3. Interpretive and supportive technique scale

The ISTS measures the clinician's therapeutic technique. Therapist technique refers to the technical procedures used to facilitate therapeutic change. The Interpretive and Supportive Techniques Scale, consisting of 14 items, quantifies the therapist's degree of acceptance of the strategies provided in supportive and interpretive psychotherapies. It also indicated the amount of interpretive and supportive techniques provided. The 14 items – ranging from 0 (no emphasis) to 4 (great emphasis) – cover a range of interpretive and supportive common to different dynamic psychotherapies (Ogrodniczuk and Piper, 1999). In the present study, Cronbach's alpha of the ISTS total score of the sample was considered good ($\alpha = 0.83$).

2.3.4. Working alliance inventory–short–therapist

The Working alliance inventory–short–therapist (WAI-S-T) (Horvath and Greenberg, 1989) validated Italian version was used (Lingiardi, 2002). evaluates the levels of the therapeutic alliance between patients and psychotherapists, from the psychotherapist's standpoint. It consists of 12 items – measured on a 7-step Likert scale from 1 = never to 7 = always – assessing three key aspects of the therapeutic alliance: (a) agreement on the tasks of therapy, (b) agreement on the goals of therapy and (c) development of an affective bond. Moreover, the scale captures three dimensions: emotional bonding, and the level of agreement on therapy tasks and goals. In the current study, Cronbach's alpha of the *WAI-S-T* total score of the sample was considered very good (α = 0.89).

2.3.5. Relationship questionnaire

The Relationship questionnaire (RQ) (Bartholomew and Horowitz, 1991; Carli, 1995) provides a measure of the four attachment categories: secure, fearful, preoccupied and dismissing. It is a single-item measure, consisting of four short paragraphs, each of which describes a prototypical attachment pattern, applied to close relationships in adulthood. There are two parts, RQ1 and RQ2. In the first part, RQ1, participants are asked to select a paragraph-long description that best describes them, without providing a numerical rating. The essential statements for RQ1 are as follows. Secure attachment: "It is easy for me to become emotionally close to others. I feel comfortable depending on them and having them depend on me. I do not worry about being alone or that others will not accept me." Fearful attachment: "I do not feel comfortable approaching others, I want emotionally close relationships, but I find it difficult to trust others completely or depend on them. I am afraid of being hurt if I allow myself to get too close to others." Preoccupied attachment: "I do not feel comfortable getting close to others. I desire emotionally close relationships, but I find it difficult to trust others completely or to depend on them. I am afraid of being hurt if I allow myself to get too close to others." Dismissing attachment: "I feel comfortable without close emotional relationships. It is very important for me to feel independent and self-sufficient, and I prefer not to depend on others or for others to depend on me." In the second part, RQ2, participants are asked to rate their agreement with each prototype on a 7-point scale. The highest rating of the four attachment prototypes is used to classify the participants into an attachment category (Bartholomew and Horowitz, 1991). The RQ evidenced good construct, convergent, and divergent validity (Bartholomew and Horowitz, 1991). In the current study, Cronbach's alpha of the RQ total score of the sample was considered good (α = 0.74).

Furthermore, for the present study, dichotomous classification was decided by dividing the subjects according to the secure and insecure attachment styles (fearful, preoccupied and dismissing).

2.3.6. Personality matching anaclitic and introjective

The patients' personality orientation was assessed using the Prototype Matching of Anaclitic-Introjective Personality Configuration (PMAI; Werbart and Levander, 2016). It is a clinician report form that presents prototypes of the anaclitic and introjective personality orientation. It consists of two items (one related to the predominantly anaclitic personality configuration or the introjective one) on a 5-step Likert scale (from 1 = poor/no match to 5 = very good match). The prototype matching method generates both categorical and dimensional ratings. Psychoanalysts were asked to rate how well their patients matched each prototype and to specify which of the two prototypes best matched the patient's personality orientation. As we aimed to compare anaclitic and introjective participants, the results of the PMAI were used to classify participants into predominantly anaclitic or predominantly introjective orientation. Cases were classified as either anaclitic or introjective, based on the highest score on one of the two dimensions and based on categorical self-assessment in cases where both dimensions had the same score. In the current study, Cronbach's alpha of the PMAI total score of the sample was considered good (α = 0.74).

3. Data analysis

Analyses were performed using SPSS 28.0 statistical software.

Skewness and kurtosis analyses were used to evaluate the normality of the distribution of the sample. All the variables, except for personality configuration, resulted within the acceptable range between −2 and + 2 (Podsakoff et al., 2003).

Descriptive statistics were used in the first section and the Chi-square test, paired sample *t*-test, ANOVA and Pearson r correlation were used in the second section.

Particularly, *T*-test and Chi-square test were used to evaluate the differences between patients with easy transition and patients with difficult transition to online psychotherapy on socio-demographics characteristics, type of issue, attachment style, levels of psychotherapeutic alliance, and psychotherapeutic technique (supportive and interpretive styles). *T*-test and Chi-square test were also performed to compare the effect of personality configuration (introjective vs. anaclitic) on the levels of the psychotherapeutic alliance, attachment style, and psychotherapeutic technique.

ANOVA was used to evaluate differences between patients with easy or difficult transitions and remote work or sessions in person in therapeutic alliance and technique.

Pearson r correlation was used to examine possible associations between attachment styles, levels of the therapeutic alliance, and psychotherapeutic technique.

A power analysis was conducted. This study in the second section was limited to 20 analysts; for *t*-test with 0.05 alpha level and 0.5 effect size, the statistical power was 33%. Accordingly, the results of this preliminary investigation must be interpreted with caution.

4. Results

4.1. First section

Descriptive statistics were derived from a total sample of 71 analysts.

During the acute phase of the pandemic, 100% of the analysts used remote therapy with at least one patient, including 47.8% with all or almost all patients. Various audio-visual tools were used: in 73.2% of the cases audio or video interviews, in 25.4% by telephone and 1.4% by written exchanges. Analysts rated the use of remote therapy as very helpful in 44.8%, fairly helpful in 44% and average or not very helpful in 10.2%. About 60% of the analysts reported that the patients had

accepted the change and 83.1% had a good acceptance of remote therapy; only 24.1% of the patients did not accept the shift to remote therapy. In most cases (77%), analysts found that patients felt welcome, and that continuity was maintained.

30% were afraid that remote therapy would increase emotional distance and 22.4% that it would alter the analyst's identity in his/her usual setting to a great or moderate extent; however, in 79.1% remote therapy was seen as a way of meeting patients' needs.

28.3% of the analysts considered remote therapy to be a natural adaptation process without consequences, while 71.7% believed it led to some consequences. 19.4% of the analysts had a lot or enough ethical concerns (privacy, etc.).

85.9% of the analysts considered active listening necessary (with an average intensity ranging from very necessary), particularly with specific categories of patients: Attachment problems (56.7%), dependent traits (31.3%), and a tendency toward autonomy (11.9%). In 93.2%, The containment function was on average, fairly or very much activated.

All analysts reported little or no loss of human contact while 75.9% reported much or quite a lot of increase in splitting defences.

Concerning the subjective aspects of the analyst, 50% of them report that the experience of the pandemic for the patients was quite or very traumatic. Concerning the therapeutic function, for 79.6% the therapeutic continuity allowed a great deal of or fairly good containment of anxiety. Concerning therapeutic activity, 20.6% of the analysts were able to initiate new treatments, of which 24.1% to cope with pandemic-related issues and 50% mainly related to other problems.

About the therapeutic relationship, for 60.1% the return to in-person setting strengthened the relationship very or fairly much, however with some difficulty in re-establishing the sense of security (43.6%); 33.4% of the analysts reported strong or fairly marked emergence of repressed contents, improving therapeutic processing. None refused to return to psychotherapy in person.

4.2. Second section

4.2.1. Preliminary analysis

For data analysis in the second section, two groups were created based on the evaluation given by the analysts: patients with easy transition ($N = 20$) and patients with difficult transition ($N = 20$). In patients with easy transition, 56.4% were female and 43.6% were male, while in patients with difficult transition 31.8% were female, 59.1% were male and 9.1% were attributed to the third gender. The differences between the two groups for gender were not significant ($X^2 = 3.15$; $p = 0.20$). Patients with easy transition had a mean age of 40.29 years old (SD = 15.8) and patients with difficult transition had a mean age of 39.86 years old (SD = 10.99); there were no significant differences with respect to age ($t = 0.11$; $p = 0.91$).

In the group of patients with easy transition, 5.1% started the therapy recently, 94.9% had been in treatment for a long time; in the group of patients with difficult transition, 45.5% started the therapy recently, 54.5% had been in treatment for a long time. The difference between the two groups was statistically significant ($X^2 = 14.47$; $p < 0.001$): patients with easy transition had a higher percentage who had already started therapy for a long time compared to patients with difficult transition.

In the group of patients with easy transition, 41% undertook therapy for problems evaluated as neurotic, 30% for personality disorders, 12.8% for psychotic and 15.4% for family problems; in the group of patients with difficult transition, 36.4% undertook therapy for problems evaluated as neurotic, 50% personality disorders, 4.5% psychotic and 9.1% about family. The differences between the two groups were not significant (Fisher's exact test = 2.86; $p = 0.41$).

Finally, patients with easy transition had a higher score in the structured family life category than patients with difficult transition ($t = 2.57$; $p = 0.013$). On the other hand, there were no significant differences with respect to the scores relating to structured working life ($t = 0.65$; $p = 0.51$) and structured relational life ($t = 1.72$; $p = 0.08$) categories.

4.2.2. Differences in attachment style, personality configuration, level of psychotherapeutic alliance, and psychotherapeutic technique

T-test and Chi-square (or Fisher exact test) were used to evaluate the differences between the two groups in attachment style, personality configuration, level of psychotherapeutic alliance, and psychotherapeutic technique.

The results showed a significant association between the type of transition to online psychotherapy and attachment style [X^2 (1;37) = 5.49; $p = 0.033$]. Patients with difficult transition to online psychotherapy had a more insecure attachment style: 95% of patients with difficult transition had an insecure attachment and 5% had secure attachment while 65.7% of patients with easy transition had an insecure attachment and 35.3% had a secure attachment.

No significant associations emerged between the type of transition to online psychotherapy and personality configurations [X^2 (1;40) = 0.1; $p = 1.00$]. In both groups, half of the patients were assessed as having an introjective personality configuration and half as having an anaclitic personality configuration.

T-test showed a significant difference between patients with easy transition and patients with difficult transition to online psychotherapy (see Table 1). Patients with difficult transition had a higher score on the RQ Dismissing scale than patients with easy transitions. Moreover, at the level of a tendency toward significance, patients with difficult transition had a higher score on the RQ Fearful scale than patients with easy transition.

TABLE 1 Differences between patients with easy transition and patients with difficult transition on attachment scales, levels of therapeutic alliance, and psychotherapeutic technique.

	Patients with easy transition ($N=20$)	Patients with difficult transition ($N=20$)	*t*	*p*	*d*
WAI-T	4.44 (0.74)	4.38 (0.74)	0.25	0.80	
ISTS	21.45 (9.04)	21.60 (8.81)	−0.05	0.95	
RQ Secure	2.41 (1.00)	2.60 (1.56)	−0.42	0.67	
RQ Dismissing	2.47 (1.17)	3.45 (1.46)	−2.21	0.034*	
RQ Preoccupied	3.41 (0.93)	3.80 (1.57)	−0.88	0.38	
RQ Fearful	2.94 (1.24)	3.90 (1.61)	−1.98	0.055+	

*$p < 0.05$, **$p < 0.01$, ***$p < 0.001$.

No significant differences were revealed between patients with easy transition and difficult transition in the level of psychotherapeutic alliance and psychotherapeutic technique.

Subgroups were also created based on the setting – remote work and return to in-person. The differences for the four subgroups based on the analysts' evaluations (20 patients with easy transition to remote work, 20 patients with easy transition back to in-person setting, 19 patients with difficult transition to remote work and 20 patients with difficult transition back to in-person setting) regarding therapeutic alliance or in the use of interpretive and supportive techniques were evaluated through univariate ANOVA. The results indicated a significant main group effect for the level of therapeutic alliance [$F(3,79) = 8.16$; $p < 0.001$]. Bonferroni post-doc test indicated that patients with easy transition to remote work had higher scores of therapeutic alliance both than patients with difficult transition to remote work ($p = 0.002$) and patients with difficult transition back to in-person setting ($p = 0.017$); patients with easy transition back to in-person setting had higher scores of therapeutic alliance both than patients with difficult transition to remote work ($p = 0.001$) and patients with difficult transition back to in-person setting ($p = 0.014$). No significant differences emerged between patients with easy transition back to in-person setting and patients with easy transition to remote work ($p = 1.00$) and between patients with difficult transition back to in-person setting and patients with difficult transition to remote work ($p = 1.00$).

Regarding the use of interpretive and supportive techniques, we found no significant main group effect [$F(3,77) = 0.03$; $p = 0.99$].

The differences for the personality configuration were evaluated, considering the two groups of patients with an introjective personality configuration ($N = 21$) and patients with an anaclitic personality configuration ($N = 19$).

Furthermore, *t*-test and chi-square were used to evaluate possible associations between personality configurations and levels of therapeutic alliance, psychotherapeutic technique, and attachment style. Fisher exact test showed no significant differences between personality configurations and attachment styles [$(1;37) = 0.43$; $p = 0.68$]. Both for patients with an introjective configuration (85%) and for patients with an anaclitic configuration (76.5%) the insecure attachment style was prevalent.

T-test showed no significant differences between introjective and anaclitic personality configurations in RQ scales, levels of therapeutic alliance, and psychotherapeutic technique (see Table 2).

Finally, through Pearson correlation analyses, we evaluated possible associations between RQ attachment scales, levels of therapeutic alliance, and psychotherapeutic technique. The results showed significant associations: the level of the therapeutic alliance was positively correlated to the RQ Secure scale ($p = 0.005$) and negatively correlated to RQ Dismissing scale ($p = 0.022$) (see Table 3).

TABLE 2 Differences between introjective and anaclitic personality configurations on attachment scales, levels of therapeutic alliance and psychotherapeutic technique.

	Patients with anaclitic personality (N=20)	Patients with introjective personality (N=20)	*t*	*p*	*d*
WAI-T	4.30 (0.79)	4.50 (0.68)	−0.84	0.40	
ISTS	22.18 (7.70)	20.92 (9.92)	0.44	0.66	
RQ Secure	2.35 (1.22)	2.65 (1.42)	−0.67	0.50	
RQ Dismissing	3.47 (1.50)	2.60 (1.23)	1.93	0.061	
RQ Preoccupied	3.41 (1.54)	3.80 (1.10)	−0.89	0.38	
RQ Fearful	3.47 (1.87)	3.45 (1.19)	0.03	0.96	

*$p < 0.05$, **$p < 0.01$, ***$p < 0.001$.

TABLE 3 Correlation between attachment scales, levels of therapeutic alliance, and psychotherapeutic technique.

	(1)	(2)	(3)	(4)	(5)	(6)
WAI-SR-T (1)	–	0.16	0.45**	−0.37*	−0.16	0.00
ISTS (2)		–	0.16	−0.16	0.05	0.11
RQ Secure (3)			–	−0.31	−0.31	−31
RQ Dismissing (4)				–	0.17	0.19
RQ Preoccupied (5)					–	0.60***
RQ Fearful (6)						–

*$p < 0.05$, **$p < 0.01$, ***$p < 0.001$.

5. Discussion

Regarding the part of the general questionnaire about how analysts perceived the transition from in-person to remote treatment for themselves and their patients, an analysis of the results reveals an overall positive picture. According to the responders, most patients accepted this transition, experienced it positively in most cases and felt they could maintain the continuity of the therapeutic work. For their part, most analysts feel that they succeeded in meeting their patients' needs, making them feel welcome and contained. However, concerns experienced by analysts regarding the setting modification and their own analytical identity also emerged, as well as the fear of creating greater emotional distance with the patient.

Regarding the remote analytical process, most analysts believe that online treatment had relevant technique-related consequences, while a third of them considered online therapeutic work to be a smooth adaptation to the lockdown conditions imposed by the pandemic, agreeing with Bolognini's (2020) observations. According to most responders, it was necessary to enhance the listening and holding functions in the therapeutic work, mainly with some categories of patients with attachment and dependency-related problems. It is also interesting to note that many of the analysts pointed out an increase in splitting defenses recruited by patients. Despite these variations, all the analysts agreed that there was no loss of human contact with patients and that the continuity of the therapeutic work provided by the online treatment enabled the containment of anxiety (as also noted by Altman, 2020; Gampel, 2020) as even with regard to the traumatic experience of the pandemic experienced by patients.

Regarding the return to in-person setting, this step also does not seem to have entailed difficulties according to the analysts. In fact, it strengthened the therapeutic relationship in the patients according to most responders, although with some difficulties in re-establishing a

sense of safety compared to sessions in person. Finally, it is interesting to note that according to about one third of the responders, the return to in-person setting allowed the emergence of unconscious contents that had not emerged in remote treatment (as also observed in the recent literature). This finding is consistent with the analysts' observation of the emergence of splitting processes in online treatment.

The results discussed above are in line with other studies. In particular Aafjes-van Doorn et al. (2021b) in a two-stage study – during the first weeks of lockdown and after about 2 months – showed that the majority of analysts considered online therapy in the follow-up as similar to in-person treatment, feeling positively connected and authentic in their work with their patients and overcoming the initial concerns about not feeling competent and experienced in the initial stage. Békés et al.'s (2020) study that compared analysts' perceptions in in-person and online treatments also shows that most of them felt they were equally connected and authentic with their patients in both therapies. In this respect, Humer et al.' (2020) study showed how a large number of the psychotherapists interviewed considered the transition to online therapy via videoconferencing to be better than expected. Finally, other studies showed that online therapy has made it possible to establish a relationship with the patient that maintains therapeutic continuity (Ehrlich, 2021; Nicolò, 2021).

On the other hand, the part of the questionnaire, which compared patients with easy transition to online treatment with those with difficult transition and aimed at investigating whether and how the psychoanalysts had experienced this transition in the patients, produced interesting results. First of all, we can consider no significant variables such as gender and age. Particularly, we had thought that age could introduce important differences regarding disposition to transition. We do know that young people – also among the psychotherapists – are generally more accustomed to using devices which connect people, and we thought that this situation could be experienced as a challenge (Aafjes-van Doorn et al., 2022). Diagnosis also did not emerge as a variable involved in determining significant differences between the two groups of patients. As we somewhat expected, the length of the treatment that had already been done facilitated an easy transition to the online approach. Indeed, the length of the treatment is often correlated to a stable alliance (Heinonen et al., 2022).

The use of some tools allowed us to better articulate these first comments about the results. In particular, while the analysis of personality configurations (anaclitic, introjective) did not show significant differences between the groups, contrary to expectations (Werbart et al., 2022b), the analysis of attachment styles showed significant differences overall, highlighting a higher frequency of insecure attachment styles in patients with difficult transition to remote therapy than in those with easy transition. In this respect, insecure attachment style emerged as a risk factor for coping with the transition to remote therapy, confirming the vulnerability aspects inherent in insecure vs. secure attachment styles (Mikulincer and Shaver, 2012; Riva Crugnola et al., 2021; Aafjes-van Doorn et al., 2021a). Moreover, among attachment styles, the significant differences that emerged between the two groups considered concerned the dismissing attachment style and, with a tendency toward significance, the fearful one that involves both anxiety and avoidance. Regarding the dismissing style, we can hypothesize that this style, which expresses difficulties with respect to the intimacy of relationships, made it difficult to adapt to the new relational mode proposed by the analysts. Regarding patients with fearful style expressing both anxiety and avoidance, the online approach could lead to the perception of "the inanimate third" – the electronic device – in the therapeutic process (Ferber et al., 2022). The presence of the "analytic third" was assumed by Ogden (2004). He refers to the connection created through the unconscious life of the analytic pair. On the contrary, "the inanimate third" emphasizes how the objectivity of the electronic device is in opposition to the subjective emotional processes involved in the psychoanalytic process.

As to the therapeutic alliance, its particular importance is confirmed. Indeed, our results show that it favored both the transition to online treatment and the return to in-person sessions. Furthermore, the therapeutic alliance is positively correlated to a secure, non-problematic attachment style comparing to those mentioned above (dismissing and anxious). In other words, the therapeutic alliance is confirmed as a construct at the basis of the psychotherapeutic process (Safran and Muran, 2000; Oasi, 2015).

Finally, the lack of distinction between types of psychotherapeutic intervention – supportive vs. expressive – could be in line with the hypothesis that remote treatments tend to "flatten the differences" (Probst et al., 2020), but it could also indicate that the working-through and supportive interventions are parts of a single process that is modeled on different levels of subjective needs in the patient and in the alternation we studied. This can be thought of as characterizing the adaptation process, which involves a partial temporary regression that occurs at critical moments (Roussillon, 2020; Guignard and Diatkine, 2021) and then triggers growth processes.

Besides theoretical considerations, generally speaking, this study highlights that the quality of the psychoanalytic process is involved in different ways during the transition from the consulting room to the online setting, but further research is needed for understanding how individual differences can intervene significantly (Johnson et al., 2022). Although some results are promising, currently even important and validated constructs such as attachment or personality orientations (see this study and Werbart et al., 2022b) do not give enough certainty. It might be important to take into consideration: the type of patients – children or adolescents vs. adult or older people (Erlandsson et al., 2022) and/or psychotherapist orientation – for ex., psychodynamic vs. cognitive (Sachs et al., 2022).

5.1. Limits and future directions

The study is not without limitations. The interviews were only addressed to the analysts and not directly to the patients. Analysts had low familiarity with the evaluation tools of the second section. Moreover, the data were collected based on the perceptions of the analysts involved. Since there were no collected data from patients, it would be important in future studies to reproduce the study from patients' perspectives. The number of the responders was low and does not allow for a generalization of data. The results obtained in this study are to be considered exploratory and preliminary. Replication of the study with a larger sample is deemed necessary and unavoidable. A final limitation concerns the validation of instruments. Of the 4 included instruments, only RQ (Carli, 1995) and WAI-S -T (Lingiardi, 2002) have Italian validation. Regarding future directions, despite the overall positive assessment outlined by the analysts in our study about

the use of remote treatment during the pandemic, many analysts also highlighted concerns about this use especially with regards to distance which can intensify defenses. At the same time, the study showed some characteristics of the patients that made the transition to remote treatment more difficult and requiring more attention in clinical practice. In any case, we faced a new frame of working with the patients which in part did not disappear once back on the coach. Further studies about how the training in some scientific community is held online (Moshtagh, 2020) and whether a specific training to conduct teleanalysis is required (Ahlström et al., 2022) are recommended.

Data availability statement

The raw data supporting the conclusions of this article will be made available by the authors, without undue reservation.

Ethics statement

Ethical approval was not provided for this study on human participants because the research was authorized by the President of the Italian Psychoanalytic Society within which it was performed and followed the principles of the Declaration of Helsinki. The patients/participants provided their written informed consent to participate in this study.

Author contributions

LLR, AW, OO, and CRC planned, designed the present study, wrote, and reviewed the manuscript. FDS and EI wrote, reviewed the manuscript, and analyzed the data. MG participated in data collection. All authors have given final approval of the version to be published.

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Conflict of interest

The authors declare that the research was conducted in the absence of any commercial or financial relationships that could be construed as a potential conflict of interest.

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Supplementary material

The Supplementary material for this article can be found online at: https://www.frontiersin.org/articles/10.3389/fpsyg.2023.1167582/full#supplementary-material

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"Let me tell you what I think about online psychological help." A thematic analysis of voluntary opinions collected at the onset of the COVID-19 pandemic

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Introduction: The COVID-19 pandemic shifted many aspects of life from face-to-face to an online form, including psychological help. Many people had to face the choice of adjourning contact with a psychologist or shifting it to the Internet. This study aimed to develop an understanding of attitudes and opinions toward relatively new phenomenon in Poland – online psychological help.

Method: Seventy two (N=72) statements about relationship between COVID-19 pandemic and online psychological help from (potential) patients were included in this research. The statements were collected from a community sample via open-ended question for volunteers added to an online survey conducted regarding an existing project. The statements were exclusively written responses to the following question: *If you want to provide us with something about the relationships between the COVID-19 pandemic and online help/psychotherapy, please let us know below.* By reason of exploratory character of our study and general phenomenological philosophical approach and constructionist approach, a thematic analysis method was used to analyze the data.

Results: The analysis led us to identify three general themes with sub-themes that refer to meaningful aspects of online psychological help: 1. Online psychological help situates in the shadow of face-to-face help, 1.1. It frustrates the needs, especially the need for psychological contact, 1.2. It contributes to negative emotions, 1.3. It is sometimes better than the face-to-face help; 2. Online psychological help is a solution during the COVID-19 pandemic, 2.1. It provides a sense of continuity during lockdown, 2.2. It is a means to adapt to exceptional circumstances, 3. The concerns about the credibility and effectiveness of online psychological help.

Discussion: The results show (potential) patients' attitudes (including emotions, thoughts, and concerns) toward online psychological help. The perspective presented here could be beneficial to professionals. A better understanding of client/patient attitudes will allow for more accurate customization of the online help and sensitize psychologists to the emotions that may occur about online psychological help. It could also be beneficial for patients to understand how other people would feel about online psychological help and develop ones' own self-awareness of the attitudes toward online psychological help.

KEYWORDS

online psychological help, online psychotherapy, attitudes toward online psychological help, thematic analysis, qualitative method, e-mental health, COVID-19, pandemic

Introduction

Technological advances have contributed to the movement of most areas of life, such as work, study, and health, into the online realm. Psychotherapy and all other forms of psychological help are subjected to technology, resulting in a plethora of modern healthcare information technologies such as mobile apps, online exercise programs, and therapeutic interventions (Hayes and Hofmann, 2020). Some forms of online psychological help are used as pure self-help, while others require regular contact with a psychologist via the Internet (Clarke et al., 2009). The majority of the literature indicates that online psychotherapy is as effective as its face-to-face counterpart (Wagner et al., 2014). Meta-analyses show small-to-medium effect sizes when Internet interventions are delivered as stand-alone self-help interventions, and medium-to-large effect sizes when delivered as therapist-guided interventions, both compared with usual care (Schröder et al., 2016). However, the results of meta-analyses are not always so conclusive, especially when studying improvements from specific disorders (White et al., 2022), suggesting potentially limited real-world effectiveness and the need to specify the conclusions that are most favorable to successful online psychological help. In addition to this, online psychological help has undoubted advantages, such as being able to help people in rural areas who may find it challenging to access psychotherapy physically (Simpson and Reid, 2014). Online interventions are also easily disseminated and are low-cost (Clarke et al., 2009).

The natural pace of moving psychotherapy from face-to-face reality to virtual space has been accelerated by the COVID-19 pandemic. The pandemic and resulting lockdowns reduced social contact and complications at work, thus creating problems not only in terms of psychological difficulties but also in the availability of face-to-face psychological help (Vindegaard and Benros, 2020). The global situation has also forced therapists to move from face-to-face to online therapy for the most acute period of the pandemic. Considering the Polish psychological help field at the onset of the COVID-19, therapists did not receive unified guidelines for organizing online support. Consequently, at the onset of the pandemic, they had to find a path to provide support in times of restrictions. Some psychologists had to decide on their own whether to switch to remote contact or suspend therapy (Zielona-Jenek et al., 2021). Some associations, e.g., the Polish Society for Psychodynamic Psychotherapy (Polskie Towarzystwo Psychoterapii Psychodynamicznej, 2020), released the statement at the beginning of the pandemic in which they did not recommend conducting therapy in an online form. However, PTPPd pointed out some specific areas of therapeutic work that can be conducted online (especially support in crisis and maintaining a therapeutic relationship). Moreover, government online psychological support programs targeting specific groups began to appear, e.g., the "Comfort Zone" of the Parliament of Students of the Republic of Poland ("Strefa Komfortu" Parlamentu Studentów Rzeczpospolitej Polskiej) as well as online help provided by companies (e.g., WeTalk Chat). Thus, at the pandemics' beginning, online psychological support in Poland was organized multidirectionally without clear legal rules or government recommendations. The abrupt transition time, often combined with a lack of preparation or experience in the online contact form, was also associated with many difficulties (Guinart et al., 2021; Lewis et al., 2021; Zielona-Jenek et al., 2021). Literature suggests that managing the transition to online psychological help depends on the psychotherapy approach; specifically, therapists identifying with the cognitive-behavioral approach presented a more positive attitudes than psychodynamics psychotherapists. One possible explanation for this difference is the emphasis on different mechanisms of change in each therapy. Psychodynamic psychologists focus more on, e.g., in-session processes, non-verbal responses, and working through silence, which may be limited, distorted, or even impossible from the perspective of conducting therapy in an online form. (Békés and Aafjes-van Doorn, 2020; Hayes and Hofmann, 2020). Moreover, some authors focused on non-professional and professional helpers point out that non-professionals rate telemedicine more critically (Schulze et al., 2019). Professionals are likely affected by the exposure effect. The literature provides the pros and cons of online help experiences stated by practitioners'. Feijt et al. (2020) mainly reported technical (e.g., unstable connection) or communication (e.g., lack of non-verbal signs) issues and unpleased needs (e.g., technical/procedural support or sufficient resources) as limitations of online help. Moreover, psychologists' negative attitudes were also related to the quality of the therapy, such as perceiving lower competence, lower confidence, and lower authenticity of the therapeutic relationship (Békés and Aafjes-van Doorn, 2020). However, convenience in making appointments, providing additional information about a client, improved contact (e.g., some clients are less inhibited) (Feijt et al., 2020) and previous experiences of online therapy, and beliefs of a positive patient experience (Békés and Aafjes-van Doorn, 2020) are considered as advantages of online psychological help.

The literature suggests that people would rather choose face-to-face than online therapy. However, they do not exclude the possibility of using remote appointments. Patients prefer face-to-face therapy rather than online therapy (e.g., Wong et al., 2018), even when all advantages related to online help are considered (Rochlen et al., 2004; Klein and Cook, 2010). March et al. (2018) noted that most respondents (85.7%) preferred face-to-face services over electronic services for mental health, but almost 40% declared intentions to use the latter in the future. Many studies show that students readily express intentions to use and favorable attitudes toward online services (Farrer et al., 2013; Dunbar et al., 2018). Moreover, some authors point out that previous experience of (online) therapy helps to develop more positive attitudes toward online psychological help. Clients who participate in videoconferencing psychotherapy without previously meeting their psychologist in-person may question its' credibility and effectiveness (Hall et al., 2022). Also, Dunbar et al. (2018) found that students with current severe psychological distress but no prior face-to-face treatment were less likely than those with a history of face-to-face treatment to endorse preferences for face-to-face services. Prior research suggests that certain attitudes can influence use of online psychological help among different groups of people, including patients. According to Apolinário-Hagen et al. (2018), some patients perceive online therapist interventions as helpful but not equal to face-to-face therapy. Patients who were more aware of the possibility of online therapy were more willing to use various forms of Internet-based psychological help. People experiencing stress preferred using guided online self-help over videoconference with a therapist. Those who developed an avoidant attachment style favored guided and unguided online self-help more than direct connection via the Internet with a therapist. McDonald et al. (2020) noted that some patients assessed online psychological help as an opportunity to be less inhibited, and more open to sharing information and establishing

interactions. Cook and Doyle (2002) point out that people who feel insecure in social situations may view online contact as more secure and consequently feel more comfortable expressing their feelings more openly. Younger patients are more likely to use the Internet for therapy (McDonald et al., 2020), especially if they prefer to use the Internet in general for purposes other than therapy (Sweeney et al., 2019). Thus, the findings are not sufficiently detailed in terms of the experiences and attitudes. Results are also inconsistent, suggesting that different groups of patients (or clients) may see different benefits and risks of online psychological help. Moreover, attitudes toward, and beliefs about, online psychological help seem to be important for its' effectiveness and trustworthiness. Schröder et al. (2015, 2018) point out that positive attitudes and beliefs are related to higher benefits and level of engagement in online psychological help. It was also observed that, in the case of suicidal thoughts, the effectiveness of online interventions is likely mainly related to program structure, monitoring, and safety procedures (van Spijker et al., 2018), which shows a commitment component, close to the acceptance of a given way of working on oneself. Considering the trustworthy issue, the literature suggests that lower online help credibility relates to psychologists' lack of knowledge about the sociocultural context (e.g., Sampson et al., 1997), but it is not specific to online help (e.g., Sue and Sundberg, 1996; Zhang and Burkard, 2008). The Internet provides the opportunity to use the support provided by psychologists worldwide (e.g., speaking the same language but living in other countries). Consequently, it creates a greater risk that the psychologist will not be familiar with the cultural code the client/patient uses daily. Thus the psychologist may omit specific issues that could be important regarding the support provided. Some authors (Maples and Han, 2008) point out that the lack of face-to-face contact itself may be a reason for the lower credibility of the support offered online. However, some authors (e.g., Axelsson et al., 2020) indicate no differences in reliability between online and face-to-face assistance, which implies some inconsistency in this matter.

Our research considers the following lines of evidence (1) that there is an ongoing process of scientific recognition of the advantages and limitations of modern technologies applied in the field of psychological help, (2) attitudes are essential for the effectiveness of online help, so understanding these attitudes can support those responsible for providing online help, (3) the pandemic, as a vast contextual factor (e.g., social, economic, political), may have influenced attitudes toward online psychological help, so the question of the image of online psychological help that people present becomes particularly important, and (4) literature about online psychological help includes more research regarding the therapist/psychologist perspective, including their theoretical background, rather than patients or clients.

The aim of our research was to develop an understanding of experiencing online psychological help by potential beneficiaries, through analyzing participants' voluntary statements from an online scientific psychological study. Our inquiry gives voice to the patients/clients and depicts their perception of online psychological help based on experiences, opinions, emotions, and attitudes. Online psychological help may be more than just a temporary solution for reduced access to face-to-face psychological help during the COVID-19 pandemic. Thus, the results of this study can help to (1) understand which patient/client attitudes are related to online psychological help and (2) improve the planning of online psychological interventions that could match its potential. We believe the presented findings would be helpful for a broad group of mental health workers and (potential) patients/clients.

Method

The main objective of this study was to describe the perception of online psychological help in the experiences and opinions of people who were, or could become, beneficiaries of such help. Given the explorative goal of our study, we decided to use thematic analysis (Braun and Clarke, 2006, 2012) for analysis of written statements. We have assumed two approaches (1) a general phenomenological philosophical approach, concentrating on deep meanings and bracketing our experiences as researchers (Major and Savin-Baden, 2010) and (2) constructionist approach focused on meanings developed in peoples' experiences (Crotty, 1998).

Sampling

The statements about online psychological help were collected regarding an existing project about online psychological help. The following question was added at the end of the survey: *If you want to provide us with something about the relationships between the COVID-19 pandemic and online help/psychotherapy, please let us know below* The general aim of the primary study was to investigate the psychometric properties of the Attitudes Toward Psychological Online Interventions – Polish version (APOI-PL; Soroko et al., 2023 under revision in Frontiers; manuscript ID: 1168579). In the original study were recruited from a community sample ($N = 304$; 200 females, 99 males, 5 did not stated their gender; age $M = 27{,}75$; $SD = 10{,}06$). All data were collected at the beginning of the COVID-19 pandemic (March 2020 – September 2020). The online survey was disseminated via Facebook (paid advertisements) and participants were also recruited among researchers' social networks via snowball selection. When asked what kind of online psychological help a person was referring to in the survey (question with many options to choose), we found that most people answered "online psychotherapy and counseling" (87.17%). Some people also indicated that for them, "online psychological help" is also web-based intervention (13.48%), internet-operated therapeutic software (13.81%), or other online activities (14.14%). Nearly a quarter of the total amount of participants (see Participants section) voluntarily decided to share their opinion. After reviewing the data, we noticed that online psychological help constitutes an unexplored and critical topic, which participants want to discuss or share their views of. We included all 72 written statements (words statistics: $M = 57.83$; $SD = 51.76$; $min = 9$; $max = 320$) in the analysis because they all contained at least one point that a participant wanted to convey. The statements were exclusively analyzed in the current study, as a separate data set.

Participants

Participants ($N = 72$; 45 females, 25 males, 2 did not stated their gender; age $M = 25$; $SD = 9.78$; $min = 19$, $max = 68$) were individuals who voluntarily shared their experiences and attitudes about online

help. Thirty-six participants declared current involvement in psychotherapy or other psychological help; twenty-eight declared current or past involvement in online psychological help; twenty-one stated that they benefit from pharmacotherapy to stabilize psychological functioning. Fifty-five participants elaborated on what type of online help they thought about when they shared their opinions and experiences. Forty-four of them talked about online help and psychotherapy, while the remainder indicated online apps or sites.

Researchers

We are aware that qualitative research, including the results, could be affected by the authors' perspectives. We therefore describe below all personal experiences or attitudes related to online contact during the COVID-19 pandemic, as well as additional information. The authors are Psychologists and Researchers associated with the *Qualitative and Mixed Method in Clinical Psychology Research Lab* at *Adam Mickiewicz University* in Poznań. At the time of this study, the first author (AW) was a PhD student and school psychologist with experience as being after-school club educator. During the COVID-19 pandemic, he took part in, and observed, online teaching in a primary school in Poland. In general, he perceived online education to be worse and less effective than in-person education. Moreover, he believed that the time that children spent in their houses may have had a harmful impact on their peer relationships, ability to cope with stress, negative emotions (e.g., anger or anxiety), and ability to focus their attention. Almost all children he talked to claimed that they prefer in-person education to online. These experiences and considerations about educational/online contact at school have increased his interest in attitudes toward online contact with mental health specialists. Thus, he monitored the differentiation of online psychological help and online education during the analysis of the present study. The second author (JS) was a psychology student, who graduated from the university during the analysis. Her own experiences considering online education made her interested in this research. Online classes at the university and during the Erasmus exchange negatively impacted her motivation, and she developed a tendency to isolate herself from others. Therefore, during the analysis, she had to be particularly careful so that her negative attitude toward living online did not affect the interpretation of the data. ES supervised this research. At the time of this study, ES also started to investigate psychodynamic psychotherapists' adaptation toward online psychological help and was in the process of building her own attitude toward online psychotherapy. However, her starting point was the resistant perspective. Thus, she was very sensitive to the valence (positive vs. negative) of the content codes and themes. Considering the number of responses to the open-ended question on online help, which was a relatively new phenomenon in Poland, the authors were curious to know how online psychological help was perceived at the onset of the COVID-19 pandemic. All authors were motivated to review their views on online psychological help.

Analysis

We applied the general phenomenological perspective to data analysis and used inductive thematic analysis according to the procedure formulated by Braun and Clarke (2006, 2012). This approach was dictated by the need to explore a relatively new phenomenon without any prior theoretic assumptions by evoking participants' perspectives. Moreover, we believed that organizing qualitative data in themes (patterns) would allow us to reach the major meaning expressed by participants. Each statement was treated as a separate analytic unit. We analyzed the statements collaboratively (Richards and Hemphill, 2018), such that the first and second (named researchers in the next paragraph) authors consulted analytic decisions with the third author (supervisor) throughout the analytic process.

The steps of the procedure were as follows. First, each of the two researchers independently read all statements to familiarize themselves with the data, and then met to decide on a direction for analysis, specific aims, and research questions. The primary research question was: what experiences or attitudes about online psychological help do participants express? They coded both explicit extracts (descriptive coding) and implicit meaning (analytic coding; Gibbs, 2018). Second, each of the two researchers independently generated initial codes, and then met to share outcomes to check if their codes were accurate, understandable, and could be derived from the extract they were assigned to. The researchers and their supervisor then discussed and unified the code set and continued to work on an expanded code set. Third, each of the two researchers independently identified themes. Fourth, each of the two researchers independently prepared a list of candidates for themes that were revised in another collaborative meeting. Each researcher checked if every theme on their list created a coherent pattern, and if every theme was valid for the whole data set. Fifth, themes were defined according to each theme's central meaning. A meeting was held to discuss and agree on a list of themes. The final wording of each theme was discussed and agreed upon during the meeting with the project supervisor. Sixth, the quotes were matched to themes and the most illustrative quotes were selected to report. During this phase, the themes were reorganized to develop a better narrative. To ensure data quality we employed strategies such as securing time to immerse in the dataset, researcher triangulation, independent coding with collaborative meetings, documentation of analytical decisions, and team consensus on themes (Nowell et al., 2017).

Results

Three general themes with sub-themes were identified in the thematic analysis. The themes refer to meaningful separate aspects of online psychological help that are present in data in the scope of research questions (Figure 1; Table 1).

Theme 1. Online psychological help situates in the shadow of face-to-face help

Participants generally made unfavorable comparisons between online and face-to-face psychological help and wrote about limitations of online psychological help relative to face-to-face help, especially considering the restraints of psychological contact and the therapeutic relationship. They indicated mostly negative aspects of online

TABLE 1 The list of themes and sub-themes.

No	Themes and sub-themes	Percentage contribution of statements
1.	Online psychological help situates in the shadow of face-to-face help	
	1.1. It frustrates the needs, especially the need for psychological contact	30.6%
	1.2. It contributes to negative emotions	22.2%
	1.3. It is sometimes better than the face-to-face help	6.9%
2.	Online psychological help is a solution during the COVID-19 pandemic	
	2.1. It provides a sense of continuity during lockdown	27.7%
	2.2. It is a means to adapt to exceptional circumstances	30.6%
3.	The concerns about the credibility and effectiveness of online psychological help	25%

Research question: what experiences or attitudes about online psychological help do the participants express?

psychological help, which do not appear (in their opinion) during the face-to-face meetings. However, they also referred to the advantages of online psychological help.

Sub-theme 1.1. It frustrates the needs, especially the need for psychological contact

This theme refers to notions about a vast array of needs that cannot be satisfied by online meetings with a psychologist. According to participants, online psychological help frustrates, for an instant, a need for security, for physical/real contact, of communion and closeness, to be understood, or for a comfortable place to meet.

Online contact was perceived to be less natural than face-to-face contact, especially because of the lack of nonverbal communication that may jeopardize the objectives of psychological help. For example, one participant wrote: *It would be more difficult for the specialist to read the patient's non-verbal signs* [while online meeting], and another: [online psychological help] *disrupts communication on a natural level.. well – it's less natural (..), physical presence promotes therapy*. This participant alludes to the need for contact rooted in physical space and attributes it to a key role for effective help. Online contact with a psychologist was also referred to as dysfunctional, unnatural, and more challenging to engage with and maintain than face-to-face contact, as evidenced through the following two statements: *Online therapy is not like „live" meetings. Online work is worse, more difficult.* (…) *you cannot keep eye contact with therapist, it's difficult to work some topics over without face-to-face contact* and *Whether in real life or in online therapy, confidentiality and a therapeutic relationship are important. In online therapy, confidentiality is assured, but the therapeutic relationship is more difficult to make.*

There were also some statements about the perceived challenge of opening up during online help, e.g., *I sometimes feel that I would rather see a psychotherapist in person and that it would be easier to talk about some of my problems*. Participants also spoke on behalf of other people, such as those suffering from schizophrenia, as they perceived certain groups would never able to adapt to online help and they would *inevitably require face-to-face care and contact with a specialist*.

Moreover, participants revealed the need of the psychotherapist's office as a place where one can feel secure. A need for security was expressed, as well as concerns about privacy deprivation and lack of confidentiality as in the following statement: *The conversation is accompanied by fears that a member of the household might overhear something very intimate*, and another: (…) *if you do not live alone, you may feel uncomfortable and be dishonest because of fear of being overheard. Home is not always a safe place*.

Sub-theme 1.2. It contributes to negative emotions

Participants mentioned negative emotions that they had experienced with online psychological help, predominantly fear, anxiety, and anger (see also Sub-theme 1.3 for positive emotions). Negative emotions were usually related to the frustration of needs, mentioned above, due in part to the uncontrolled conditions of online meetings but that are absent in face-to-face appointments (e.g., behavior of others in the household or technical difficulties). The following quotes illustrate fear and anxiety related to others in the household: *When using online help, it can be difficult to open up if you live with other people because there is a fear of being heard*, and another: *The conversation is accompanied by fears about whether any member of the household will accidentally hear something very intimate* (…).

However, not all negative emotions seem to be induced by frustrated needs. Some participants stated that online appointments are more stressful than face-to-face, e.g., *The transition from traditional, or face-to-face, therapy to online therapy is quite a stressful event for many people. Many people I know feel tremendous stress, even more than during a regular visit*. Their negative emotions were related to uncontrolled technical issues: *I also feel the fear of technical problems that may affect the quality of the online meeting (…)*; or general dissatisfaction related to the transition from face-to-face to online therapy, e.g., *Because of my psychological well-being, I decided to continue therapy online. I am not happy about it (..)*

Some also pointed out uncertainty about whether help can be provided professionally online. One participant said: *Professionals do not necessarily know how to help others through a phone or computer screen*. Another participant expressed anger, saying, [online psychological help] *is terrible, during online consultation I feel ignored, belittled, mute*!

Sub-theme 1.3. It is sometimes better than face-to-face help

In the participants' statements, we also observed some comparisons made in favor of online help. Participants claimed that online help could resolve some economic or transportation problems, such as driving to the psychological clinic for those who live in small

towns or villages, e.g., *to people having difficulty traveling to a larger city*. One participant described how online help could be an antidote to overcome limited access to healthcare: *Many people do not have access to a psychotherapist or psychiatrist close to where they live, and such online help is de facto the only help they can afford if they cannot see a specialist in person. A*nother participant highlighted the opportunity to support people with various disabilities, e.g., *better solution for those with various disabilities*.

Moreover, online psychological help seems to reduce fear and anxiety related to revealing the fact of being in therapy to others. The online nature of the meetings helps to maintain confidentiality, e.g., *It is good that it is possible to meet a psychologist/psychotherapist via the Internet because patients do not have to worry that someone will see them when they enter the psychologist's clinic*. Participants also mentioned relief, happiness, or pleasure in relation to the possibility to continue having contact with a psychologist/psychotherapist during the pandemic, e.g., *For me* [online psychological help] *works well, I'm happy with the results, and I also think it's better to continue online therapy and try to convince myself rather than abandon it completely.*

Theme 2. Online psychological help is a solution during the COVID-19 pandemic

Participants perceived that online psychological help was a forced adaptation to the COVID-19 pandemic that should be reversed as soon as possible so as to avoid negatively impacting psychotherapy as a professional activity. Here, we identified two sub-themes: providing a sense of continuity during lockdown and adapting to exceptional circumstances.

Sub-theme 2.1. It provides a sense of continuity during lockdown

According to research participants, online psychological help provides a sense of continuity in the use of psychological help that had been previously started in a face-to-face setting. Participants, who referred to their own psychotherapy process, experienced a forced choice between online meetings or to cease/suspend current contact. The involuntary aspect was highlighted, e.g., *No possibility of "live" meetings!*; *No therapy is worse than online therapy when there is no other option*.

Some participants described online psychological help as the only safe option to maintain contact with a psychologist or psychotherapist in the pandemic and lockdown. Some participants referred to the experience of moving from face-to-face to online contact, e.g., *My psychotherapy began in the office but was interrupted by a lockdown. Very quickly, the therapist suggested online meetings, initially as a "maintenance of the therapeutic relationship."* Other participants reported that online help during the pandemic was widely needed, and there were people who experienced abandonment by therapists, particularly when they did not switch to online help, and were left alone with intense emotions, e.g., (…) *when faced with canceled appointments – they do not know what to do, where to go, who will help them. Patients left on their own cannot cope because their original problem/disorder is joined by panic attacks, hysterical crying.* The potential lack of any psychological help (during the pandemic) was perceived to be hard to cope with on a daily basis, e.g., *I am frightened by the vision of not having therapy and the help of a psychiatrist in my everyday life.*

Sub-theme 2.2. It is a means to adapt to exceptional circumstances

At the time of data collection, for many participants, online psychological help was a temporary adaptation, e.g., *I had to switch to this form of therapy in these strange times. But ultimately I'm supposed to have psychotherapy in real life*. For others, online psychological help was a more permanent means of communication between patient and therapist, which could regularly act as *a substitute in crisis situations,* at least for certain groups of people in need, e.g., *only an emergency form of assistance for the bereaved*. Participants elaborated on the specific conditions under which online psychological help is more desirable, e.g., *if online psychotherapy is conducted by a professional, and the choice of this form is not due to a desire to avoid involvement in one's psychotherapeutic process, but is due to objective reasons* (e.g., *quarantine, lack of a Polish-speaking psychotherapist in the area*), *then it makes sense and is needed*.

Online psychological help was also recognized as an effect of pecuniary or organizational adjustment, ultimately mitigating the impact of COVID-19 on people and the economy. One participant wrote: *If it were not for the fact that it was possible to enforce remote work during the epidemic situation using ICT tools, it would have been a disaster. Financially -for the National Health Service, therapists and clinic staff, and most of all for patients, who would lose the possibility of support and continuity of therapy*. Another participant using English (potentially to express cosmopolitan feelings) demonstrated gratitude or relief: *Thank gods for the internet!* In the longer term, experiences with online psychological help that have been accelerated by the COVID-19 pandemic may affect professional help in a general sense, especially by *gaining a wider reach than if there were the absence of a pandemic threat.*

Theme 3. The concerns about the credibility and effectiveness of online psychological help

Some participants expressed concerns about the effectiveness of online psychological help or its' credibility. The statements draw attention to the difficulty in verifying the credibility of the psychologist, the risks of seeking help from an unreliable source (e.g., an online forum or a website of unknown origin), and sometimes to direct harmfulness from non-professional groups, which are difficult for lay people to distinguish from professional groups due to advertising or positioning. Many participants also expressed their concerns or doubts about the effectiveness of online psychological help.

A lack of confidence toward psychotherapists working online was also expressed. The lack of control and the impossibility of discovering the truth about professionalism of the therapist, and the interplay between easy access and restricted service quality, were indicated, e.g., *The downside is that anyone can advertise as a therapist, and it is easy to come across a charlatan*. The image of a self-regarding psychologist was also described, e.g., *offering psychological help to people in crisis is more therapeutic for the psychologist him/herself, who also feels anxiety and tries to deal with it by being useful*.

Attention was also drawn to online groups, which can be confused with receiving online professional help. Online groups may look similar to a place where people can get psychological support from people commenting on online posts. However, *the comment is made by an ordinary Kowalski* [Mr. Smith] *who has no psychological training and his advice does not help the person concerned, it can only harm him.* Even if there are psychologists in support groups, they are *random people from the Internet who do not know you intimately.* In addition, *in front of the computer it is easier to pretend,* so *it is easy to sweep some* (*key*) *problems under the carpet*. Online psychological help can offer the illusion of help by misleading those most in need, e.g., *therapeutic apps of all kinds are usually bullshit, possibly helping people who, despite their problems, have no problem with motivation and regularity*).

Moreover, without professional care, there can be some social viral processes that can impede coping with the pandemic and other crisis. Indicating an *increasing number of posts tinged with panic, anxiety, and questions about how others deal with panic. As this is not a group of psychologists, these people do not get reliable answers, but ones that "feed" the panic.* The lack of a Psychologist can increase the harmfulness of online groups. Thus, the potential harm of online groups or forums mainly concerns mistaking them for professional help, and some are not sufficient for reaching health benefits. However, in some cases, *forums like Quora or Facebook groups can serve as a good source of psychological knowledge, but for individual work, regular therapy is definitely more helpful.*

Many participants also expressed their concerns about the effectiveness of online psychological help. Some have questioned the efficacy of online psychological help in therapy for specific disorders, e.g., (…) *With schizophrenia and other similar disorders, I think such* [online] *help would not be very successful*. Others are (…) *not sure that online meetings with a person you meet online will be as effective* [as face-to-face help]. Consequently, the participants tend to undermine the effectiveness of online psychological help in general, e.g., (…) *people who have already been diagnosed with mental problems, the symptoms will get worse or remain at the same level regardless of online help*, or *Psychotherapy over the Internet due to the epidemic situation 90 percent of the time does not meet the help that a psychologist, psychotherapist would offer in the office*.

Discussion

Our study aimed to develop an understanding of experiencing online psychological help by (potential) patients and clients form a community sample. It is important to note that the study occurred at the beginning of the COVID-19 pandemic in Poland. Using thematic analysis, which we embedded in a phenomenological and constructionist approach, we analyzed the voluntary statements of 72 research participants. Three main themes, along with sub-themes, were identified, addressing the question of what attitudes and experiences of online psychological help are expressed by the participants (see Table 1 and Figure 1). Below we discuss the themes and present the practical implications of the findings, in order to improve the planning of future online psychological interventions.

Our study found that online psychological help situates in the shadow of face-to-face psychological help. We identified an apparent viewpoint that online psychological help frustrates the needs of patients, especially the need for psychological contact, and that online psychological help contributes to negative emotions but is sometimes better than face-to-face help. Online help is discussed in the context of face-to-face help. People treat online psychological help, adequate to its preceding place in health care, as secondary and derivative to face-to-face psychological help. Our findings show that comparing online and face-to-face help is common and often is not in favor of online therapy, especially regarding the quality of the help and the frustration of the range of relational needs, resulting in negative feelings, mainly anxiety, anger, and disappointment. This image of online psychological help can discourage people from engaging in it, even when it would be advisable. As mentioned previously (Farrer et al., 2013; Dunbar et al., 2018; March et al., 2018; Hall et al., 2022), research on attitudes toward online interventions are inconsistent; however, in our community sample of young participants, we identified the presence of a rather negative attitude. This may be related to the timing of the study (the onset of the pandemic) in tandem with the need to adapt ones' views to changes in health care (the transition of private practices and national centers to remote interventions), which may have radicalized and hardened views. Moreover, limited experience in using face-to-face help before a first online psychological appointment, which was also present in our sample, may favor the idealization of face-to-face contact and reduce openness.

Online contact proves particularly desirable, but only under certain conditions. Advantages are mainly considered in the context of overcoming the limited access to healthcare resulting from objective factors (e.g., geographic, economic, disability), which is often discussed in the literature (Clarke et al., 2009; Stoll et al., 2019). Better conditions for anonymity and privacy are also indicated, and perceived, or actual, anonymity may lead to reduced inhibition and, in turn, greater openness in discussing emotional topics (see more in Stoll et al., 2019). On addition, from a technological point of view (e.g., unsecured websites or unencrypted communication tools), the privacy, confidentiality, and security issue of e-health are overrated (Stoll et al., 2019). The issue of anonymity may be particularly important for shaping attitudes: on the one hand, patients may truly benefit from greater anonymity, but on the other hand, it is informative of the fear of stigma present in society as a result of using health care and may require anti-stigma interventions, such as education combining social contact (Lien et al., 2021), but also technology education.

One such objective factor relevant to attitudes toward online psychological help was the COVID-19 pandemic. One could say that we captured a moment of attitude change in terms of recognizing the suitability of online psychological help. Participants demonstrated that online psychological help is one type of solution because it provides a sense of continuity during lockdown and is a means to adapt to exceptional circumstances. Thanks to online help, the continuity of the therapeutic relationship could be maintained after the disruptive transition to remote therapies. In turn, internet-based interventions, in a situation of a pandemic-related mental health crisis, were able to begin to support self-care in the area of mental health for many patients. While the potential of online psychological interventions has been recognized, its uncertainties and limitations have been pointed out (e.g., only maintenance psychotherapy, lack of accessibility for those suffering from severe mental disorders, or when therapists refuse to switch to an online form and stop contact). This shows the exclusivity still present in the e-mental health field, in that availability

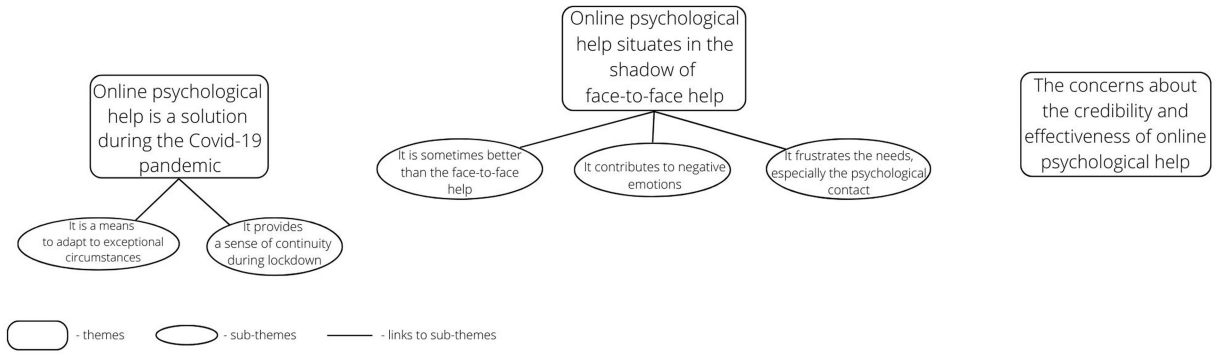

FIGURE 1
The thematic analysis map.

and access to online psychological help is both an advantage and disadvantage, but directed toward different groups of potential beneficiaries (Stoll et al., 2019).

Participants recognized online psychological help as a means to adapt to exceptional circumstances, paying attention to its provisionality. Issues of temporality were also observed in research about the transition from face-to-face to online treatment for eating disorders (Lewis et al., 2021). Most participants (68%) stated that they would not choose to continue online therapy given the option after lockdown. Factors such as higher COVID-19 anxiety, longer duration of treatment, and stronger therapeutic alliance were associated with more positive views toward the permanent transition to the online form.

Our findings indicated that the help provided online was the result of a process of adaptation, both among patients (who expressed gratitude for the possibility of contact or the availability of options beyond face-to-face contact) as well as therapists and the overall environment in which mental health care organization occurs. In the recent literature, we find descriptions of these complex processes considering psychotherapists and centers (Sasangohar et al., 2020; Vostanis and Bell, 2020; Green et al., 2021), but we did not find literature on the process of patients' adaptation to online help. Meanwhile, the need for self-determination and to develop one's own opinions is evident in the statements of the participants in our study. We have identified the expression of conscious acceptance of a temporary form of therapeutic contact or sensitivity to patients who would not benefit from such a form. The apparent sensitivity to others may manifest altruistic attitudes noted in pandemic-threatening situations that have been shown to influence prosocial and altruistic behavior (Grimalda et al., 2021) and increased loyalty in the social groups of patients, which may be a socially new phenomenon.

In our research, participants referred to the fact that online psychological help could become harmful in certain circumstances. Participants drew attention to the and uncertainty of who was on the other side of the computer (mainly processes that were initiated via the Internet), and also to the risk of receiving unprofessional advice on the Internet, for example, in groups or forums, or even treating advice erroneously as psychological help. In research on help and psychotherapy, the study of adverse or detrimental effects is rarely addressed (Klatte et al., 2022). In our case, we encountered an occupation with a concern about the detrimental effects of help, stemming from knowledge about the functioning of the Internet, especially social media, which can pose a threat to the public and individual health, e.g., by facilitating the spread of misinformation or anonymous, hateful comments (Walter et al., 2021). Critical thinking and caution toward supportive content on the Internet were present. There is an apparent need for the community to critically consider and develop strategies to counteract the true-to-life limitations of online psychological help. For professionals, this signals the need to develop and promulgate standards for professional online help.

Practical implications

The experiences, attitudes, and opinions about online psychological help, as captured in the themes and sub-themes presented above, allow us to make some practical implications for mental health professionals. Internet interventions might help to bridge the large treatment gap, but should be well-introduced with regard to evidence-based knowledge. The availability of face-to-face psychological support is still limited worldwide. For example, Schröder et al. (2018) showed that only a minority of people suffering from depression receive adequate treatment. Scientific evidence is emerging that online psychological help is a good solution to extend the reach of mental health care by introducing internet-based interventions, especially for patients with depression or substance misuse (Fu et al., 2020). Therefore, attempts are being made to better understand factors that might impede or facilitate the use of these services, and questions are open on how to best encourage translation of intentions to use online psychological help into behavior (March et al., 2018). Some data show that enhancing confidence and familiarity with technology might be the first step. Others suggest that, to meet the needs of youth, in-person options and diverse, accessible, technologically stable virtual services are required (Hawke et al., 2021). Solutions such as a stepped-care approach to treatment are also being introduced, as an example of increasing the efficiency of available mental healthcare resources (Ong et al., 2021). Our study also suggests that it is important to support clients', patients', or beneficiaries' self-understanding (e.g., emotions), especially in the context of expectations of the therapeutic relationship in online psychological help. With well-managed and transparent rules, disappointment and other negative emotions could be reduced, and reaching out for online help may be more reasonable, e.g., matching the type of intervention to the patient's problem or using online

psychological help only in certain circumstances that are acceptable to the patient. Our research suggests that online mental health care in social, climate, and energy crises may also be gaining recognition, as the process of becoming accustomed to online solutions has begun and online solutions are being acknowledged as reasonable.

Psychological services meant to be conducted online require clear, and perhaps distinct but not necessarily more liberal, criteria for assessing their quality. People need more sound knowledge in order to develop a better idea of the quality of the online help offered and its potential range of helpfulness, or usefulness, without attributing it as a panacea for every problematic condition and without instinctively rejecting it. Patients highly value a low price and personal contact with a psychotherapist, as well as proven effectiveness (Phillips et al., 2021); thus, there is a requirement to disseminate the results of research into the effectiveness of individual online assistance programs and to familiarize people with technological aspects. Standardized (Fu et al., 2020) but also client-informed implementation of online psychological interventions are necessary.

A notable reflection on the professionalization of online support has been undertaken on using mobile apps for mental health (Marques et al., 2021). It was shown not only that mobile apps are not suitable for all psychological issues, but also that mental healthcare professionals should be involved in co-designing these apps and apply suitable psychological theories (e.g., cognitive-behavioral). Another suggestion is to develop and share guidelines to evaluate mental care mobile apps and incorporate the citation of sources and privacy information to the end-users. Similar processes of quality care and psycho-education are needed on a large scale.

Limitations and future directions

According to the criteria of quality qualitative research (Flick, 2018), our findings cannot be generalized but rather understood from the perspective of the respondents' specific social and psychological situations. The study participants took part in the questionnaire survey but additionally wished to share their experiences and opinions. A significant limitation is that the circumstances of their motivation remain unknown to us. Furthermore, we can only guess from the emotionality of the statements that it was an opportunity for participants to express their forming views or regulate their emotions. In turn, we infer from the temporal timing of the survey that these attitudes are about online assistance expressed at a moment of intense transformation, so people were sharing hotly-formed views on an ongoing basis. We are not in a position to determine the validity of the image of online help we received, but only to describe those thematic areas that we recognize as significant for the "destiny" of online psychological help now and in the future.

In addition, the opinions and experiences of our participants ranged widely in terms of online psychological help, including online psychotherapy (which had previously been conducted face-to-face, and one which included remote contact from the beginning of the process), online counseling, mental care mobile apps, or step-by-step programs. Further research should undoubtedly focus on attitudes toward specific forms of online help, especially self-help, so that we can begin to differentiate attitudes better.

Moreover, the time of data collection could be perceived as one of the study's limitations. On the one hand, data collected at the beginning of the COVID-19 allows interpreting the results exclusively as a picture of attitudes toward online psychological help precisely during the intensive shift (different both from the pre-pandemic period and today) face-to-face to online contact. On the other hand, the presented research could induce further studies on current attitudes in order to make an attempt to show how people have been adapting to online psychological help during more than 2 years of the pandemic. Thus, the outcomes could capture changes in attitudes toward this kind of psychological help.

Another limitation is the fact that the sample was not recruited specifically for the current study. The participants are nearly a quarter of the total number of participants who took part in different research investigating psychometric properties of the APOI-PL and voluntarily shared their opinions about online psychological help in open-ended question at the end of the survey. Therefore, the motives for answering the questions are not known. Given the studys' overall conclusion (negative rather than positive opinions, emotions, and attitudes), it is possible that those who answered the question primarily wanted to share their concerns. Accordingly, it would be fruitful to design a study to investigate precisely attitudes toward online psychological help. Thus the results could present the attitudes in a broader and more comprehensive perspective.

Not all participants declared current or past involvement in therapy or other forms of online psychological help. Consequently, our results include attitudes developed both from their own experience and opinions and information that participants heard from others or read on the Internet. Further study could focus on attitudes toward those with and without experience of participating in online psychological help, attempt to determine their origins, and compare them (e.g., which are more positive/negative and why).

Philosophical assumptions allowed us to adopt a non-evaluative position toward the participants, in that we successfully bracketed our preconceptions and stayed by the participant. At the same time, the potential of phenomenology as an approach could not be fully exploited because we analyzed foundational data. Further research, therefore, is needed to explore attitudes toward online therapy using in-depth interviews, whereby researchers can explore how participants' experiences are organized before they are fully categorized.

The analytical technique (thematic analysis) has apparent limitations, but it allowed us to recognize patterns in the data. In our case, these were the major themes of attitudes toward online psychological help, which we extracted through our engagement with the topic as a research team. We, therefore, take full responsibility for the story we heard from the subjects. We presented in the report what we read from participants who took the opportunity to share statements about online psychological help or discuss the phenomenon. This article gave them a voice and let both (potential) beneficiaries and caregivers know more about attitudes, concerns, and general experiences related to online psychological help in the context of pandemic experiences.

Conclusion

In summary, if the effectiveness of online psychological help is influenced by attitudes toward it, the current findings support practice, especially the practice of mental health care professionals.

The results show the attitudes, emotions, thoughts, hopes, concerns, and limitations that are related to current or imagined involvement in online psychological help as a patient (client). Awareness of these perspectives could help to improve the planning of online psychological interventions, taking into account potential difficulties that patients face. Moreover, our results could allow (potential) patients/clients who are considering the use of online psychological help to view other people's feelings about such services.

Data availability statement

The raw data supporting the conclusions of this article will be made available by the authors, without undue reservation.

Ethics statement

Ethical review and approval was not required for the study on human participants in accordance with the local legislation and institutional requirements. The patients/participants provided their written informed consent to participate in this study.

Author contributions

AW, JS, and ES were responsible for research conceptualization. AW and JS contributed to the datasets' formal analysis. AW was the project administrator and managed the thematic analysis process, which ES supervised. AW and JS wrote the original draft. ES and AW reviewed and edited the original version. AW visualized the thematic analysis map. All authors contributed to the article and approved the submitted version.

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Conflict of interest

The authors declare that the research was conducted in the absence of any commercial or financial relationships that could be construed as a potential conflict of interest.

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Innovative moments in low-intensity, telephone-based cognitive-behavioral therapy for depression

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Background: Innovative moments (IMs), defined as moments in psychotherapy when patients' problematic patterns change toward more elaborated and adaptive patterns, have been shown to be associated with a clinical change in patients with depression. Thus, far IMs have been studied in face-to-face settings but not in telephone-based cognitive-behavioral therapy (t-CBT). This study investigates whether IMs occur in t-CBT and examines the association between IMs and symptom improvement, and reconceptualization and symptom improvement.

Methods: The therapy transcripts of n=10 patients with mild to moderate depression (range: 7–11 sessions, in total 94 sessions) undergoing t-CBT were qualitatively and quantitatively analyzed. Symptom severity (Patient Health Questionnaire-9) and IMs (levels and proportions) were assessed for each therapy session. Hierarchical linear models were used to test the prediction models.

Results: The rating of IMs was shown to be feasible and reliable using the Innovative Moments Coding System (IMCS) (84.04% agreement in words coded), which is indicative of the applicability of the concept of IMs in t-CBT. Only reconceptualization IMs were shown to have a predictive value for treatment success (R^2=0.05, p=0.01).

Discussion: The results should be interpreted with caution due to the exploratory nature of this study. Due to the telephone setting, it was necessary to adapt the IMCS. Nonetheless, the extent of IMs identified in the low-intensity t-CBT investigated was comparable to IMs in face-to-face therapy. Further studies are needed to clarify the association between IMs and treatment success as a change process, especially for low-intensity treatments.

KEYWORDS

depression, change process, innovative moments, reconceptualization, telephone-based cognitive-behavioral therapy, digital psychotherapy

1. Introduction

Innovative moments are conceptualized as moments in psychotherapy in which the patients' problematic patterns change toward more elaborated and adaptive ways of thinking, feeling, and acting and have, therefore, been discussed to predict symptom decrease and clinical change (Batista et al., 2020). To date, no study has identified IMs within a telephone-based cognitive-behavioral therapy for depression.

1.1. Innovative moments

Innovative moments (IMs) are behaviors, thoughts, or feelings that occur during the therapeutic dialog, which contrast the dominant and problematic self/life narrative (White and Epston, 1990). Although they occur in therapeutic dialog they can refer to past, present, or future (Gonçalves et al., 2012) and may occur spontaneously in psychotherapy sessions or may be prompted by therapists' interventions. They can also occur between sessions (e.g., reflections on IMs between the session) and be addressed in the next session (Batista et al., 2020). Moreover, IMs can be understood as process measures (to activate change), and, therefore, be understood within the principles of change or outcome variables. Taking this into consideration, there are several other concepts such as the treatment and in-session processes (Kazantzis et al., 2018) or common factors of psychotherapy (Grawe, 2004), with which IMs are associated. However, investigating through the lens of IMs can provide more details about what is actually changing and what these changes entail through the different types and levels of IMs that can be identified.

There are three types of IMs: action, reflection, protest, and reconceptualization, which can occur on three different levels. In level 1, IMs happen as "initial processes of changes," in which client's distance themselves from the maladaptive way of thinking or behaving, they may express new understandings of the problem, rejecting its assumptions or acting in a new way (Batista et al., 2020). In level 2 IMs, clients can tell what is changing (temporal contrasts to the maladaptive framework) or how/why it is changing (identification of the change process). In level 3 IMs, clients articulate both the changes in problematic behavior/self-narrative and their understanding of how this transformation is taking place, this is called "reconceptualization" (Batista et al., 2020). Therefore, IMs can be gateways for substantial therapeutic change (Gonçalves et al., 2009, 2017a) in the sense of weakening or even transforming problematic self-narratives. Even though IMs originate from a narrative tradition in psychotherapy, they can be identified across diverse therapeutic approaches (Gonçalves et al., 2021, see Table 1, column 2 for an overview). All therapies mentioned in Table 1 were on-site therapies.

1.2. Telephone-based cognitive-behavioral therapy for depression

Depression is one of the most common mental health disorders, affecting approximately 280 million people worldwide (World Health Organization, 2021). However, there is insufficient use of healthcare services, especially for mild to moderate depression, which often does not correspond to the treatment guidelines as these suggest psychotherapy or a combination of psychotherapy and antidepressants rather than antidepressants alone (World Health

TABLE 1 Study overview of innovative moments (IMs), therapeutic approach, disorder, interrater agreement, number of sessions, interrater reliability, and included clients.

	Therapy	IM-portion (%)	Sessions	Inter.-Rel. %, κ	*N* (Sessions)
Matos et al. (2009)	NT for victims of violence	GOG: *M* = 10.76 (SD = 4.84) POG: *M* = 5.38 (SD = 1.79)	*M* = 12.7 (SD = 3.74)	86 0.89	10 (127)
Mendes et al. (2010)	EFT for MD	GOG: *M* = 30.31 (SD = 4.02) POG: *M* = 8.90 (SD = 5.97)	*M* = 17.50 (SD = 1.87)	88.70 0.86	6 (105)
Gonçalves et al. (2012)	CCT for MD	GOG: *M* = 11.13 (SD = 5.50) POG: *M* = 5.82 (SD = 3.74)	*M* = 16.83 (SD = 0.98)	86 0.97	6 (93)
Alves et al. (2014)	Therapy for grief	*M* = 22.9	*M* = 13.83 (SD = 0.98)	86.45 0.86	6 (83)
Gonçalves et al. (2017b)	CBT for MD	GOG: *M* = 15.51 (RKS: 3.22) POG: *M* = 4.14 (RKS: 0.83)	*M* = 18.67 (SD = 3.27)	90 0.94	6 (111)
Gonçalves et al. (2017a)	NT for MD		*M* = 18.7 (SD = 1.83)	89.9 0.91	10 (180)

IM, innovative moment; Inter.-Rel., interrater reliability; *N*, sample; NT, narrative therapy; EFT, emotion-focused therapy; CCT, client-centered therapy; CBT, cognitive-behavioral therapy; GOG, good-outcome-Gruppe; POG, poor-outcome-Gruppe; RCS, reconceptualization; *M*, mean; SD, standard deviation; κ, Cohen's Kappa for coded levels.

Organization, 2021). Telephone-based cognitive-behavioral therapy (t-CBT) attempts to address potential barriers to treatment (e.g., going to the clinic on-site, shame). Some t-CBT can be classified as guided self-help (although in a rather intensive form), whereas in other t-CBTs only the setting differs from face-to-face CBT. In a meta-analysis including 12 trials by Mohr et al. (2008), a significant pre–post improvement of depressive symptoms ($d = 0.81$, $p < 0.0001$) and a significant superiority of telephone psychotherapy over control groups including treatment-as-usual or minimal intervention ($d = 0.26$, $p < 0.0001$) was found. Beyond symptom improvement, the rate of therapy dropout of 7.6% was lower in the telephone setting than for on-site treatments. In a randomized-controlled trial (Mohr et al., 2012), in which 325 participants with depression were treated with 18 sessions of CBT, the reduction in symptoms did not differ between the two conditions (telephone vs. on-site). However, dropouts in the t-CBT group were significantly lower than in the on-site treatment (20.9% vs. 53%). In their meta-analysis including 10 randomized-controlled trials, Castro et al. (2020) found significant symptom improvement with t-CBT in the pre–post comparisons. Although digitalized psychotherapy process research holds the potential to enhance process research due to specific properties such as ecological momentary assessment, is a rather novel branch of research (Domhardt et al., 2021). In a narrative review by Berger (2017), therapeutic alliance in Internet interventions (e.g., real-time video-conferencing therapies, e-mail therapies, and chat therapies) is described as equivalently rated compared to face-to-face therapies independent of communication modalities, diagnostic groups, and amount of contact, thereby suggesting that a positive alliance can be established in Internet interventions (Berger, 2017). The review also provides an overview of alliance-treatment outcome associations and concludes that the affective bond between the patient and therapist might be less important in Internet interventions than in face-to-face therapy as none of the studies provided evidence for an association between the personal bond and treatment outcome (Berger, 2017). Findings from qualitative research also indicate how a positive therapeutic alliance can be fostered in Internet-based CBT by focusing on the four basic needs (e.g., attachment) through certain therapeutic techniques (e.g., active listening and validation) (Theurer and Wilz, 2023). However, little is known about whether similar processes occur in telephone-based psychotherapy (i.e., t-CBT) as in on-site psychotherapy.

1.3. Innovative moments and depression

The concept of IMs has been investigated in several process–outcome studies; however, future studies must expand our knowledge by employing disentangling research questions and appropriate study designs. Overall, the main findings are that effective psychotherapies differ from less effective ones by (a) a higher overall percentage of IMs and (b) specifically by a higher percentage of level 3 IMs (Gonçalves et al., 2017a). In contrast, no significant difference in the aforementioned groups resulted so far in the occurrence of IMs of low levels—regardless of the therapeutic approach (Gonçalves et al., 2017a). As shown in Table 1, IMs have been studied several times in clients with depression, although not in digitalized psychotherapy such as t-CBT. IMs were identified as reliable predictors of depressive symptomatology in CBT (Gonçalves et al., 2017b). Gonçalves et al. (2017b) confirmed a reliable use of the IMCS in CBT (percent agreement in the numbers of coded IMs words: 90%, Cohen's Kappa regarding IMs levels: 0.94) on six clients who had been diagnosed according to the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV). To compare depressive symptomatology, two groups of three individuals each were formed, one group responded to treatment and the other one did not. The former showed a mean IMs percentage of 24.14% with 3.22% level 3 IMs, while the latter had a mean IMs percentage of 15.51% with 0.83% level 3 IMs. In a single-case study that was derived from the trial, Fernández-Navarro et al. (2018) examined the treatment transcript of a 39-year-old Portuguese woman who suffered from major depression. After completing narrative therapy, the patient was considered remitted. Interestingly, she showed the highest proportion of level 3 IMs compared to the rest of the participants. In another study, two samples were merged resulting in a total contingent of 7,903 level 3 IMs (with a mean salience of 1.95%, SD = 2.18) (Fernández-Navarro et al., 2018), which were further used as predictors of symptom change. According to Fernández-Navarro et al. (2018), all three integrated predictors (level 3 IM, contrasting self: what has changed and change process: how it changed) were significantly predictive of symptom improvement in each subsequent therapy session, provided that a separate model was calculated for each of the three level 3-IM predictors: $R^2corr. = 0.59$, contrast: $R^2corr = 0.59$, change process: $R^2corr = 0.58$). When all three variables were integrated into the same hierarchical–linear model, only level 3 IMs showed significant predictive performance ($R^2corr = 0.60$). However, these results should be interpreted with caution due to the study design and as the first indications that IMs and therapy outcomes in depression may be related.

To date, IMs have been studied in face-to-face psychotherapy but never in t-CBT, therefore, this study pursues the following objectives:

1. Investigating IMs in a t-CBT.
2. Predicting depressive symptoms post t-CBT with IMs.

   2.1. How is the total percentage of IMs associated with the depression score at the end of therapy compared to the beginning of therapy?
   2.2. How are level 3 is IMs in one therapy session associated with a decrease in depressive symptoms in the next session?

2. Methods

2.1. Study design

The present study applies a descriptive, explorative mixed-method design. Therapy transcripts were coded qualitatively using the innovative moments coding system and then analyzed quantitatively. For this purpose, a secondary analysis using a correlative design was carried out on a sample, that is, based on a randomized-controlled trial (Watzke et al., 2017). The data in the present study were composed of therapy transcripts (for further information: Haller and Watzke, 2021) of 10 patients (94 sessions in total) who were part of a larger study aimed to analyze the effectiveness of a telephone-based cognitive-behavioral therapy (Watzke et al., 2017) as well as homework engagement (Haller and Watzke, 2021).

2.1.1. Patients

For the present study, data from the intervention group have been used ($N = 24$). A sufficient proportion (>80%) of the therapy sessions was available in transcribed form for 21 of the participants, as some recordings were missing due to technical reasons. For this study, 10 patients were selected based on their improvements (pre–post-treatment) on the PHQ-9, which is in line with previous studies applying a similar procedure (e.g., Batista et al., 2020), as this method includes different changes in symptomatology. Of the 10 selected patients, seven were female subjects. At baseline, 10 subjects were 59.9 years old on average (SD = 18.2, range: 25–79) and had an average PHQ-9 score of 13.4 (SD = 4.6, range 6–20) indicating a moderately depressed sample (Kroenke and Spitzer, 2002). The baseline PHQ-9 scores were compared with the scores at the end of the therapy, and patients with different levels of decrease in symptomatology in PHQ-9 (pre–post: −11, −11, −8, −6, −6, −5, −3, −2, 0, +2) were selected. The patient characteristics are described in the results section (see Table 2 for more details).

2.1.2. Therapists

Three therapists from the Psychotherapy Outpatient Center of the University of Zurich conducted the t-CBT. On average, the three therapists were 34 years old (SD = 5.9), in advanced, postgraduate training to become CBT therapists (average duration of training: $M = 4.3$ years, SD = 1.5) and had experience in treating patients with depression. Before the start of the study, they were trained by an experienced clinical psychotherapist and researcher in t-CBT and were supervised regularly during the study.

2.2. Treatment

The patients in the intervention group first met face-to-face with their assigned therapist, followed by 8–12 telephone sessions as digital remote treatment. In the beginning, sessions took place weekly, later, and by arrangement fortnightly, and lasted approximately 40 min on average. The treatment was structured along the manualized guided self-help CBT "creating a balance" (Simon et al., 2004; Steinmann et al., 2016). The program, designed as a low-intensity, short-term intervention, was based on a therapist manual and a client workbook. The patients were asked to use a workbook in between the sessions. The content of the therapy comprises psychoeducation, activity-building activation, cognitive restructuring and self-control, and relapse prevention. Therefore, it is a rather intense form of guided self-help with approximately 450 min of human interaction.

2.3. Measures

2.3.1. Patient Health Questionnaire-9

Depressive symptoms were assessed by the German version of the Patient Health Questionnaire 9 PHQ-9 (Löwe et al., 2002) and rated on a 4-point Likert scale with values between 0 = "not at all" and 3 = "nearly every day" at the beginning of each session. The final score is calculated as the sum of all items. Kroenke and Spitzer (2002) defined the following cutoff values of the PHQ-9 regarding the severity of a depressive episode: 0–4 points = no depression; 5–9 points = mild; 10–14 points = moderate; 15–19 points = moderate to severe; 20–27 points = severe. Studies provide evidence that the PHQ-9 has satisfactory psychometric properties (internal consistency: 0.82) if used on the phone (Pinto-Meza et al., 2005).

2.3.2. Innovative moments coding system

The innovative moments coding system (IMCS) (Gonçalves et al., 2011, 2019) proposes a systematic way of tracking the transformation of clients' maladaptive framework of meanings through the identification of IMs in transcripts or videos of psychotherapeutic sessions. In most studies, two raters perform the coding independently, one codes 100% of the material, and the second one codes between 30% and 100%. Afterward, the interrater agreement indices are calculated according to the proportion of IMs words in transcripts/proportion of IMs time in video ratings. An intercoder agreement between 84% and 94% (Gonçalves et al., 2011) has been accepted as reliable, and the interrater reliability of the coded levels is reported as acceptable between 0.80 and 0.97 (Gonçalves et al., 2011). See Table 1 for an overview of intercoder agreement (column 3) and reliability (column 5).

2.3.3. Innovative moment coding system for t-CBT

The IMCS allows for the identification of three different levels of IMs. The interrater reliability of the IMCS has been demonstrated in the context of different disorders and therapeutic approaches (Gonçalves et al., 2011). The average agreement on coded words in previous studies ranged between 84% and 94%, the Cohen's Kappa for the coded types and levels between 0.80 and 0.97, which indicates an adequate interrater agreement (Hill and Lambert, 2004, see Table 1 for IMCS). As the IMCS has not been applied in t-CBT before, certain assumptions and adaptations were made due to the communication *via* telephone (see Supplementary material I). The current manual of the IMCS (Gonçalves et al., 2019) was used to identify IMs and rate their level. The two raters were trained in a 5-step training guided by two experienced coders for several weeks on standardized material first (see Batista et al., 2020 for more detail) and then on the material of this study. Based on the first transcript of each session, the coders created a problem list derived from what the patient had said within the first session and continuously updated this problem list throughout the therapy for each patient which resulted in covering central problem areas. The raters met regularly during the analysis process for interactive and collaborative discussion of the sessions analyzed by both raters for final consensus-based coding. Based on the first coding, interrater reliability was calculated, and for the analysis, consensus-based coding was used. Out of the 94 therapy transcripts, 75% were coded by both raters. The two raters matched 84.04% of the words identified as IMs (in 75% of the sessions both coded). The Cohen's Kappa for agreement on IMs levels was 0.93, which is above the minimum value of 0.75 required by Gonçalves et al. (2019) and corresponds to a high level of agreement according to Hill and Lambert (2004).

2.4. Statistics

All calculations and all graphs illustrating the results were carried out and produced using the statistical program R (R Core Team,

2019). Interrater reliability was assessed to capture the extent of a reliable application of the IMCS in t-CBT. For this purpose, the percentage agreement was calculated with regard to the number of words that had been classified as IMs, first for each session and later for all words spoken in all therapies. The words assessed as IMs by both raters were divided by the total number of IMs words identified. Furthermore, the agreement between both raters on the levels was assessed by determining Cohen's Kappa. A linear regression was computed to investigate the association between IMs and treatment response. Additionally, single regression models were calculated by including each level as a predictor separately. Hierarchical linear models (HLMs) were computed to calculate whether the number of IMs in one session was predictive of a decline in depressive symptomatology in the subsequent session. HLM was performed using non-linear mixed-effect modeling with fixed effects using the R package lme4 (Bates et al., 2014). According to the QQ-plot of the residuals, the error values were both normally distributed and on average zero, the prerequisites for the application of the HLM were fulfilled accordingly.

3. Results

3.1. Innovative moments in telephone-based CBT

Innovative moments (IMs) were found in t-CBT for depression. Table 2 provides an overview of the levels and types of IMs along with their contents and examples in t-CBT.

In sum, 1,129 IMs were coded throughout all therapy transcripts (see Table 3 for more detail on IMs for each patient). Level 1 IMs occurred 973 times and comprised on average 6.77% of all the words spoken in all sessions (SD = 2.73%). A total of 175 IMs were coded as level 2 IMs (2.98% of all the words spoken in all sessions (SD = 2.32%)) and 17 as level 3 IMs (0.64% of all the words spoken in all sessions (SD = 0.93%)). The average percentage of IMs per session was 10.39% (SD = 4.99%). While IMs of level 1 and level 2 were found in all therapies, no level 3 IMs were found in four patients. As the level increases, the average number of words per IMs approximately doubled (level 1: 51 (SD = 51), level 2: 101 (129), level 3: 213 (141)). The number of words per IMs differed significantly ($p < 0.01$) between the three levels.

The percentage of different level IMs varied throughout the sessions (see Figure 1, individual courses of level-specific percentages of IMs and depression can be found in Supplementary material II). The individual depression and IMs trajectories in Supplementary material II show that L1 and L2 IMs were found in all patients over the entire duration of therapy. In contrast to L2 IMs, which did not occur at all or only sparsely in most of the patients at the beginning of therapy and in eight out of 10 in the first therapy session, all patients except for patient 5 (in session 7) consistently showed L1 IMs. While four of the 10 patients did not show a single L3 IMs throughout the entire therapy, L3 IMs tended to appear in the second half of the therapy for the other six patients, earliest from session 4 onward. For the patients, in which L3 IMs were found (patients 1, 7, 8, and 10), a parallel change in depressive symptoms can be seen in both directions, all of them were patients with the strongest decrease in depressive symptomatology.

3.2. Association of IMs with treatment outcome

The overall number of IMs was not significantly associated with $p = 0.42$ with a decline in depression (pre–post-treatment, $\beta = -0.25$, $R^2 = 0.08$, $p = 0.42$). Testing the levels separately also revealed that there was no significant association between any level and the decline of depression. Results of the linear regressions can be found in Supplementary material III. Subsequently, an HLM was calculated with L3 IMs as a predictor and the decline of symptoms in the following session as the outcome. L3 IMs in one therapy session significantly ($\beta = -0.25$, $R^2 = 0.05$, $p = 0.01$) predicted a decrease in depressive symptoms in the next session.

4. Discussion

This is the first exploratory study focusing on IMs in the context of a telephone-delivered psychological treatment following the principles of a CBT approach to depression, i.e., in the context of low-intensity and remote treatment. Some adaptations had to be made due to the telephone setting, e.g., reassuring a stable connection or how to code answers of clients to PHQ-9-monitoring due to the specific intervention program and the telephone setting (see Supplementary material I for more detail). Overall, IMs were detectable in t-CBT; therefore, the IMCS was found to be feasible for transcripts of telephone-delivered therapy sessions. Moreover, we found high interrater reliabilities, comparable to those in face-to-face psychotherapy (see Table 1, Gonçalves et al., 2021). This is the first study examining whether the same change processes found in face-to-face therapy also emerge in a remote format of treatment. Interestingly, the average proportion of words classified as IMs (6.77%, SD = 2.73%) per session and the average proportion of IMs in each session (10.39%, SD = 4.99%) are comparable to other studies (see Table 1, e.g., Gonçalves et al., 2012). While IMs of level 1 and level 2 were found in all therapies of our patient sample, level 3 IMs were not found in four patients. Due to the content and format of the treatment manual used, it is unsurprising, that most of the IMs found in t-CBT were level 1 or level 2 as the treatment is designed as a short-term intervention focusing on core elements of CBT for depression, e.g., behavioral activation, bringing actions into everyday life (most likely L1 IMs or L2 IMs, see Table 2). Given the brevity of the manual, integrating new meanings of self-narratives was not emphasized (except cognitive reconstruction). Interestingly, level 3 IMs were still found in six patients, who showed a pronounced symptom improvement, which may have been stimulated by cognitive restructuring. The extent to which short-term interventions (i.e., minimal interventions and e-mental health interventions) can also stimulate reconceptualization processes (L3 IMs) and how this is related to symptom improvement should be the subject of further research. However, whether IMs are predictors or outcomes of therapy remains in question.

A major strength of this study is that all sessions were coded rather than a pre-defined selection of sessions (e.g., first, fifth, and last session of each case) being coded. Therefore, the change in IMs level and extent of IMs can be seen as a continuous process rather than only in a limited selection of therapy phases. This is advantageous because the occurrence of IMs in one session can be directly linked to current

TABLE 2 Innovative moments in telephone-delivered cognitive-behavioral therapy are divided into three levels and seven types.

Levels	Types and definition	Contents (examples)	Examples in t-CBT
Level 1 Centered on distancing from the problem (low level) Allow the detachment from the problematic experience using moments critique, needs, doubts, coping-strategies	Action I: Performed or intended behaviors	• New behavioral strategies to overcome the problem(s) • Active exploration of solutions • Searching for information about the problem(s)	*Action I: "And […] the feeling that I described before, which I felt over the course of the afternoon, I have only in the course of the evening then so in connection with uh with the togetherness with the friends, with the common meal and the common conversations actually dissolved."*
	Reflection I: New understandings of the problematic experience and its effects	• Reconsidering the causes of the problem(s) • Awareness of the effects of the problem(s) • Formulations of new problem(s) • Adaptive self-instructions and thoughts • Intention to fight demands of the problem(s) • General references of self-worth and/or feelings of well-being	
	Protest I: Objecting the problem and its assumptions	• Rejecting problem(s) or objecting to the problem(s) • Position of critique towards others who support it • Position of critique towards problematic facets of oneself	
Level 2 Centered on the elaboration of change (high level) New aims, experiences, activities or projects, anticipated or in action, as a consequence of change (not directly related to the problematic experience)	Action II: Generalization of good outcomes into the future and other life dimensions	• Investment in new projects or relationships as a result of the process of change • New skills unrelated to the problem • Problematic experience as a resource for new situations	*Reflection II: "And then we came to the common theme of learning to accept what is, and how difficult that is in everyday life, of course. Because we are both more movement and sport-oriented, actually we both liked the dynamic life somehow. And now we, he even more than I, are somehow confronted with this and it did us a lot of good to talk about it again with a friend who knows about it from his own experience."* *Action II: "So (um) what I take with me are the (um) keeping to the daily structure, and simply paying more attention and also enjoying the beneficial activities. And simply um that it is also um yes that it is that that it is important that I am also aware of this. And not to take it for granted. That it is like that and that I can actually experience a relatively rich activity every day, actually. Or that is (um) starting with the housing situation, and all the things that I can still do myself. Actually, um that's actually very very very much. And (um), and I just take that with me and try to make myself aware of it again and again."*
	Reflection II: Elaborations upon change and its consequences	• What is changing • Generating meaning/insight about how/why changes are occurring • References of self-worth and/or feelings of well-being (as consequences of change)	
	Protest II: Assertiveness and empowerment	• Centering on the self • Affirming rights and needs	
Level 3 Integration of new meanings in an articulated way	Reconceptualization: Meta-cognitive process description; articulates a shift between two self-positions and access to the process underlying this transformation	Contrasting self (what changed/is changing?) AND Change process (how/why change occurred/is occurring?)	*Reconceptualization: "Client: I really did, I think I did it well now. So now there is simply a new side to me.* *Therapist: What helped you to master this situation?* *Client: To have the inner certainty that I know that the truth, that is, I had an inner truth where I said, even if it says the opposite, I know what is and what I actually need. And I do not want to back down. I actually have no reason not to appear."*

Adapted from Gonçalves et al. (2019) and Batista et al. (2020).

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TABLE 3 Innovative moments and depressive symptoms for each patient.

		PHQ-9		Innovative moments (%)			
ID	N_s	Pre	Post	Level 1	Level 2	Level 3	Total
1	7	11	0	4.87	2.39	0.35	7.61
2	10	7	7	6.61	1.19	0	7.8
3	11	18	12	7.48	1.96	0	9.44
4	10	14	12	3.22	0.71	0	3.93
5	9	9	4	12.15	7.76	0	19.91
6	8	9	3	7.61	3.28	0.71	11.61
7	9	12	1	7.44	4.73	1.99	14.16
8	9	17	9	6.31	5.42	2.6	14.32
9	11	6	8	9.07	1.71	0.62	11.4
10	10	9	6	2.96	0.68	0.09	3.72
M (SD)	9.4 (1.26)	11.2 (4.05)	6.2 (4.21)	6.77 (2.73)	2.98 (2.32)	0.64 (1.00)	10.39 (4.99)
Average (words per IM)				51 (51)	101 (129)	213 (141)	

ID, participant identification code; N_s, number of therapy sessions; PHQ-9, Patient Health Questionnaire-9 items; Pre, pre-therapy; Post, post-therapy.

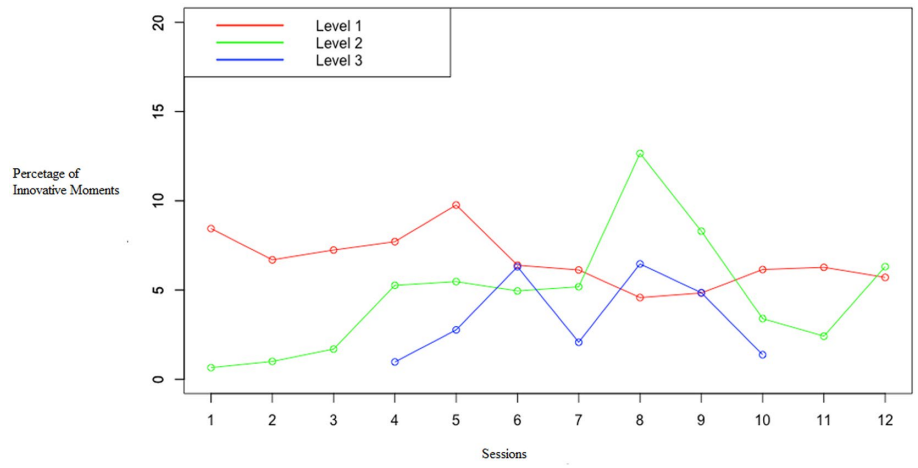

FIGURE 1
Level-specific percentages of IMs for therapy.

symptom severity and its process. Interestingly, the individual trajectories (IMs and PHQ-9) show a wide range of changes in symptomatology and IMs. In this context, it would be interesting to identify the moments that could have fostered L3 IMs. Both intrasession and intersession processes may have to be considered.

Our findings are in line with prior results regarding the association between depressive symptoms and IMs, thus there is no causal interpretation, but a prediction of decreases in depressive symptoms from increases in L3 IMs. Nevertheless, some limitations need to be considered: Despite the high number of coded sessions (96), it is a small sample of 10 participants. Therefore, the results of this exploratory study need to be interpreted as such and with the utmost caution; studies with larger samples are needed. In addition, and in line with previous research, 10 patients with different extents of symptom changes between pre- and post-treatment were selected (e.g., Batista et al., 2020), which may have artificially increased the variance and should be reconsidered for studies with larger samples including the full range of symptom change.

The assessment of depression over the telephone might also have led to effects of social desirability; however, research has proven the feasibility of PHQ-9 over the telephone (Pinto-Meza et al., 2005). However, a more specific measure of depression could address this problem through an ecological momentary assessment. Additionally, blinding of coders was not possible because the PHQ-9 was a part of the beginning of each session and could not be cut out of the audio recording as it involved relevant information due to more detailed patient responses. Therefore, the coders were aware of the patient's current symptom severity. This may have led to an overestimation of the level of IMs in situations when patients expressed less burden. However, how much the raters actually payed paid attention to the change in PHQ-9 remains in question as they were focused on coding IMs.

Interestingly, the IMs found were often in the context of reflection on homework and moments of change, which represented a large part of this format of t-CBT (Haller and Watzke, 2021). Therefore, the overlap between homework engagement and IMs remains unclear in this specific intervention and could be addressed in further research. Perhaps a systematic analysis of the types of IMs (e.g., type "action" during behavioral activation) or qualitative content analysis (are there other moments of relevance/change) could also help to clarify the IMs of relevant change in this specific intervention. As in our results, level 3 IMs have been of particular interest in previous research (Gonçalves et al., 2017a; Fernández-Navarro et al., 2018), as they have been found to be predictive of a decrease in depressive symptoms. This may lead to a clinical and research interest: How could level 3 IMs be promoted by the therapist? Are there specific methods or strategies to promote level 3 IMs, i.e., reflective questions on change processes? Educating psychotherapists in the IMs concept and especially sharpening their focus to level 3 IMs could be addressed in clinical practice.

Nonetheless, this study can be seen as an approach to identifying a process of change in t-CBT for depression that was first found in face-to-face therapy. In order to justify the derivation of practical implications, testing for a causal relationship between IMs and treatment success as a change process still remains, especially for low-intensity treatments.

Data availability statement

The data analyzed in this study is subject to the following licenses/restrictions: The raw data supporting the conclusions of this article will be made available by the authors, without undue reservation. Requests to access these datasets should be directed to marie.druege@uzh.ch.

Ethics statement

This study was performed in line with the principles of the Declaration of Helsinki and was approved by the local Ethics Committee of the Canton of Zurich (Ref. Nr. 2015-0417). The patients/participants provided their written informed consent to participate in this study.

Author contributions

MD and RS planned and conceptualized the study, and trained and supervised CS and VR to collect, analyze, and interpret the data. MD drafted and revised the manuscript. EH supervised the transcription process and revised the manuscript. BW supervised the study, involved in the study conceptualization and interpretation of data, and revised the manuscript. All authors contributed to the article and approved the submitted version.

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Conflict of interest

The authors declare that the research was conducted in the absence of any commercial or financial relationships that could be construed as a potential conflict of interest.

Publisher's note

Supplementary material

The Supplementary material for this article can be found online at: https://www.frontiersin.org/articles/10.3389/fpsyg.2023.1165899/full#supplementary-material

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Mastery of teletherapy is related to better therapeutic relationship and presence in teletherapy: the development of the teletherapy intervention scale

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Introduction: Providing teletherapy requires a unique therapeutic approach and mastery of the teletherapy context. We aimed to develop a self-report scale for therapeutic interventions pertinent to teletherapy, and to examine its relationship with teletherapy process variables, and therapists' attitudes towards teletherapy technology.

Method: A total of 839 therapists participated in a survey study that included standardized measures of therapeutic process (real relationship, working alliance, therapeutic presence), attitudes towards and intention to use teletherapy in the future, and a list of 13 teletherapy intervention items that we hypothesized to be specific to the teletherapy format.

Results: Twelve of the 13 teletherapy intervention items loaded on one factor, with good reliability. The 12-item Teletherapy Intervention Scale was positively related to working alliance, the real relationship, therapeutic presence in teletherapy sessions, as well as to positive attitudes towards teletherapy and intention to use teletherapy in the future.

Discussion: Aspects specific to the practice of teletherapy may be successfully captured by a self-report scale, and adequately navigating the challenges and opportunities of teletherapy might enhance the therapeutic process. Further studies are needed to provide additional validation of the scale, and in how to best use this Teletherapy Intervention Scale in research and clinical training.

KEYWORDS

teletherapy, therapeutic presence, therapeutic intervention, working alliance, attitudes

Introduction

Although the use of teletherapy is increasingly common, and the therapeutic outcomes appear to be similar to that of in-person therapy (e.g., Lin et al., 2022), teletherapy comes with unique therapeutic challenges and opportunities (Aafjes-van Doorn et al., 2021; Békés et al., 2021a,b; Aafjes-van Doorn, 2022). Despite the clear benefits for patients who otherwise could not have access to mental health care, therapists have long been reluctant to use teletherapy in

their practice. Therapists have expressed concerns about its efficacy and about their own ability to create a strong working alliance via videoconferencing (Brooks et al., 2020; Perry et al., 2020). These concerns greatly impacted attitudes towards teletherapy and hindered its utilization (Connolly et al., 2020). The global transition to teletherapy in 2020 provided an opportunity for therapists and patients to get familiar with teletherapy and obtain first-hand experience of this treatment format. Since then, teletherapy has become part of standard practice for many clinicians (Van Daele et al., 2020; Sheperis and Smith, 2021; Kwok et al., 2022), and a vast amount of research has suggested comparable efficacy with in-person treatment (e.g., Lin et al., 2022). Lots has been written about therapists' experiences of the therapeutic process in teletherapy during the pandemic (Békés et al., 2020; Perry et al., 2020; Rosen et al., 2020; Van Daele et al., 2020; Hanley and Wyatt, 2021; Helps and Le Coyte Grinney, 2021; Nuttman-Shwartz and Shaul, 2021; Poletti et al., 2021; Machluf et al., 2022; Stukenberg et al., 2022; Aviram and Nadan, 2023). These studies showed that overall, therapists had a reasonably favorable experience, often better than they expected, and their attitudes toward teletherapy became more positive (Békés et al., 2020; Humer et al., 2020). Many therapists were able to do their therapeutic work by making minimal adjustments. However, many other studies also highlighted unique therapeutic challenges, such as a lack of emotional connection with patients, being more easily distracted during sessions, and difficulty maintaining privacy and a professional frame (Aafjes-van Doorn et al., 2021; Békés et al., 2021a,b; Shklarski et al., 2021). Maybe unsurprisingly, therapists also felt less competent in using their therapeutic skills (e.g., warmth) and extra-therapeutic influence (e.g., providing resources), when doing teletherapy (Lin et al., 2021).

Qualitative findings about teletherapy interventions

The initial quantitative studies were followed by more in-depth qualitative investigations of therapists' lived experience and found further examples of therapists' ways of using some new opportunities and overcoming the hurdles of the therapeutic process via videoconferencing. Several therapeutic opportunities were highlighted: First, several qualitative studies reported on a more balanced power dynamic, and the ability to relate in a more genuine human-to-human way. For example, a "democratizing" effect was noted, as patients are now in their own "territory," instead of entering the therapists' official space, making the therapy situation feel more equal (Simpson et al., 2019; Mitchell, 2020). Therapists noted that they had become more open and willing to share their personal experiences compared to their in-person practice (Mitchell, 2020). Similarly, some therapists (as well as patients, see Shtrackman, Békés et al., 2023) reported a sense of connecting more as humans besides professional and patient, and letting patients see more of them as persons (Békés et al., 2023). Some therapists reported that they used self-disclosure as a tool to compensate for the physical distance, especially when supporting patients during a time of global distress (Nuttman-Shwartz and Shaul, 2021; Aafjes-Van Doorn et al., 2023). This increased self-disclosure appeared to be related to an increase in self-disclosure of the patient, and might thus indeed have been therapeutic (Luo et al., under review).

Interestingly, although some boundaries were loosened, other boundaries became easier to keep. Among the several advantages noted regarding teletherapy, for example therapists found it easier to start and end the sessions on time in teletherapy than they did in their in-person sessions (Aafjes-van Doorn et al., 2022). As noted by therapists, another opportunity in teletherapy is accessing the patients' home environment via the screen. Many therapists were also able to take advantage of the opportunity to actively ask and gain more insight into the patients' home, family, and everyday life.

However, therapists also reported several challenges in teletherapy. For example, therapists noted that the teletherapy sessions often feel less deep emotionally and more superficial, and the teletherapy setting pulls them to provide support and counseling rather than engaging in a more open-ended exploration of the patients' inner world (Békés et al., 2023). Therapists often attempted to compensate for this by becoming more active and directive, and avoiding silences in teletherapy sessions. In addition, therapists reported that creating emotional closeness via teletherapy required a more active effort (McCoyd et al., 2022). Further, some therapists reported that it was more difficult to read their patients' emotions and they tended to feel more disconnected from their patients; as one therapist put it: "The one thing I am missing is the feel in the room" (Békés et al., 2023). In order to make up for the lacking nonverbal signals from body movement, therapists tended to make an effort to express their own feelings and emotional reactions verbally. Therapists also noted that it was more challenging to stay focused and present in teletherapy sessions and they get more easily distracted in teletherapy by online activities (e.g., notifications popping up on the screen, zoom fatigue) and offline activities in their home environment (e.g., family members, pets; Békés et al., 2020, 2021a,b; Shklarski et al., 2021; McCoyd et al., 2022).

Psychotherapy process in teletherapy

In contrast to skeptical expectations, several teletherapy studies conducted during the pandemic suggest that the quality of the therapeutic relationship tends to be of similar, regardless of the in-person or teletherapy format (therapist-reported ratings for a typical teletherapy session and in-person therapy session in survey studies; Aafjes-van Doorn et al., 2021; Békés et al., 2021a,b). Initial studies on the real relationship, another aspect of the therapeutic relationship concerning the genuine, sincere, and realistic perceptions between therapist and patient, indicated that therapists may actually report relatively higher quality of real relationship in their typical teletherapy session than their typical in-person therapy (Aafjes-van Doorn et al., 2020; Békés et al., 2020, 2021a,b).

Besides these aspects of the therapeutic relationship (working alliance and the real relationship), the maintenance of therapeutic presence has also been argued to be a precondition for effective therapeutic relationships and a positive working alliance in teletherapy (Haddouk et al., 2018; Hilty et al., 2019; Geller, 2021; Ruble et al., 2021). Given the many potential technical distractions and concerns about not feeling connected in teletherapy (Aafjes-van Doorn et al., 2020) therapists might find it particularly challenging to achieve therapeutic presence.

Recent teletherapy research conducted at the tail end of the pandemic in 2022 (using the same dataset we use in this study) found

that therapists reported feeling significantly less present in teletherapy and their perceptions of the real relationship were somewhat impacted, but there were no average effects on their perceived quality of the working alliance (Aafjes-Van Doorn et al., 2023). Furthermore, other studies found that besides more positive attitudes towards teletherapy in general during the pandemic, therapists who reported stringer therapeutic relationship in teletherapy with their patients, also reported more positive attitudes towards teletherapy and more intention to use it in the future (Békés et al., 2021a,b).

Aims

The first aim of our study was to develop a therapist self-report scale for the use of therapy interventions pertinent to teletherapy based on findings from previous qualitative studies on patients' and therapists' experiences of teletherapy (Aafjes-Van Doorn et al., 2023; Békés et al., 2023). Second, we aimed to explore how this newly developed Teletherapy Intervention Scale relates to the teletherapy process, specifically the therapeutic relationship (therapeutic alliance and real relationship), therapeutic presence, and attitudes towards teletherapy and future intention to use it.

Methods

Procedure

The present study includes a subset of data from a larger study comparing in-person and teletherapy processes, which was pre-registered at https://osf.io/qa382/?view_only=ab5158d0656845a6af654937d5b3470e. The present study focuses on hypothesis 12 listed in the pre-registration;[1] results on other hypotheses based on the same dataset have been published [omitted for peer review]. We collected therapists' responses on a large-scale survey (see https://osf.io/h9xfz). English speaking licensed therapists and therapists in training were eligible to participate if they had conducted teletherapy via videoconferencing at least once in the past 3 years. Participants were recruited via professional email listservs for clinicians from different mental health professions, therapeutic orientations, and with different patient populations, from graduate programs in counseling, clinical psychology and social work, as well as through professional networks. In addition, information about the study was posted on international social media groups for mental health professionals worldwide (Facebook, Reddit). After signing the therapist consent form, therapists completed an about 20-min anonymous survey. The survey included demographic questions, individual items, and standardized psychotherapy process measures. Participants did not receive any compensation for completing the survey. All study data were collected between March 08, 2022 and June 30, 2022, a period of time during which the COVID-19 incidence rate was relatively low and the social restrictions and mask requirements had been lifted in most countries. The study was approved by the [local - omitted for peer review] institutional review board.

1 https://osf.io/96yr7

Participants

A total of 839 therapists of the 1,298 who started the survey completed the Teletherapy Intervention items in the survey (see description below) and were included in the present study. This subsample differed from therapists who only started the survey but did not complete the Teletherapy Intervention items: Completers were older, t (1296) = 2.30, p = 0.003, with more clinical experience, t (1271) = 3.31, p < 0.001 more process-oriented (rather than cognitive-behavior) in their primary therapy approach, t (988) = 5.42, p < 0.001. There was no difference based on reported gender t (1283) = 0.63, p = 0.529, or licensure t (1296) = 0.15, p = 0.88. The average age of the participating therapists was 42.87 years old (SD = 16.60). Most therapists identified as female (n = 549; 65.4%), White (n = 570, 67.9%), and North American (n = 742; 88.5%). Most of the therapists were trained in psychology (n = 436; 52%) or social work (n = 108; 12.9%) with an average of 10.76 (SD = 6.89) years of clinical experience and 15.86 sessions (SD = 10.51) per week. Most therapists identified with the Psychodynamic (n = 242; 28.8%) or Psychoanalytic (n = 180; 21.5%) approach, and treated adults (n = 585; 69.7%) or adolescent patients (n = 122; 14.5%). Detailed demographic data about the study sample is presented in Supplement A.

Measures

The individual items and standardized measures used in this survey can be found at https://osf.io/qa382/?view_only=ab5158d0656845a6af654937d5b3470e. The instruction of the standardized measures was adapted to ask participants to respond considering their "typical experience" in teletherapy [adapted from Lin et al. (2021) and Probst et al. (2021)].

Teletherapy intervention scale

We included 13 new items that reflect therapists' mastery of the teletherapy setting, that is, their use of the opportunities and counteracting the inherent challenges specific to the teletherapy setting. The items were developed based on a review of previous qualitative studies on therapists' experiences regarding the specifics of the teletherapy process and interventions. Authors of previous qualitative studies on teletherapy acted as experts in reviewing and editing these items so that they capture the essence of therapists reported experience [omitted for peer review]. Items aimed to capture ways that therapists cope with and counteract certain challenges posed by teletherapy (e.g., being active in sessions to compensate for a sense of disconnection, verbalize feelings to compensate for reduced nonverbal cues, being more humane as opposed to professional to facilitate a sense of closeness despite physical distance), other items are related to positive experiences despite the challenges (e.g., managing to feel focused in session and attuned to the patients despite commonly experienced challenges with these, deepening the sessions despite a pull to stay on a more superficial level), while other items described taking advantage of opportunities arising through the tele-sessions (e.g., exploring the patients' home environment, starting and ending sessions on time).

Specifically, the 13 items were the following, based on a 1–5 Likert rating scale, ranging from 1- Not at all typical, to 5 - Very typical: (1)

I share my personal experiences with my patients; (2) I am emotionally attuned to my patients; (3) I am active in session, trying to engage the patient and direct the session; (4) I express my feelings not only in my face/tone, but I also verbalize my feelings explicitly; (5) To understand my patient's feelings I rely on nonverbal signals; (6) I let patients see me as I really am; (7) I am fully focused and present in the sessions; (8) The sessions are deep, intense (as opposed to superficial); (9) We connect as humans besides professional and patient; (10) I tend to start and end my sessions on time; (11) I am comfortable with the use of silences in my sessions; (12) I make active efforts to connect emotionally with my patient; (13) I express curiosity about the patients' home environment.

In this study, the Chronbach's alpha of this scale was 0.84.

Working Alliance

Therapeutic alliance was assessed with the Working Alliance Inventory - Short Revised - Therapist (WAI-SRT; Hatcher and Gillaspy, 2006). The WAI-SRT is a 10-item scale that uses a five-point Likert scale, ranging from *seldom* (1) to *always* (5). Following Bordin's (1979) theoretical model, the WAI-SRT has three subscales: Bond, Goal, and Task. Cronbach's α for teletherapy WAI-SRT was 0.89.

Real Relationship

The Real Relationship Inventory Therapist Form (RRI-T; Gelso et al., 2005) was used to assess the real relationship. It includes scales measuring realism and genuineness. The RRI-T has altogether 24 items to rate on a 5-point Likert scale from *Strongly Disagree* (1) to *Strongly Agree* (5). Cronbach's α for the RRI-T overall score was 0.87, for the subscales realism and genuineness were 0.73 and 0.76, respectively.

Therapeutic Presence

The Therapeutic Presence Inventory Therapist (teletherapy-T; Geller et al., 2010) is a 21-item self-report questionnaire regarding the therapist's in-session experience with various aspects of therapeutic presence, including physical, emotional, cognitive, relational, and spiritual aspects. Participants respond on a 7-point Likert sale, ranging from *Not at all* (1) to *Completely* (7). Cronbach's alpha was 0.80 for this scale in our sample.

Attitudes towards teletherapy technology

The Unified Theory of Acceptance and Use of Technology Therapist Version (UTAUT-T; Békés et al., 2022) was used to assess attitudes towards teletherapy. The 21-item UTAUT-T Attitudes subscale includes items related to performance expectancy, effort expectancy, social influence, and facilitating conditions regarding using teletherapy. Additional two items assess behavioral intention, that is, declared intent and plan to use teletherapy in the future. Items of the UTAUT-T scales are scored on a Likert scale ranging from 1 (Strongly disagree) to 5 (Strongly agree). The UTAUT-T has strong psychometric properties (Békés et al., 2023). In the present study, the UTAUT-T's Cronbach's alpha was 0.79.

Data analysis

First, to identify the latent constructs associated with the ratings on the 13 teletherapy intervention items, we conducted exploratory factor analyses (EFAs). EFA is recommended when identifying the factor structure of a newly developed measure with limited evidence to specify a prior factor model (Fabrigar et al., 1999). We used the Maximum likelihood (ML) method because there was no evidence of severe non-normality in the distributions of measured variables. We used the Promax with Kaiser normalization rotation method, which allows the items to be correlated. Two criteria were used to determine the number of factors retained; (1) Assessing rating scores of the 13 items, such that factors with eigenvalues above one were retained; (2) Inspecting a scree plot of the observed eigenvalues ordered from largest to smallest, looking for natural break or drop-off point where the curve flattens off, and using the number of data points above the drop-off point as an indicator of number of factors to retain.

Second, we calculated Cronbach's alphas to assess the internal consistency of the scale. Third, to establish relationships between teletherapy interventions and other variables, first we used zero-order Pearson correlations and independent samples t-tests to establish whether the Teletherapy Intervention Scale was related to demographic variables, such as age, gender, and self-reported primary therapeutic orientation, subsequently, we controlled for significant variables when running Pearson correlational analyses between Teletherapy Intervention Scale and therapeutic alliance, real relationship, therapeutic presence, and attitudes towards teletherapy and intention to use teletherapy in the future variables.

We created a binary variable for self-reported primary therapeutic orientation, which included cognitive and/or behavioral (CBT) approaches versus process-oriented approaches (including humanistic, psychodynamic/analytic, and systemic). Gender was treated as a binary variable (1 = female, 2 = male). The small number of nonbinary participants ($n = 9$) were removed for this covariate analysis.

All statistical analyses were conducted using IBM SPSS Statistics (Version 28).

Results

Teletherapy intervention scale

Exploratory factor analysis of the 13 teletherapy intervention items showed a two-factor solution, see Figure 1. However, only one item loaded on the second factor ("*I share my personal experiences with my patients*"), and three items were cross loading on both factors with higher loadings on the first factor. The 13-item items' factor loadings are included in Table 1. Next, we conducted a reliability analysis for the 13-item scale, which showed that the one item loading on the second factor had weak correlation with the total scale with a correlation coefficient ($r = 0.291$), below the commonly used threshold of $r < 0.3$ (Field, 2013). Therefore, we decided to remove this item from the scale and continue with a 12-item one factor solution. We calculated internal consistency of the scale and correlations with other study variables using this 12-item scale.

The teletherapy intervention scale and other variables

Next, we explored whether the created 12-item Teletherapy Intervention Scale was related to other therapeutic variables. First,

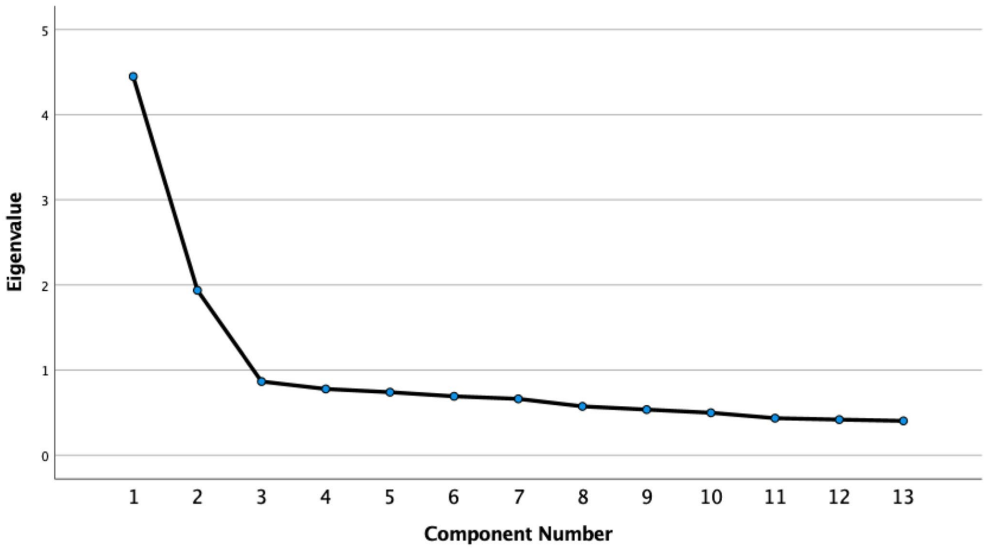

FIGURE 1
Scree Plot of the 13 Teletherapy Intervention Items in the Exploratory Factor Analysis. The 12-item scale's Chronbach's alpha was 0.83, indicating a good internal consistency. Inter-scale correlation coefficients were all $r > 0.30$, $p < 0.001$.

we found that Teletherapy Intervention Scale was positively associated with clinical experience ($r = 0.10$, $p = 0.006$), but not with primary therapeutic orientation (CBT or process orientation, $t\ (636) = -0.11$, $p = 0.912$); therefore clinical experience was controlled for in the subsequent analyses. The Teletherapy Intervention Scale was positively related to the following scales completed for teletherapy: therapeutic alliance, real relationship, and therapeutic presence, as well as attitudes towards teletherapy and behavior intention to use teletherapy in the future, see Table 2.

Discussion

In this study we aimed to develop a self-report scale to assess interventions specific to teletherapy. This new Teletherapy Intervention Scale intends to assess mastery of teletherapy, that is, coping with and counteracting challenges and using opportunities inherent in the teletherapy setting. We also examined the relationship between the Teletherapy Intervention Scale and other process variables in teletherapy regarding the therapeutic relationship, therapeutic presence, and therapists' attitudes towards teletherapy technology and intention to use it in the future.

Exploratory factor analysis showed that 12 items out of the originally included 13 items of the Teletherapy Intervention Scale could be conceptualized as representing one underlying construct. One item, ("I share my personal experiences with my patients"), did not load on this factor, possibly because it was not seen as therapeutic *per se*, or reflects a therapeutic stance more generally, rather than a unique teletherapy experience.

The Teletherapy Intervention Scale was positively related to the therapeutic alliance, the real relationship, therapeutic presence in teletherapy, which provides preliminary support for the Teletherapy Intervention Scale's validity, since it implies that using teletherapy interventions may results in being able to create a better therapeutic relationship with patients and being more present in teletherapy sessions.

Moreover, therapists with higher teletherapy intervention scores also tended to have more positive attitudes towards teletherapy, and they were also more likely to intend to continue using teletherapy in the future. In line with previous research on attitudes towards teletherapy, it is likely that therapists who sufficiently adapt their therapy process to make use of the benefits of teletherapy and address the challenges of therapy, are also more favorable towards teletherapy technology more generally. Previous research suggests that more experience with teletherapy decreases therapists concerns about teletherapy, increases their sense of competency using teletherapy, and also relates to higher perceived therapeutic relationship quality, even in the midst of the pandemic (Békés et al., 2021a,b, 2023; Aafjes-van Doorn et al., 2023).

Clinical implications

Pending on further future validation of the Teletherapy Intervention Scale, it may have several clinical implications for therapist training. This scale may be used in future process research on teletherapy treatments, as an add-on scale to the validated multitheoretical list of therapeutic interventions (MULTI; McCarthy and Barber, 2009; Solomonov et al., 2019) that was developed for in-person treatments. This might be especially relevant because interventions specific to teletherapy appear to be linked with the working alliance in teletherapy, just as therapy interventions were linked to the quality of alliance following alliance ruptures in in-person therapy (Chen et al., 2020). Of note, the items of the Teletherapy Intervention Scale are transtheoretical, and thus could potentially capture common interventions in various therapeutic orientations. Accordingly, there might also be a bidirectional relation between use of these common

TABLE 1 Factor loadings of the teletherapy intervention items.

		Component	
Teletherapy intervention item	Mean (SD)	1	2
1. I share my personal experiences with my patients.	2.69 (1.37)	0.320	0.726
2. I am emotionally attuned to my patients.	4.11 (0.97)	0.640	−0.439
3. I am active in session, trying to engage the client and direct the session.	3.52 (1.25)	0.542	0.401
4. I express my feelings not only in my face/tone, but I also verbalize my feelings explicitly.	3.4 (1.24)	0.578	0.496
5.To understand my patient's feelings, I rely on nonverbal signals.	3.79 (1.03)	0.622	−0.128
6. I let patients see me as I really am.	3.47 (1.12)	0.548	0.515
7. I am fully focused and present in the sessions.	3.99(0.96)	0.675	−0.304
8. The sessions are deep, intense (as opposed to superficial).	3.87 (0.97)	0.768	−0.337
9. We connect as humans besides professional and patient.	3.71 (1.10)	0.655	0.175
10. I tend to start and end my sessions on time.	4.03 (1.04)	0.454	−0.383
11. I am comfortable with the use of silences in my sessions	3.76 (1.11)	0.595	−0.311
12. I make active efforts to connect emotionally with my patient.	4.04 (1.04)	0.698	−0.188
13. I express curiosity about the patients' home environment	3.74 (1.17)	0.496	0.144

TABLE 2 Partial correlation between study variables.

Measures	M (SD)	1	2	3	4	5	6
1.Teletherapy Int	3.79 (0.65)	–	–	–	–	–	–
2. WAI	3.98 (0.71)	0.770	–	–	–	–	–
3. RR	3.58 (0.54)	0.518	0.618	–	–	–	–
4. TP	4.85 (0.84)	0.532	0.594	0.696	–	–	–
5. UTAUT-T	3.58 (0.57)	0.472	0.542	0.492	0.561	–	–
6. Beh Intention	3.84 (0.97)	0.340	0.418	0.359	0.411	0.727	–

All correlations are $p < 0.001$. Teletherapy Int, Teletherapy Intervention Scale, WAI, Working Alliance Inventory; RR, Real Relationship; TP, Therapeutic Presence; UTAUT-T, Teletherapy Technology Acceptance for Therapists; Beh, Behavioral.

teletherapy related factors and the development of the working alliance, as there was for "common factors" techniques and alliance in in-person therapy (Solomonov et al., 2018).

Importantly, conceptually, the better use of teletherapy specific interventions by the therapists may relate to better therapeutic outcomes as well. There is strong evidence for the relationship between the therapeutic relationship and symptom improvement both in teletherapy (Norwood et al., 2018) and in in-person therapy (Cataldo et al., 2021; Smith et al., 2022), and given the relationship between teletherapy interventions and relational variables in our study, teletherapy interventions might also relate to better outcomes in teletherapy.

Moreover, the newly developed Teletherapy Intervention Scale could also be used by graduate schools and training institutes to aid the development of skills in teletherapy. It could, for example, be used as an observer-rated competency scale when evaluation video recorded teletherapy sessions, to assess how therapists in training navigate the unique aspects of the teletherapy process. It could also be used as a self-report scale for therapists themselves when they review their own work and want to identify micro skills they need to target in their deliberate practice. This scale could also be used more generally as a concrete tool to teach therapists about research findings on the teletherapy process and how it might impact their own clinical practice.

Limitations and future directions

Several limitations and future directions can be identified. First, this study reported on the initial development and validation of a Teletherapy Intervention Scale, and as such it needs further validation. It is surprising that 3 years after the start of the sudden transition to teletherapy, no therapy intervention scale has been developed that taps into the teletherapy context specifically. Therefore, this initial development of the teletherapy intervention scale is important, and needs validation in larger, more diverse samples. Relatedly, a further limitation is that the validity of the standardized scales of working alliance, real relationship and therapeutic presence could be questioned, given that these measures were used to assess the therapists' experiences with their typical in-person sessions and teletherapy sessions, rather than a specific session with a specific patient as originally intended by the standardized scales.

Second, our study reported on therapists' perspectives of the frequency of used interventions. We know from previous research that

therapists might not be the best judge of what interventions they actually use in their therapy sessions. Further studies are needed to explore differences in therapeutic interventions in in-person and teletherapy settings as perceived not only by therapists but also by patients, and to provide practical guidelines for training and clinical practice in using teletherapy interventions.

Third, this cross-sectional survey study did not report on actual session-by-session ratings of the relational variables, but ratings across typical teletherapy sessions. A longitudinal study investigating session-by-session ratings of these teletherapy interventions would be a welcome validation study for these identified 12 items. Specifically, given that using teletherapy appears to lead to more positive attitudes toward it, it is possible that therapists may also be able to use the teletherapy interventions in better ways; or might feel more comfortable with the use of teletherapy specific interventions when it is no longer associated with the stressful pandemic time (Messina and Loffler-Stastka, 2021). Furthermore, our study did not include treatment outcomes; future studies should assess the potential relationship between the use of teletherapy interventions and treatment efficacy.

Conclusion

This study is unique in that it operationalizes how exactly therapeutic interventions in teletherapy are different from interventions used in in-person therapy. It reports on the development of a scale for teletherapy interventions which captures therapists' mastery over the inherent challenges and opportunities of teletherapy, and which could be used for research, professional development, and training purposes. Overall, our findings indicate that certain interventions in teletherapy sessions appear unique to teletherapy and that therapists using these may also be able to experience better relational quality in their teletherapy sessions, be more present in their teletherapy sessions, and had more positive views of and intention to continue using teletherapy.

Data availability statement

The raw data supporting the conclusions of this article will be made available by the authors, without undue reservation.

Ethics statement

The studies involving human participants were reviewed and approved by Western IRB, Yeshiva University's IRB. The patients/participants provided their written informed consent to participate in this study.

Author contributions

VB developed the concept, collected data, conducted the data analysis, and wrote up the first draft of the manuscript. KA-vD developed the concept, collected data, and wrote the manuscript. XL collected data and edited the manuscript. SB edited the manuscript. CH developed the concept, collected data, and reviewed the manuscript. All authors contributed to the article and approved the submitted version.

Conflict of interest

The authors declare that the research was conducted in the absence of any commercial or financial relationships that could be construed as a potential conflict of interest.

Publisher's note

Supplementary material

The Supplementary material for this article can be found online at: https://www.frontiersin.org/articles/10.3389/fpsyg.2023.1206960/full#supplementary-material

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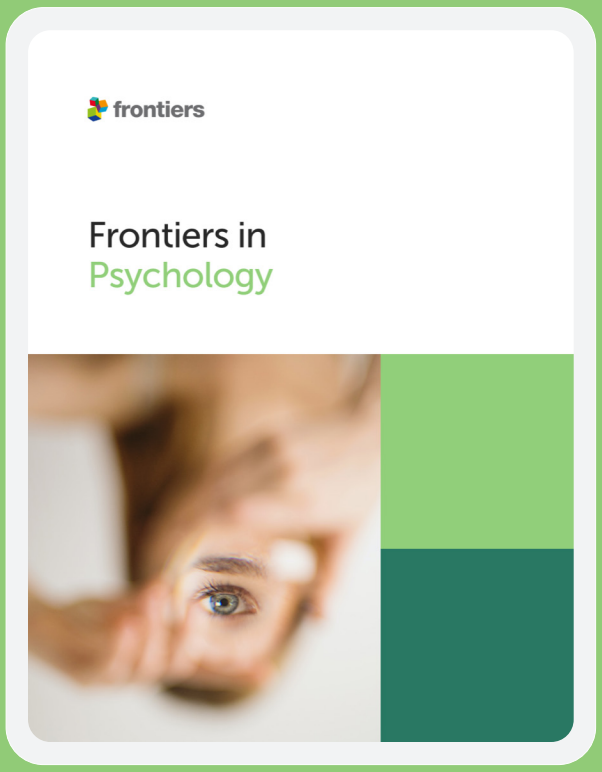

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