

Psychotherapists' self-determined motivations and experiences in  
shifting to online psychotherapy during the COVID-19 pandemic:  
A Rapid Review

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Supervisor: Dr L Nel

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## Declaration of Authenticity

I, Indira Pillay, declare that this mini-dissertation submitted in partial fulfillment of the Master of Social Science in Clinical Psychology at the University of the Free State, is my own work. This work has never been submitted for examination. All the sources used in this mini-dissertation have been referenced using the American Psychological Association guidelines and have been language edited accordingly (see Appendix D). I certify that the submission of this mini-dissertation is exclusively for examination and no other purposes.

*Indira Pillay*

04/12/2024

Signature

Date

04 December 2024

## **PERMISSION TO SUBMIT**

Student: Indira Pillay

I hereby provide permission for the mini-dissertation *Psychotherapists' self-determined motivations and experiences in shifting to online psychotherapy during the COVID-19 pandemic: A Rapid Review* to be submitted for examination – in fulfilment of the requirements of a Master's degree in Clinical Psychology in the Department of Psychology, University of the Free State.

Sincerely,



Dr L Nel

Supervisor

04/12/2024

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## SECTION 1: Overview

### 1.1. Introduction

This section serves as an overview of literature, as well as an outline of the procedure followed in conducting this rapid review.

In 2020, the world suffered the onslaught of the Coronavirus pandemic (COVID-19), throwing daily life into disarray. This virus primarily affects the respiratory system of infected individuals, leading to flu-like symptoms, coughing, difficulty breathing, fever, headaches and fatigue among other symptoms. In severe cases, infected individuals experienced pneumonia and other serious conditions leading to death (World Health Organization, 2021). Vulnerable individuals included the elderly, children, individuals with weak immune systems and those with chronic medical conditions such as asthma, cancer, cardiovascular disease and diabetes, among others (Liu et al., 2023).

Countries across the world had gone into lockdown, meaning travel to work, school and other daily activities had been prohibited or severely restricted. Among these regulations came limitations to health care. In guidelines released by the World Health Organization (2020), and in accordance with the rights of health care workers, employers and managements were required to allow healthcare workers to exercise their right to remove themselves from potentially harmful conditions and environments (World Health Organisation, 2020).

While medical doctors and emergency personnel continued to work, many practitioners rendering psychological therapy had a tough decision to make, considering their own safety and that of their patients. The fear of contracting or transmitting the virus during in-person consultations caused many psychotherapy practitioners to move their practices to virtual platforms over the internet (Singh & Sagar, 2022). In addition to other platforms, *Skype*, *Zoom* and *Microsoft Teams* were utilised.

While online psychotherapies have been established as an effective way of rendering certain forms of psychotherapy (e.g. cognitive behavioural therapy), some practitioners had concerns about several external challenges (Luo et al., 2020). In low- and middle-income countries, access to the internet and devices, as well as connectivity reliability, became the focus of concern

(Singh & Sagar, 2022). In South Africa, for example, navigating rolling blackouts of electricity supply known as ‘load shedding’ was a major challenge. Issues such as overcrowding and congestion within “spaces” where virtual psychotherapy was being conducted, was another challenge. Psychotherapists found that these challenges led to a lack of confidentiality during therapy with patients. As a result, overall functional capabilities to support online psychological consulting during COVID-19 were severely lacking in contexts like the South African public mental health system (Pillay & Kramers-Olen, 2021).

With the increased demand for psychotherapy, a specific need for intervention to address fears, anxieties and general stress caused by the COVID-19 pandemic, was created. According to Pillay (2019) one in six individuals across South Africa had been suffering from, among other disorders, depression, anxiety and substance-use disorders shortly before the pandemic. However, the onset of COVID-19 and the initial lockdown showed that 33% of South Africans experienced feelings of depression and 45% were fearful and anxious (Orkin et al., 2020).

During this period, the South African Depression and Anxiety Group (SADAG) saw a significant increase in telephonic calls on their crisis line. This included a substantial concern over the relapses of patients living with mental illness who were not able to access follow-up care in the context of the lockdown (The South African Depression and Anxiety Group, 2021). This new challenge forced mental health care practitioners to take a step back and reevaluate the best way to continue the provision of mental health services, while still prioritising the physical health and safety of patients and practitioners. The shift from in-person assessment and therapy to online consultations had begun (Hilty et al., 2013).

With the sense of ‘normality’ disturbed, previous experiences were insufficient to develop best practice approaches in pandemic times. Many mental health care workers who were adapting their practice to online consulting were now navigating uncharted territory. *Teletherapy*, as it became known, is a way of providing psychotherapy using technology (e.g. smartphones, computers), with the therapist and patient in different locations.

Teletherapy is an important innovation, and a welcome option for mental health care when physical distancing is necessary. It can allow for mental health evaluations, treatment, consultations, and psychoeducation. However, this approach to psychological care poses several challenges that are absent in in-person consultations (Lin et al., 2022).

One of the challenges experienced with teletherapy during COVID-19 was the difficulty in accurately observing patients' nonverbal cues, which psychotherapists rely on to provide richer information to aid diagnostic and psychotherapeutic work (Marra et al., 2020). However, in a study conducted by Lin and Anderson (2022), findings suggest that therapists with healthy non-verbal skills described enhanced therapeutic skills, the ability to create a good therapeutic alliance and achieve positive outcomes when transitioning to teletherapy. Another challenge was the possible blurring of boundaries because patients were now seen (virtually) in their homes, and the consequential effect of possible bias on the therapeutic process has been raised (Russell, 2021). Similarly, therapists consulting from their homes were also at risk of blurred boundaries, as patients could now catch a glimpse into their personal lives. However, Simpson et al. (2021) found that certain applications provide artificial backgrounds that protect client and psychotherapist's personal lives.

On the other hand, many patients found it easier to portray their authentic selves while seated in their own familiar environments (Simpson et al., 2021). Others found it easy to carry psychotherapy into their day-to-day lives (e.g. their homes) and find new ways to incorporate psychotherapy into daily challenges (von Below et al., 2023). Unexpectedly, this authenticity appeared to facilitate psychotherapists arriving at the root of patients' difficulties at an expedited rate, as opposed to navigating through many sessions of rapport building to allow the patient to become comfortable to be their authentic selves in the psychotherapists' environment (Sampaio et al., 2021).

## **1.2. Aims and Objectives of the Study**

This study aimed to review existing literature to understand the role of self-determination in psychotherapists' decisions to shift to online psychotherapy during the COVID-19 lockdown restrictions.

The objective of this research was to understand how self-determination influenced psychotherapists' motivation, experiences, challenges, and adaptations to shifting to online psychotherapy during the COVID-19 restrictions.

### 1.3. Coronavirus Pandemic and Healthcare

COVID-19 had a significant impact on healthcare globally, exposing flaws in health systems, deficiencies in quality and service, and even assaults on the healthcare system (South African Medical Association, 2023). Health care systems were challenged globally, and poorer countries struggled even more to cope with the overwhelming demand for COVID-related care. Health care systems were stretched beyond belief and had to cope with pressures never previously experienced. Cutler (2023) noted that hospitals resembled ‘battlefield medicine’ rather than normal health care practice (p.1), but felt that health care systems were quite resilient, despite the onslaught of infectious cases needing care. At the same time, certain areas of health care experienced massive reductions in demand, e.g. general practitioners, oncology, and various screening services (Nematswerani et al., 2023).

Mental health services also saw a substantial decline in requests for care with numerous patients failing to follow-up on psychotherapy sessions or avoiding collecting ongoing medications (Pillay & Kramers-Olen, 2021). Fear of contracting the virus, prevented many from seeking or obtaining mental health care, thus increasing the global burden of disease. Healthcare workers faced physical safety concerns within hospitals, both from the new and unknown virus as well as the stigmatisation from misinformed people (van Stekelenburg et al., 2023). Many healthcare workers were left confused, unsupported, overwhelmed and short of resources necessary for treatments. Due to the onslaught of hospital admissions, hospital wards were converted into COVID-19 isolation units (Chen et al., 2023).

Insufficient support for healthcare workers was noted globally, including inadequate personal protective equipment (PPE), and drastic changes in the roles of healthcare professionals and how they worked. Many healthcare workers reported a lack of autonomy during the pandemic, for example, being told to reuse face masks to save money (Kranenburg et al., 2022). However, several countries in the global North provided mental health care, financial and childcare assistance, amongst others, for healthcare workers during the COVID-19 pandemic (Williams et al., 2020).

While healthcare workers faced increased pressures in their work contexts, they also had to adopt newer or different approaches to their clinical work, sometimes quite different from what they learned during their training. Among these innovations was the use of internet-based

platforms to consult with patients and provide care (De Witte et al., 2021). However, being a relatively new way of consulting, it came with challenges that had to be maneuvered.

The present study explored psychotherapists' decisions to use online consulting or teletherapy and their experiences in navigating the shift during the COVID-19 period. As a theoretical framework, the study used the Self Determination Theory of Deci and Ryan (2008) to understand psychotherapists' needs, motivations, and experiences in the context of their decision to switch to online therapy.

#### **1.4. Self Determination Theory**

Through the stress of COVID-19 and navigating psychotherapy within a “new normal” context, health care professionals rendering psychotherapy needed to make decisions and generate alternative solutions of how to best serve their patients and respective communities. As a result, these professionals needed to engage in a process of self-determination, to motivate themselves to make some necessary changes (Ryan & Deci, 2000). While COVID-19 was a scary experience, the world saw many psychotherapists become motivated to continue providing psychological care, albeit in a safer, physically distanced format.

While keeping these advantages and challenges in mind, many psychotherapists persevered and worked hard to cope with their health and safety, and to provide the essential service to patients. This speaks to their motivation to keep working and continue their healthcare duties and professional obligations. To better understand the *why* behind their decisions, the Self Determination Theory (SDT), and more specifically, the Basic Psychological Needs (sub)theory (BPNT), was used to contextualize and explain how self-determination impacted the motivation of psychotherapists.

The Self Determination Theory (SDT) focuses on an individual's motivation and drive in social contexts that distinguishes between independent and constrained motivation (Deci & Ryan, 2012). The Self Determination Theory looks at how people become motivated to act when they think that their actions will affect the outcome (Ryan, 2017). This theory has been used widely in the areas of sport (Lourenço et al., 2022), education (Guay, 2022), health care (Deci & Ryan, 2012), psychopathology (Ryan, 2009), and psychotherapy (Deci & Ryan, 2008).

Within the SDT, six mini-theories emerged which formed an extension of this theory. In the present study, the Basic Psychological Needs Theory (BPNT) was used.

### **1.5. Basic Psychological Needs Theory**

As mentioned above, the Basic Psychological Needs Theory (BPNT) is one of six mini-theories stemming from the Self-Determination Theory (Ryan, 1995). According to Ryan (1995), the description of basic psychological needs within this theory relates to “*a psychological nutrient that is essential for individuals’ adjustment, integrity, and growth*” (p 410). As a result, basic psychological needs in this theory are limited to autonomy, competence and relatedness, but should be acknowledged as having the possibility of expansion (Ryan, 2017). According to Vansteenkiste et al. (2020), the BPNT takes into consideration how these basic psychological needs are influenced when satisfied or when frustrated.

The first basic psychological need is Autonomy, which refers to the experience of “*volition and with internal coherence*” (Ryan, 1995, p 419). This means that an individual may experience a sense of having a choice in their behaviour and goals, and allows individuals to take charge of the direction of their life (Ryan & Deci, 2017). According to Vansteenkiste and Ryan (2013), when autonomy as a basic psychological need is met, an individual has the experience of authenticity and integrity when their thoughts, feelings, and behaviors are genuine and internalized. However, when autonomy in an individual is not met, an individual may experience feelings of pressure and internal conflict, such as being pushed into contexts which are undesirable (Vansteenkiste & Ryan, 2013).

Competence, as the next basic psychological need, is understood to be met when an individual experiences mastery and feelings of success (Ryan, 1995). This means that an individual will meet this psychological need when the desire to become more effective at what one does in order to attain goals and the sense of control over the elements that impact one's life has been met. If this basic psychological need is not met or frustrated, an individual may likely experience feelings of ineffectiveness and have negative impacts within emotional, social and occupational domains in their lives (Vansteenkiste & Ryan, 2013).

The last basic psychological need is Relatedness, which enhances motivation to do something when individuals experience a sense of belonging and connection to others (Ryan & Deci, 2017). This involves the need to feel taken care of, appreciated and connected to other people. According to Ryan (1995), if this need is not met or frustrated, an individual will experience feelings of isolation, estrangement and exclusion.

The present study explored how these three basic psychological needs motivated psychotherapists to continue providing mental health care, despite the disruptions to traditional, in-person psychological consultations. Furthermore, the study looked at the experiences, challenges and adaptations involved in providing online psychotherapy while maintaining autonomy, relatedness and competence.

In a preliminary search conducted, it has been found that there is little to no research data available on psychotherapists' decisions and experiences on transitioning to teletherapy. Against this background the present research aim was to understand the role of self-determination in psychotherapists' decisions to shift to providing online psychotherapy during the COVID-19 lockdown.

## **1.6. Research Design and Method**

### *1.6.1. Research Approach*

A qualitative research approach was used to allow the researcher to gain a “thicker”, more in-depth knowledge and understanding of the topic under study (Creswell et al., 2007). Qualitative research provides deep, nuanced, and multifaceted understandings of participants' attitudes, actions, and experiences. It makes it possible to research new topics, identify patterns, and build ideas that could eventually help in the formation of the policies required for community development. It also makes it possible to more fully comprehend the environment in which people interact, live, and work while giving participants' voices a fair and accurate platform, serving to create a forum for the discussion and sharing of experiences (Clarke & Braun, 2013).

### *1.6.2. Research Design*

The research design involved the use of a rapid review of relevant literature to understand how psychotherapists experienced the COVID-19 challenges, as well as the role of self-determination

in their motivation to shift to online consultation. It is widely acknowledged that the rapid review methodology facilitates a quicker, but reliable alternative to systematic reviews, while ensuring the expected credibility and quality (Haby, et al. 2024). Additionally, rapid reviews assist in the synthesis of large quantities of knowledge published in the public domain, in a digestible format for researchers.

Rigorously conducted rapid reviews can offer researchers an idea of possible gaps in research that need to be filled. They are cost-effective, quick, and can meaningfully contribute to the understanding of context-specific topics (Schünemann & Moja, 2015). In doing a literature review, the researcher spends a great deal of time analysing the literature and noting study findings that are reliable and useful. Rapid reviews have been especially recommended in the context of the pandemic where quick, but rigorous analyses of literature needed to be undertaken (Moons et al., 2021). Additionally, rapid reviews allow for a *snapshot* view of a given topic which may provide a summary of relevant and important information, in a timely and cost-effective manner.

### *1.6.3. Research Method*

To address the study's aim and objectives, the researcher opted to use an evidence-informed rapid review approach, as recommended by Onwuegbuzie and Frels (2012), as cited by Du Toit and De Klerk (2022). This design follows an 8-step process to consolidate and produce information and is viewed as a simplified form of a systematic review, delivering findings in a shorter timeframe, but with methodological credibility.

#### *Step 1: Stating the aim of the rapid review and formulating the research question:*

According to Du Toit and De Klerk (2022), without leading the search in any biased direction, the researcher needs to state clearly, the research question that needs to be answered. The question in the present study was: How did self-determination influence psychotherapists' motivation, experiences, challenges, and adaptations in shifting to online psychotherapy provision during the COVID-19 restrictions?

#### *Step 2: Setting the eligibility criteria and inclusion and exclusion criteria:*

In this step, the researcher and supervisor discussed and set the eligibility criteria for which relevant data would be sought. Data to be included were articles with full texts, qualitative in nature, peer-reviewed studies, and published between 2020 and 2023. As this study looked at

teletherapy and the motivation of healthcare workers to continue practicing during COVID-19, relevant data included research on professionals rendering psychotherapy. To ensure validity and reliability, no specific speciality or discipline criterion was applied. Articles excluded from this study were those published before 2020, unpublished theses and dissertations, studies not focused on rendering teletherapy, and non-peer-reviewed articles. The inclusion and exclusion criteria were applied to ensure that articles carried work relating to the COVID-19 period or shortly thereafter and used a qualitative methodology to ensure that the studies focused on narrative responses, with in-depth, thick descriptions from the psychotherapists interviewed.

The following keywords were then entered into the databases to facilitate appropriate data retrieval: “psychotherapy” OR “counselling” OR “therapy” AND “online” OR “e-therapy” OR “teletherapy” AND “experiences” AND “psychotherapist” OR “mental health worker” OR “mental health professional” OR “psychologist”.

*Step 3: Formulating the search strategy:*

Once all relevant data was retrieved from the various databases in question, data was then extracted and uploaded to RAYYAN, which is a free software programme, to assist researchers in the process of sifting through large quantities of data (Ouzzani et al., 2016). Academic databases utilised in this research study included: EBSCOhost, PubMed, APA PsycArticles, APA PsycInfo, MEDLINE with Full Text. These databases were carefully chosen as they are highly regarded and are trusted to provide information on globally conducted scholarly research.

*Step 4: Screening and selection of literature:*

The screening procedure looked for studies that were pertinent to the purpose, research question, eligibility requirements, and keywords. This step included sifting through the generated pool of articles for relevant and appropriate articles. In this study, 361 articles were identified through the database search; 2 articles were removed as they were duplicate records; 359 articles were then screened; 265 articles were excluded as they did not meet the inclusion criteria; 94 articles were then considered for inclusion; 82 articles were excluded due to no full-text access; finally, 12 articles were included in this research study.

*Step 5: Extraction of data from included literature:*

To extract data from articles which have been included in the study, the researcher undertook a process of tabulating study characteristics such as authors, title, date of publication, country of study, participants, outcomes and findings/results. Rapid reviews may conduct the data

extraction process by multiple reviewers independently in order to verify applicability and ensure trustworthiness.

*Step 6: Quality and risk of bias assessment of included literature:*

To maintain the quality and reduce the risk of bias in assessment, two steps were taken by the researcher. The researcher employed the Joanna Briggs Institutes - JBI Critical Appraisal Checklist for Qualitative Research (Lockwood et al., 2015). This tool was used to assist in assessing the reliability, relevance and findings of articles included in this research study (Joanna Briggs Institute, 2017). Secondly, a verifying examination of the selected articles was done by the study supervisor to help provide a further level of independent assessment to enhance the credibility and trustworthiness of the findings.

*Step 7: Synthesis and analysis of included literature:*

The data was analysed using thematic analysis (Braun & Clarke, 2006). By employing this method, the author and supervisor were able to identify noteworthy findings that they subsequently combined to create themes (Nowell et al., 2017). To create the report, they employed thematic analysis to familiarize themselves with the data, create preliminary codes, search, review, define, and name themes. The studies that are part of this research were analysed using these procedures. The author and supervisor read each piece, which informed the development of thematic areas within these studies by following the process outlined by Braun and Clarke (2006).

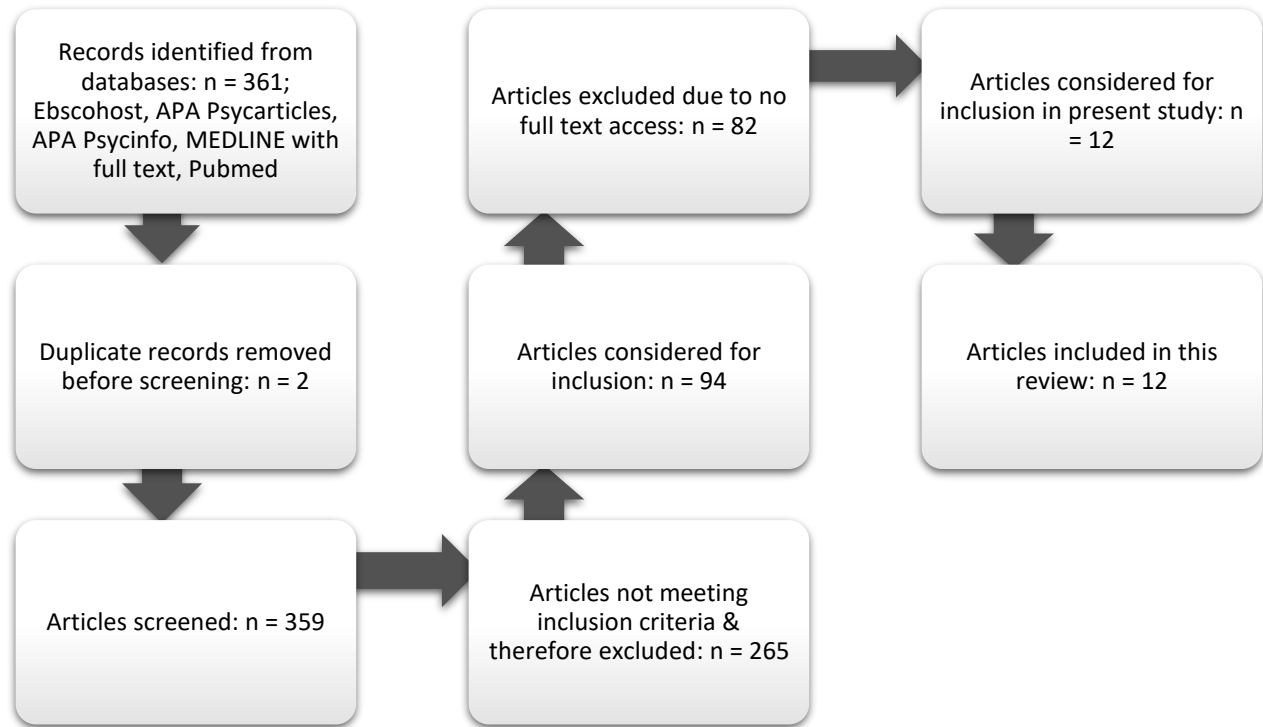
*Step 8: Stating the limitations of the rapid review:*

Limitations of this study included the difficulty of not being able to access articles without full-text availability. Additional limitations include possible biases during the data collection and analysis stage of the research. Lastly, there is a possibility that in the data collection process, relevant data complying with the inclusion criteria were excluded. While these are possible limitations, the researcher attempted to ensure trustworthiness by having the supervisor examine data for inclusion appropriateness. According to Cheng and Phillips (2014), numerous obstacles exist in such research, despite attempts by researchers to expand access to research data, especially in low- and middle-income countries where access to academic resources is limited.

#### *1.6.4. Procedure of data collection*

Peer-reviewed published articles with full-text availability were retrieved using these academic databases: EBSCOhost, PubMed, APA PsycArticles, APA PsycInfo, MEDLINE with Full Text.

Figure 1 below reflects the procedure and numbers of articles initially identified using the keywords and phrases, through to the stage of final selection for inclusion, based on the inclusion and exclusion criteria detailed earlier (indicated in Step 2 above).



**Figure 1: Flow diagram for data collection**

### 1.7. Data analysis

The retrieved articles considered for final inclusion were read and the findings were analysed using thematic analysis, which is a technique for identifying, extracting, and interpreting common patterns and themes running through qualitative data sets (Terry et al., 2017). The generated themes were discussed with the extant literature on the subject. A hybrid approach was used, incorporating inductive and deductive reasoning methods, with specific premises informing more general conclusions, while some general principles allowed specific conclusions. The resultant themes were examined and understood in the context of the SDT concepts of autonomy,

competence, and relatedness and how they relate to the psychotherapists' experiences, motivations, and decision-making regarding the shift to online therapy (Ryan & Deci, 2017).

According to Braun and Clarke (2006), this approach can be used quite effectively by researchers with little research experience and has the advantage of being able to summarise the main features of large amounts of data. They also note that this method of data analysis can generate insights that were not anticipated in the research and can be useful for analytical processes that are geared towards informing policy development.

### **1.8. Trustworthiness**

To maintain trustworthiness in the research process, the criteria of credibility, transferability, dependability, and confirmability were carefully considered and managed (Lincoln & Guba, 1985). The researcher and supervisor analysed and decided which of the articles were utilized in this study, to ensure credibility. Often rapid reviews are critiqued on the basis of trustworthiness. According to Tricco et al. (2015), while rapid reviews are often used to streamline information many processes may be side stepped in order to provide data in a timely manner. These include; not utilising the appropriate protocol, using a limited literature search and inclusion criteria, only one person screening the data collected, and not engaging in a quality appraisal of the data. As a result, data may not often be trustworthy or reliable. The process of conducting a rapid review in a thorough manner, without bias filtering through may assist the researcher in avoiding incorrect interpretations of the findings (Thomas et al., 2013).

This report provides a full account of the data extraction method that was executed, to assure reliability and transferability. In terms of confirmability, the researcher ensured that biases were not intentionally introduced into the process of gathering and analysing data, by constantly bracketing out any other views or attitudes relating to the subject that were not part of the extracted data.

## **1.9. Ethical considerations**

Ethics approval was obtained from the General/Human Research Ethics Committee (GHREC) at the University of the Free State. The clearance number for the approval of this research is UFS-HSD2023/0972 (see Appendix A). Attention was given to ensuring accurate article identification, data extraction, interpretation and conclusions. To ensure ethical research practice, the researcher completed the *Training and resources in research ethics evaluation* (TRREE) course (see Appendix B). Additionally, ethical integrity was ensured by the researcher working collaboratively with her research supervisor to ensure a process of triangulation in the research.

Ethical risks were lower since the researcher was working with articles in the public domain, and further use for research analysis is implied by publication (Tripathy, 2013). An ethical consideration that was maintained was ensuring the integrity of the data collected so as to avoid plagiarism. Additionally, the researcher and her supervisor ensured that all sources were used with appropriate citations. This is to ensure that the researcher respected copyright and intellectual property during the data collection and write-up phase of this rapid review.

In order to maintain ethical research practice and be true to the research studies included in this review, the researcher and supervisor attempted to ensure a true reflection and interpretation of the content of the studies reviewed. For example, the researcher focused on the studies pertaining specifically on ‘motivation’ in shifting to online psychotherapy, and not manipulating the data to suit any preconceived research outcome. The additional use of the JBI Critical Appraisal Checklist for Qualitative Research was helpful for a novice researcher to ensure a rigorous approach to the rapid review, thus enhancing overall quality of the findings, without violating research ethics (Lockwood et al., 2015).

## **1.10. Conclusion**

In summary, section one on this dissertation provided an overview of the relevant literature, theory and method used in this research, in accordance with the university requirements. The researcher provided a background to the Coronavirus pandemic, the challenges experienced by the healthcare system and professionals providing psychotherapy services. The theoretical foundation for the study was also outlined. The problem statement and the planned methodology

were discussed in detail, and the relevant ethics considerations and issues of trustworthiness were presented.

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## SECTION 2: MANUSCRIPT

As part of the qualification for the Master of Social Science in Clinical Psychology, a mini dissertation in the form of an article (below) will be submitted for possible publication in *Psychotherapy*. This is a journal of the American Psychological Association and the submission guidelines are available at <https://www.apa.org/pubs/journals/pst>. According to the journal scope statement “*The journal strives to foster interactions among individuals involved with training, practice theory, and research since all areas are essential to psychotherapy*” (American Psychological Association [APA], n.d.) (see Appendix F).

**MANUSCRIPT**

*Title of article:* Psychotherapists' self-determined motivations and experiences in shifting to online psychotherapy during the COVID-19 pandemic: A rapid review

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## **Abstract**

The COVID-19 pandemic imposed various social and professional contact restrictions, with health care, and especially psychological consultations, significantly affected. Online platforms for patient consultations became an alternative format, with many psychotherapists opting for this medium. The present research used a rapid review of the scholarly literature to understand psychotherapists' experiences and motivations as they shifted to online therapy. The Self-Determination Theory (SDT) and specifically the Basic Psychological Needs (sub)Theory (BPNT) was used as the theoretical foundation for the study, and peer-reviewed, qualitative research published between 2020 and 2023 was included for analysis. A qualitative approach was used, and a deductive method was employed to generate the thematic areas. The first theme identified was the psychotherapists' loss of autonomy and related attempts to regain a sense of autonomy. The second theme was the concept of competence and included the attainment of personal and professional growth. The final theme was that of relatedness. While the therapeutic relationship was affected by the technological space, the shared feelings of concern and anxiety regarding the uncertainty of COVID-19 seemed to have a bonding effect between the patient and therapist. This, perhaps, enhanced the therapeutic alliance, given their equal concerns with respect to COVID-19. Overall, the reviewed literature showed that, despite the challenges, psychotherapists adapted well to the online therapy shift necessitated by the COVID-19 lockdown.

*Keywords:* COVID-19; psychotherapy; motivation; self-determination; teletherapy; mental health

## **Introduction**

The 2020 Coronavirus pandemic (COVID-19) left mental health care professionals in a predicament when decisions needed to be made to continue service provision using traditional face-to-face consultations or to move to online consulting. While online psychotherapy was being conducted before COVID-19, its use was limited and increased substantially since the 2020 lockdown (Gangamma et al., 2022). Interestingly, only four years before the pandemic, the Psychological Society of South Africa (PsySSA) released its guidelines for telepsychology (Evans, 2018). Despite the lack of urgency for online therapy or teletherapy, at the time, the organisation recognised the future of this medium of psychotherapy. However, the emergence of COVID-19 and the lockdown witnessed an increased demand for mental health care to address the prevailing anxieties and stress, among other problems. As a result, many psychotherapists were left in a state of uncertainty regarding the ability to continue the provision of psychotherapy on an online platform.

. Globally it became evident that citizens needed access to psychotherapy, thus necessitating the shift to online therapy (Downing 2021; Fish & Mittal 2021). Research on mental health problems in South Africa had revealed that one in six people had mental health problems before the pandemic, but this changed dramatically during lockdown when 33% of people were found to experience hopelessness, 45% anxiety, and 29% felt alone (Nguse & Wassenaar, 2021; Orkin et al., 2020; Pillay, 2019). The present researchers were, therefore, interested in the motivations and experiences of psychotherapists in making the move to teletherapy.

## **COVID-19 and mental health care**

Despite many challenges, the move to teletherapy was initially considered an optimistic shift as an alternative medium of care (Mittal et al., 2023). Some of these challenges included physical attendance/non-verbal cues, psychotherapists' own anxieties, depressive symptoms and lack of self-care in the rather novel situation of COVID-19 (Mittal et al., 2023; Nguse & Wassenaar, 2021; Pillay & Barnes, 2020; Pillay & Kramers-Olen, 2021). The pandemic affected mental health care professionals' ability to provide services as usual and, as a result, the need to navigate

a “new normal” became evident – a situation which allowed practitioners to continue providing a service that was in high demand, albeit in a somewhat different context.

### **Self-determination Theory**

To continue providing the much-needed psychotherapy services during this period, mental health care professionals had to be self-motivated to change the way they worked. This motivation was likely needed as many psychotherapists were not trained in this format, nor had they rendered psychotherapy in this way before. The self-determination theory (SDT) was, therefore, considered useful in understanding how psychotherapists motivated themselves to continue providing psychotherapy in this changed manner (Ryan & Deci, 2000). This theory has been widely used, for example, in the areas of sport (Lourenço et al., 2022), education (Guay, 2022), health care (Deci & Ryan, 2012), psychopathology (Ryan, 2009), and psychotherapy (Deci & Ryan, 2008).

Stemming from the SDT, six mini-theories exist, including the Basic Psychological Needs Theory (BPNT) (Ryan, 1995). Basic psychological needs, according to Ryan (1995), relate to critical psychological 'nutrients' and contribute to motivation and self-determined behaviour. This theory identifies three fundamental psychological needs that, if met, shape human motivation and behavior. These are (a) *Autonomy*, which is the urge to experience agency, control, and decision-making capabilities in one's choices and actions, (b) *Competence*, which is the requirement to feel skilled, capable, and effective in reaching one's intended results, and (c) *Relatedness*, which is the urge to experience a sense of belonging, mutual respect, and appreciation (Ryan & Deci, 2000). When an individual can manage these components in equilibrium, he/she becomes intrinsically motivated. These components, combined, form intrinsic motivation, which spearhead an individual's behavioural engagement.

Against this backdrop, the researcher sought to zoom in on the motivation behind new or changed behaviour i.e. shift to teletherapy, by psychotherapists. As the global society experienced COVID-19 lockdowns, many psychotherapists shifted to teletherapy. The area under investigation here focuses on the motives behind their shifts, as well as their experiences in doing so.

## **Method**

### **Study Design**

A rapid review design was used, during which some of the components of a systematic review process are utilized to answer a focused research question (Smela et al., 2023). Compared to other types of reviews, a rapid review consists of scope limitations and involves a narrower, more focused search strategy, helping to make quicker deductions and produce information in a timely and reliable manner. Challenges include the reality that data gathering may not be as comprehensive as with a systematic review (Watt et al., 2008).

A rapid review was used in this study due to the focus on ‘motivation’. Since there has already been research published on the experiences and challenges in the shift to teletherapy, the present study attempted to gain an understanding of psychotherapists’ motivations in opting for the teletherapy approach during COVID-19.

### **Search Strategies and Study Selection**

The study followed the 8-step framework outlined by Du Toit and De Klerk (2022). Stage One included stating the aim of the review and formulating the research question. Stage Two set the eligibility or inclusion and exclusion criteria. Only articles with full text availability, qualitative, peer-reviewed studies, published between 2020 and 2023 were included, while articles published before 2020 and unpublished or grey literature were excluded. In Stage Three, the search strategy included accessing the following databases: EBSCOhost, PubMed, APA PsycArticles, APA PsycInfo, MEDLINE with Full Text.

The following search terms and phrases were used to identify relevant articles: “psychotherapy” OR “counselling” OR “therapy” AND “online” OR “e-therapy” OR “teletherapy” AND “experiences” AND “psychotherapist” OR “mental health worker” OR “mental health professional” OR “psychologist”. Throughout this manuscript the more generic term “psychotherapist” is used for ease of reporting, and also because it is a term used in several countries where the research studies had been conducted. Stage Four screened and selected literature, looking for studies that were pertinent to the purpose, research question, eligibility requirements, and keywords. In Stage Five the included literature was tabulated using the following characteristics: authors, title, date of publication, country of study, participants, outcomes and findings/results.

Two steps were taken in Step Six to ensure high quality and reduce the risk of bias: first, the Joanna Briggs Institute's - JBI Critical Appraisal Checklist for Qualitative Research was used to assess the reliability, relevance and findings of selected articles (Lockwood et al., 2015; The Joanna Briggs Institute, 2017). Second, a verifying examination of the selected articles was done by the study supervisor to provide a further level of independent assessment and enhance the credibility of the findings. In Step Seven the data was analysed using thematic analysis (Braun & Clarke, 2006).

This review followed a deductive based approach wherein thematic areas were predetermined based on the theory (Nowell et al., 2017). The two authors read each piece, then developed the thematic areas by following the methodical process outlined by Braun and Clarke (2006). Stage Eight highlighted the limitations of the rapid review, which included the unavailability of full-text articles in some cases, possible bias during data collection and analysis stages, and the possible exclusion of articles that should have been included. Despite these possible limitations, the researcher attempted to enhance reliability by having the study supervisor examine inclusion appropriateness.

### **Ethical Considerations**

Ethics clearance for this research was received from the General/Human Research Ethics Committee (GHREC) at the University of the Free State. Since the research involved secondary data without human participant involvement, no further ethics clearance was required. Although this review did not require human participants and ethical risks were lower, the researchers was cognisant of ethical considerations in rapid reviews. As a result, the researchers ensured that biases were not intentionally introduced into the process of gathering and analysing data. Additionally, to ensure ethical integrity, the researcher collaborated with her research supervisor to ensure a process of triangulation in the research.

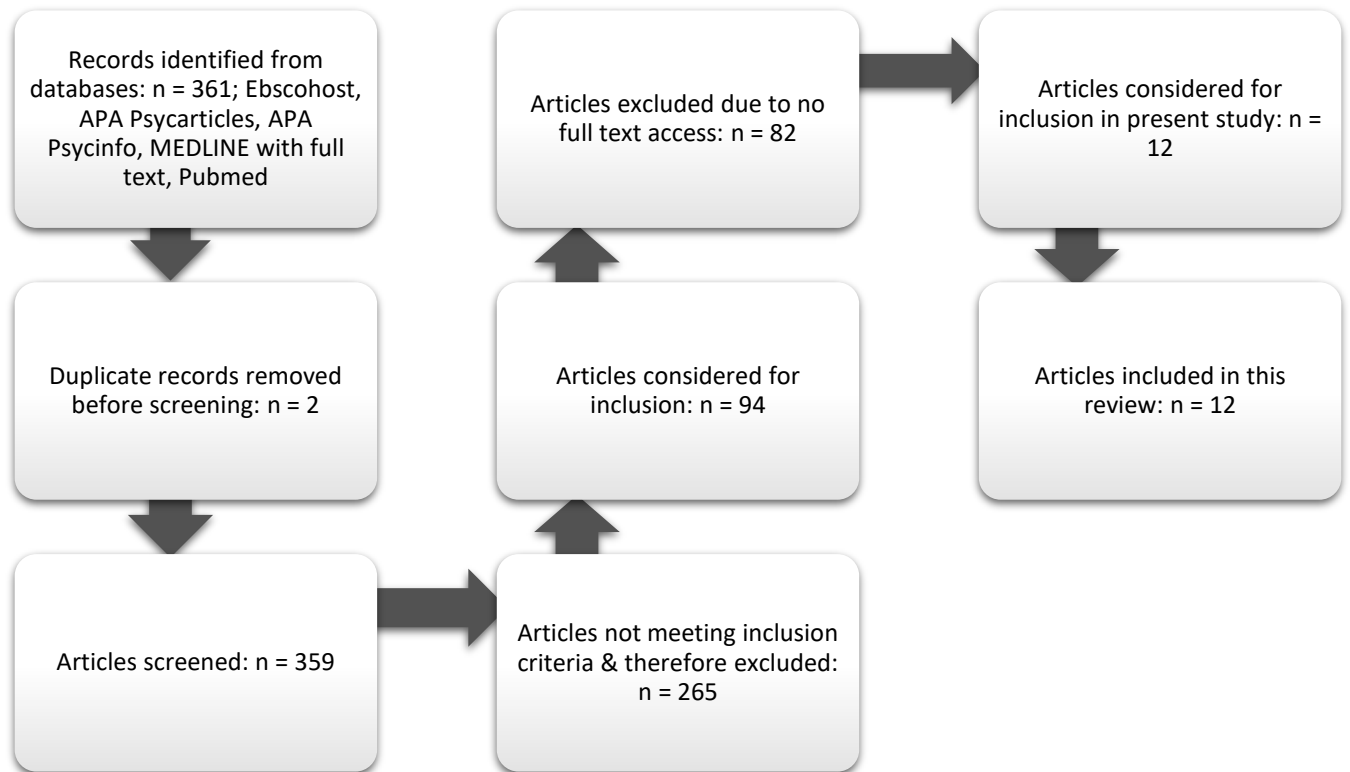
## **Findings**

A description of the articles as well as their relevance to the research question is presented below.

### **Description of the Sample and analysis**

An initial cohort of 361 articles was identified but, as illustrated in Figure 1 below, duplicates, full-text non-availability and other exclusion criteria resulted in 12 final acceptances (see Table 1). Appendix C provides further details for each of the articles.

Based on this research process outlined above, the researcher began with a set of codes derived from the self-determination theory on which the present study was foundationed. In the initial phase of the analysis process, deductive (closed) coding was used whereby the researcher created codes according to the SDT, more specifically the basic psychological needs theory which is regarded as one of the six mini-theories embedded in the SDT (Deci & Ryan, 2008) (see Appendix E). As the analysis progressed, additional open coding was done in response to interesting and impactful observations noted within the data. Table 2 illustrates how the primary codes that were developed from the articles fed the sequential development of secondary and tertiary codes which finally informed the themes.



**Figure 1: Flow diagram for data collection**

The 12 articles finally selected were conducted in the USA (5), Netherlands (2), Sweden (1), Australia (1), United Kingdom (1), Scotland (1) and Ireland (1). The methods used in these studies included empirical research (11) and therapists' reports (1). Most studies involved psychologists offering psychotherapy. Table 1 summarizes the results from the 12 articles.

**Table 1: Summary of studies**

No.	Authors and Date	Study Context	Purpose of Article/ Results	Target Population	Participants	Data Collection
1	Fish, J.N., & Mittal, M. (2021)	USA	Experiences offering mental health care during the early months of the pandemic in the United States	US-based mental health care providers	137 mental care health providers	Survey including 5 open-ended response questions; administered (n = 137)
2	Mittal, M., Morgan, A.A., Du, J., Jiang, J., Boekeloo, B., & Fish, J.N. (2023)	USA	Understanding mental health care providers experiences of living and working as clinicians in June and July 2020	U.S.-based licensed mental health care providers	136 mental health care providers	Open-ended questions
3	Wade, B. (2020)	USA	A personal account of discomfort experienced by a psychotherapist working in a hospital for acute and chronic MHCU's	U.S. based mental health providers	1 mental health care provider	Personal account
4	Werbart, A., Jonsson, M., Jankowski, B., & Forsström, D. (2023)	Sweden	Therapists' longer-term experiences of remote psychotherapy after this transition	European based mental health providers recruited via Facebook	10 mental health care providers	Semi-structured interviews
5	Kotera, Y., Kaluzeviciute, G., Lloyd, C., Edwards, A.M., & Ozaki, A. (2021)	USA	Explore perception towards online therapy from the therapist perspective, and offer suggestions for future therapeutic practice	Licensed and qualified psychotherapists' work conducted in California, the United States (US)	9 mental health care providers	Semi-structured interviews
6	Griffith, B., Archbold, H., Berruga, I.S., Smith, S., Deakin, K., Cogan, N., Tanner, G., & Flowers, P. (2023)	Scotland	Frontline experiences of delivering remote mental health support during the COVID-19 pandemic	Mental health care workers associated with NHS health board in the West of Scotland	20 mental health care providers	Online semi-structured interviews

7	Bierbooms, J., van Haaren, M., IJsselsteijn, W.A de Kort, Y.A.W., Feijt, M., & Bongers, I.M.B. (2020)	Netherlands	Exploration of the Integration of Online Treatment Into the “New Normal” in Mental Health Care in Post–COVID-19	Psychotherapists working in a mental health care organization in the Netherlands	11 mental health care providers	Semi-structured interviews
8	Downing, L. (2021)	Australia	Telepsychology brought about new relationalities between therapists and their patients during the COVID-19 pandemic	Solo-practice psychologists’ in Melbourne, Australia	50 mental health care providers	Online survey
9	Feijt, M., de Kort, Y., Bongers, I., Bierbooms, J., Westerink, J., and IJsselsteijn, W. (2022)	Netherlands	Practitioners’ Experiences of Providing Mental Health Care during COVID-19	Practicing mental health care professionals (82 percent female, 18 percent male) working in Netherlands with an average age of 38 years	51 mental health care providers	Online qualitative survey
10	Reilly, K., Maher, M., Smith, E., Coyne, E., Murphy, S. & Wilson, C. (2022)	Ireland	Exploration of psychologists' experiences of teletherapy within the Irish Public Mental Health System	Clinical and counselling psychologists employed in the Health Services	15 mental health care providers	Semi-structured interviews via telephone
11	Linardi, N., Herrera, C. & Cacace, C. (2021)	USA	Non-profit organisation’s experiences of Teletherapy during COVID-19	Community-based agency clinicians	20 mental health care providers	Survey
12	Brandon, L. & Fragkiadaki, E (2023)	UK	Experiences and resilience of private clinicians in England moving to teletherapy	Local private clinicians	5 Mental health care providers	Semi-structured online interviews

## Findings: Themes and sub-themes

**Table 2: Code Generation and Themes**

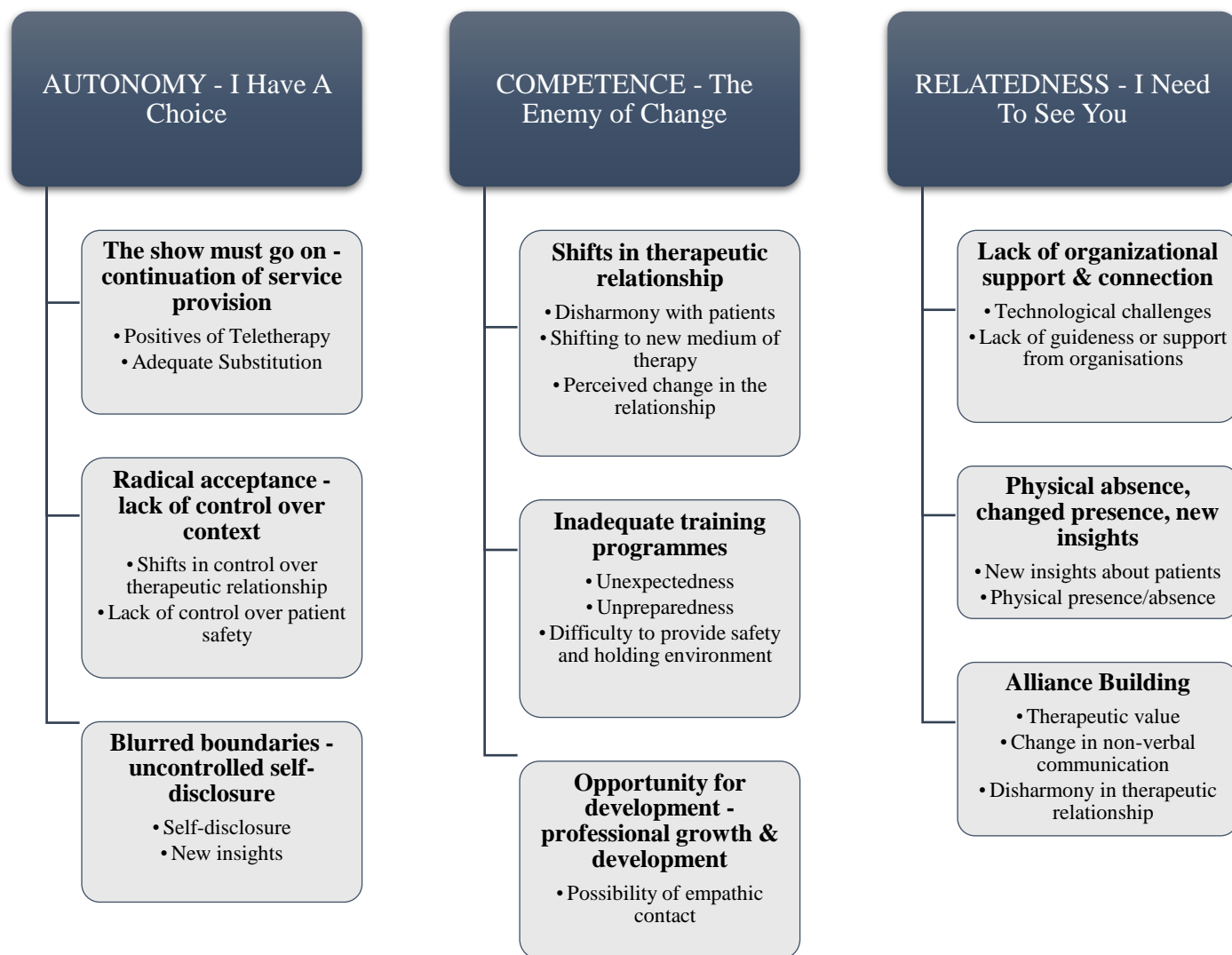


Table 3 presents the three major themes identified from the data, as well as the sub-themes comprising each theme.

**Table 3: Themes and sub-themes**

<p>Theme A: AUTONOMY - I Have A Choice</p>	<ul style="list-style-type: none"> <li>• The show must go on - continuation of service provision</li> <li>• Radical acceptance - lack of control over context</li> <li>• Blurred boundaries - uncontrolled self-disclosure</li> </ul>
<p>Theme B: COMPETENCE - The Enemy of Change</p>	<ul style="list-style-type: none"> <li>• Shifts in therapeutic relationship</li> <li>• Inadequate training programmes</li> <li>• Opportunity for development - professional growth &amp; development</li> </ul>
<p>Theme C: RELATEDNESS - I Need To See You</p>	<ul style="list-style-type: none"> <li>• Lack of organizational support &amp; connection</li> <li>• Physical absence, changed presence, new insights</li> <li>• Alliance building</li> </ul>

### ***Theme A: Autonomy: I have a choice***

The first theme focuses on the autonomy psychotherapists had in deciding to continue providing therapy during the COVID-19 lockdown. This is a psychological need which is fundamental to BPNT, and is important for an individual to become intrinsically motivated. Autonomy, in this context, refers to clinicians having a choice in their behaviour and goals. Despite the uncertainty and anxiety faced during the COVID-19 lockdown, psychotherapists had the ability to choose to continue service provision using teletherapy.

#### ***A.1 The show must go on – continuation of service delivery***

This subtheme refers to psychotherapists deciding to continue service provision despite the emergence of COVID-19. Psychotherapists experienced feelings of anxiety and uncertainty regarding the move to teletherapy as evidenced in Article 3, “... *What kind of therapist am I? I should be practicing what I preach. I’m so self-critical. I should be gentle with myself. Maybe I should meditate. For those who have ever looked at their therapists and wondered how they were*

*so high functioning, I'll let you in on a secret: We are not.*” (Wade, 2020). This is further confirmed by Article 1, *“Mental health providers are also not impervious to personal challenges, loss, and stressors related to the pandemic, which are compounded by their responsibility to hold space for their clients on these very same issues”* (Fish & Mittal, 2021). Similarly Downing (2021) noted in article 8 *“the COVID-19 crisis puts us in tension with our own corporeality and demands that we perpetually reassess and confront issues of uncertainty, risk and trust in our day-to-day social interactions”*. However, Reilly et al. (2022) identified an important motive within the context of choice and autonomy. They found that psychotherapists became *“...desensitised to the crisis ‘in order to survive’...”* (Article 10). Another participant in that study was motivated towards teletherapy because *“they felt they could not ‘leave these people with no support’”*. Also, the revelation by a participant in article 5 *“I feel really grateful that I can keep working”* sums up the intrinsic motivation in the context of the personal hardships that were obviously experienced by psychotherapists at the start of the pandemic (Kotera et al., 2021)

### ***A.2 Radical acceptance - lack of control over context***

Even though psychotherapists had felt little control over how the transition to teletherapy would turn out, there was a sense of acceptance. The radical acceptance speaks to the motivation to make the shift to teletherapy, because the alternative was not ideal, given the lockdown, COVID-19 and the likely dangers associated with in-person consultations. Article 10 referred to this transition as *“the baptism of fire”* because of the anxious uncertainty and limited control that faced them, but also the need to accept and adjust to the situation (Reilly et al., 2022). Similarly, in article 2, Mittal et al. (2023) cited a psychotherapist focusing more on the positive consequences of the lockdown (for example, not having to commute to work) *“... rather than the ambiguity of the situation and the lack of control.”* However, article 10 noted the concern of psychotherapists regarding clients having greater access to their emails and mobile devices and *“...things that I wouldn't have given to clients routinely before’, as participants need alternative ways of contacting their clients should the call drop.”* It was clear that psychotherapists felt they had little choice but to accept the COVID-19 situation with the teletherapy transition as an almost inevitable way forward.

### ***A.3 Blurred boundaries - uncontrolled self-disclosure***

A major concern in the transition to teletherapy has been the virtual opening up of psychotherapists' and clients' home environments to the other, thus crossing the line that traditionally characterised the psychotherapy relationship. However, article 3 by Wade (2020) revealed a psychotherapist's insight into the opportunity to learn to modulate the dose of self-disclosure. The article quotes the participant stating "*I have since come to understand that a healthy dose of self-disclosure is an invaluable tool in building transformative therapeutic relationships.*" Participants also appear to have found the transition beneficial, as Werbart et al. (2023), in article 4 stated "*I've probably been even more open and transparent with my thoughts and concerns with her just based on the technology*". Although boundary and self-disclosure issues are concerning, these articles suggest that the transition has not necessarily had a negative impact in this respect. It has also been shown that the transition to teletherapy, necessitated by the pandemic, has enabled psychotherapists to develop a greater awareness of the extent of self-disclosure and boundary blurring. This was evidenced in the findings of Mittal et al. (2023), in article 2, where a participant stated "*...I'm worried that I may be inappropriately disclosing with clients. I haven't, but [I am] concerned about possibility*" (Mittal et al., 2023). These findings show that teletherapy may have made psychotherapists more aware of the issue of self-disclosure that they previously considered.

### ***Theme B: Competence: The Enemy of Change***

One of the prominent themes emerging throughout this review was the feelings of incompetence within the context of the suddenly changing work environment. Fundamental to BPNT, competence is a basic component for an individual to become intrinsically motivated. As a result, the initial transition to online psychotherapy placed a spanner in the works for clinicians' ability to be effective in psychotherapy. Many clinicians reported anxiety, unpreparedness and concern about the evidence-base for online therapy, resulting in hesitancy.

### ***B.1 Shifts in therapeutic relationship***

Research literature over the decades highlighted the substantial impact of the relationship on therapeutic efficacy (Stubbe, 2018). With the shift to teletherapy, many psychotherapists were

concerned about how to facilitate a strong therapeutic relationship without being in the same room and also without being able to see the patient's body language. Werbart et al. (2023), in article 4, reported that many psychotherapists shared a concern about the relationship, noting "... *as if psychotherapy at a distance gave rise to increased distance in the therapeutic relationship...*" Similarly, another area of concern regarding competence and the therapeutic relationship emerged with psychotherapists feeling anxious about patient's safety given the distance between them and their patients, as noted in Article 12 (Brandon & Fragkiadaki, 2023). Considering the relationship, safety concerns and the increased distance created in the virtual therapeutic relationship, psychotherapists felt motivated to compensate with alternative strategies and techniques as evidenced in the findings of Downing (2021) in article 8. They noted that psychotherapists shifted to "*relying on exaggerated facial expressions rather than body gestures in order to account for the limitations of the screen*". It is clear that while the teletherapy context was initially perceived as hampering the relationship, psychotherapists developed additional competencies to mitigate the perceived challenges at the relationship level.

### ***B.2 Inadequate training programmes***

With the emergence of COVID-19 and the lockdown, psychotherapists found themselves scurrying to learn the teletherapy approach while continuing service provision and patient care. In this context, article 5 highlights psychotherapists feeling inadequately trained in teletherapy, with one stating "*[Online therapy] was not part of my master's programme or my supervision. It's something that I've learned more about, now that I'm doing it...*", revealing the motivation to learn. While navigating their own anxieties and practicing in an ethical manner, psychotherapists identified further training inadequacies, for example their previously heavy reliance on observable nonverbal communication from patients. Article 12 states that the "*absence of nonverbal communication and the lack of a designated safe space for therapy were identified as challenges participants faced with the changes to mental health provision. Yet, practitioners spoke of solutions to maintain a therapeutic space...*" (Brandon & Fragkiadaki, 2023). The latter section of this quote also revealed participants' motivations to learn and develop new competencies to enhance their effectiveness in the novel teletherapy approach. Another example is given in article 5 wherein a participant disclosed "*Similarly, I wish I have been taught the ground rules more from the beginning to asking about the address, you know,*

*those tips like: make sure you check with the clients that they're in a private space, that they do not have any distractions, even other screens, phones, things like that...*" (Kotera et al., 2021). While this may seem quite obvious, these practical steps have been highlighted in the articles.

### ***B.3 Opportunity for development - professional growth and development***

Although this was a time of distress and uncertainty, Werbart et al. (2023) noted that psychotherapists reported feeling motivated to transition to teletherapy as it *"triggered their creativity and they adapted to the new circumstances, finding new ways of working, developing new skills, and learning how to calibrate the therapeutic distance in remote sessions"* (Article 4). It was also evident in article 9 that *"As many practitioners were first-time users of online treatment tools, ... the technological skill set of practitioners will probably become more sophisticated..."*, suggesting that despite being a new technique, psychotherapists felt motivated to develop their online therapy skills (Feijt et al., 2020). This aspect was also emphasized in article 7, where Bierbooms et al. (2020) found that, despite their initial reluctance, psychotherapists came to realise *"that much more is possible in online treatment than what they had initially expected"*, thus strengthening the motivation to integrate teletherapy into their daily practice.

### ***Theme C: Relatedness: I Need to See You***

With the sharp increase in COVID-19 cases, and the lockdown forcing physical distancing, the move to teletherapy was a decision made during the early stages of the pandemic. As humans are inherently social beings, this came as a serious challenge to traditional ways of conducting psychotherapy.

#### ***C.1 Lack of organizational support***

Given the changed requirements for conducting psychotherapy, practitioners needed support from their organisations in order to provide patient care. This is evidenced in the findings of Reilly et al. (2022), in article 10, that *"...psychologists themselves feel uncontained from being insufficiently supported..."*. However, seeing the greater need for mental health services during COVID-19 provided the motivation for psychotherapists to persevere. This was despite the

disconnect that psychotherapists reported in relation to their organisations, as cited in article 6, feeling as though “*a bomb going off underneath us*” (Griffith et al., 2023). Similarly, in Article 11, psychotherapist participants highlighted the “*challenges related to privacy, distractibility, outdated technology, efforts to teach clients how to use the platforms ...*” (Linardi et al., 2021). As a result of the lack of support received, poor technological infrastructure and faulty network connections were noted to be at the forefront of the challenges experienced by psychotherapists. For example, Feijt et al. (2020) in article 9, noted that “*some practitioners reported to lack sufficient support from their organization to help them work with the available software or devices, and guidelines about which tools meet privacy regulations...*”. This is quite a serious finding because it speaks to practitioners having to render a health care service without being provided with the necessary tools.

### ***C.2 Physical absence, changed presence and new insights***

Teletherapy ushered in a new format characterised by a lack of physical presence and immediate proximity within the therapeutic dyad. However, as Reilly et al. (2022) noted, in article 10, some psychotherapists felt that “*... the perceived absence of boundaries in teletherapy makes them feel ‘freer’ and can enable them to ask questions that they would not normally ask in person...*”. This appears to have generated a motivation to be less guarded and more open in facilitating the relationship. Similarly, it emerged in the data (article 12) that “*the participants and clients were on an equal status, and the notion that this “humanised” the practitioner...*” was evident (Brandon & Fragkiadaki, 2023). A further advantage cited by psychotherapists, in article 9, was stated as “*...the ability to see more of the clients’ home environments and their behavior outside the therapy room, which can lead to new information that is valuable for treatment.*” (Feijt et al., 2020). It was also noted that the teletherapy format could be “*advantageous for specific conditions such as anxiety disorders, as it increased accessibility*” (Brandon & Fragkiadaki, 2023; article 12). These perceived advantages appear to have motivated psychotherapists to engage and continue the teletherapy format after initial trials. From the articles, it became clear that while screen-based therapy impacted the therapeutic relationship, it was not completely negative – psychotherapists and patients appeared to negotiate this electronic medium reasonably successfully, given the challenges of the time.

### ***C.3 Alliance building***

Progress in psychotherapy is dependent on the strength of the therapeutic relationship and heavily influenced by the alliance that develops between the therapist and patient. This view was evidenced in article 7 by Bierbooms et al. (2020) who found that “... *a number of professionals and clients perceive regular face-to-face treatment as the only way to create a therapeutic alliance.*” Although the shift to teletherapy appeared to threaten the building of the therapeutic alliance, the research findings seem to also suggest otherwise. For example, article 12, by Brandon and Fragkiadaki (2023) noted that “*participants found themselves on equal terms with their clients, sitting together and sharing the reality of the pandemic. It appears that as a result, they found that it deepened and strengthened the therapeutic relationship*”. Given the role that power dynamics plays in a therapeutic relationship, it is interesting to note the findings of article 4 by Werbart et al. (2023), who noted that “*The new ways of interacting affected the relational dynamics and led to changed patient and therapist roles, as well as an altered power balance in the therapeutic relationship.*” The motivational influences evident in the latter two quotes which speak to successful outcomes are themes that have appeared in the articles examined, alongside the few that initially viewed teletherapy in a negative manner.

## **Discussion**

The purpose of the study was to understand how self-determination influenced psychotherapists’ motivation for and experiences of the adaptations they made in shifting to online psychotherapy provision during the COVID-19 restrictions. The findings presented above reveal several aspects of psychotherapists’ motivation to shift to the teletherapy modality and their experiences in the process, which can be understood within the SDT, and more specifically the BPNT constructs of Autonomy, Competence and Relatedness.

The issue of Autonomy is an interesting one in the context of the COVID-19 lockdown and human behaviour, because at a macro level, citizens’ autonomy was largely taken away from them, especially regarding freedom of movement and related aspects of physical and social contact. However, at a micro level there were certain decisions that could be taken by individuals, for example, the decision to shift to teletherapy to avoid physical contact in traditional in-person consulting. Thus, we see the self-determined shift by psychotherapists

which ultimately facilitated positive growth and change during the time of crisis. Moreover, it is evident that the basic psychological needs (namely continuing to work and provide mental health care) were also addressed in this cognitive and behavioural shift made by many psychotherapists in the time of the pandemic (Deci & Ryan, 2012). The finding in Article 3 speaks to therapists' autonomous consideration of the situation and their own role in patient care, even reflecting self-critically on the need to provide mental health care to others (Wade, 2020). It is encouraging to note the concern expressed for patients' wellbeing, even though the pandemic period instilled fear in health practitioners, as well. Clearly, psychotherapists had to balance their fears for their own (and their family's) safety with their professional obligations to their patients. They had to evoke their abilities of self-determination by making critical decisions that addressed the basic needs their patients as well their own/ family lives (Deci & Ryan, 2012; Ryan, 1995). Perhaps the findings of Reilly et al. (2022) explains the psychological mechanism involved in their ultimate motivation and decision-making regarding the shift to teletherapy. In becoming desensitised to the COVID-19 situation they were able to survive, obviously in both a literal and metaphorical way. There was also a financial motive, because, understandably, psychotherapists needed to practice in order to earn a salary. As Kotera et al. (2021) noted, psychotherapists were grateful that they could keep working. Thus, we see the dual motives of self-benefit as well as professional obligations of delivering care, which fits within the Self-Determination Theory and the BPNT (Deci & Ryan, 2012; Ryan, 1995).

The concept of radical acceptance is also an interesting decisional process in the context of motivation to change, making it clear that even though there is anxiety and reluctance regarding change, psychotherapists realised that there is little choice, and the motivation to change grew out of that mindset. In this context, as we learned from Aaron Beck's (1976) work, that led to the development of cognitive-behaviour therapy, the ability to focus on the positives in any situation can be helpful in motivating our decision to change our behaviour. The opportunity to work from home and not commute to the office or other place of work, as noted in the Mittal et al. (2023) article, was one of the positive ways in which psychotherapists viewed the shift to teletherapy, and which provided the required motivation.

While some psychotherapists felt the screen views of each other was a level of self-disclosure that made them uncomfortable and opened their personal lives to scrutiny by patients, others saw this as an opportunity to facilitate autonomy, to get a better understanding of their patients'

lives, while also arguing that a healthy level of self-disclosure was good (Wade, 2020). Still others reported that the virtual platform resulted in them being more transparent and open in expressing their thoughts to patients (Webart et al., 2023). Clearly, there was mixed reaction to the potential blurring of lines and self-disclosure, but many psychotherapists managed this in a positive manner and made it work for them. It is important to remember that a basic need and requirement in the professional practice of psychotherapy is having close contact with patients while also respecting personal boundaries - it appears that many psychotherapists appeared to have made the transition work for them in this respect.

*Competence* was raised as an experiential and motivational issue because psychologists and psychotherapists are highly trained mental health care practitioners, and the sudden shift to conducting teletherapy was obviously unsettling to them, especially regarding the quality of the therapeutic relationship and the technology (Bierbooms et al., 2020; Stubbe, 2018). Increased concern about patient safety, since they were physically distant, is a real concern, especially in the case of suicidal or other high-risk patients (Brandon & Fragkiadaki, 2023). However, some psychotherapists were able to mitigate this concern by developing ways of focusing more intensely on facial expressions than body gestures, which were no longer visible due to on-screen limitations (Downing, 2021). These experiences suggest a level of competency, innovation and positive adaptation to the new context, which is really what the COVID-19 pandemic required of us. This is another example of self-determination in the psychotherapists who made shifts to adjust to the changing environment while still addressing the basic needs of their patients (Deci & Ryan, 2012).

Unfortunately, the basic training of psychotherapists has not generally included focus on teletherapy and the related technology issues which, therefore, made practitioners anxious about embarking on the approach (Kotera et al., 2021). This points to the need for training programmes to re-orientate towards hybrid forms of consulting, because that is likely to be a future scenario. The early (pre-COVID-19) development of teletherapy guidelines by the Psychological Society of South Africa was an important pre-emptive step in this direction (Evans, 2018). However, much more is required if we have to adequately prepare for the next pandemic, which must be considered a future reality.

Notwithstanding the concerns over basic training deficiencies regarding online consulting, this rapid review highlighted the resilience in psychotherapists who used the lockdown

restrictions as an opportunity for professional growth and development (Webart et al., 2023). This has been a positive finding because patients with mental health problems are vulnerable individuals depending on practitioners to find a way to help them, despite the challenges of the time. It was also evident that in the context of being relatively unskilled in the teletherapy modality, many psychotherapists felt motivated to develop their online skills, despite their initial guardedness (Feijt et al., 2020). The narratives regarding competency issues by psychotherapists reflect an experiential finding as well as a motivational one in certain instances.

The need for *Relatedness*, which is fundamental to the BPNT, was a recurring theme through the review findings (Ryan, 1995). A particular example was the psychotherapists' feeling of disconnect and inadequate support from their organisations. Despite the dissatisfaction with the lack of support, the practitioners persevered in their attempts to provide therapy to their patients, thereby reflecting their motivation as rooted in the professional ethics and concern about their patients (Feijt et al., 2020).

At the level of the therapeutic relationship, although some psychotherapists expressed concerns about creating or maintaining a sense of relatedness through the therapeutic relationship online, others found that the changed boundaries and virtual environment made them feel less restricted in probing certain areas (Reilly et al., 2022). The increased visual access of patients' home environments was also viewed by some therapists as enhancing their understanding of their patient's lives (Feijt et al., 2020). These perceived advantages could be motivating factors influencing the continuation of teletherapy and ultimately contributing to their self-determination to continue service provision using the online format. The findings of the Brandon and Fragkiadaki (2023) research are useful in that they reflect on how COVID-19 had a levelling effect on the status of psychotherapists and patients, and served to help patients view their therapists as human, with ordinary vulnerabilities. Considering the value of the relationship in therapeutic efficacy, this must be viewed in a positive light (Stubbe, 2018). The relationship is strengthened by patients' and therapists' shared experiences of the pandemic because they were all going through the same crisis, thus altering the traditionally held ideas about the power balance in the therapeutic relationship (Brandon & Fragkiadaki, 2023; Werbart et al., 2023). For psychotherapists who do not want to hold all the power in the therapeutic relationship, these shifts provide the motivation to work in, and even prefer this online format.

## Conclusion

The researcher undertook a rapid review, using the Self Determination Theory, and more specifically the Basic Psychological Needs (sub)Theory, to understand the motivations and experiences of psychotherapists making the shift to teletherapy during the COVID-19 pandemic. The findings noted psychotherapists' struggles with the loss of *autonomy* and decision-making as the first identified theme. However, the evidence showed that most clinicians adapted to the situation to make things work, thus regaining a sense of autonomous decision-making. They also used the shift to attain personal and professional growth, which connects with the second major theme, namely *competence*. Feeling less competent to manage the online therapeutic relationship was a significant concern, and inadequate training for online therapy was a prominent sub-theme. With the lockdown forcing the shift onto them, clinicians did their best to adjust and work with, rather than against, the prevailing conditions. The final theme emerging was *relatedness*, which is fundamental to the way psychotherapists work. Insufficient organisational support came through strongly for psychotherapists working in such settings. However, the shared feelings of anxiety regarding the uncertainty of COVID-19 seemed to have a bonding influence between the patient and therapist, and perhaps enhanced the therapeutic alliance, given that they had equal struggles in that respect. In summary, the reviewed literature showed that, despite the challenges, psychotherapists adapted to the online therapy shift that COVID-19 necessitated.

## Limitations

A limitation in this study is the limited research on psychotherapists in global South countries and their motivations and experiences of transitioning to online psychotherapy in the face of a pandemic. Given our geopolitical context, it is important that we understand the challenges and successes experienced in these countries. In under-resourced countries, findings may reveal challenges faced by psychotherapist's in transitioning to teletherapy. This may be due to factors such as poor infrastructure and in some cases poor government and/or organisational support to facilitate this transition. While many psychotherapists in the global North were able to transition despite these challenges, many psychotherapists in the global South may not be able to make this transition primarily due to socioeconomic, infrastructural and political factors (Dodoo et al.,

2021). As a result, autonomy within BPNT may not be facilitated, competence may not be nurtured or encouraged while relatedness may be compromised in a way that may motivate psychotherapist's self-determination to cope with the challenges (Deci & Ryan, 2012; Ryan, 1995). Another limitation in this study was that several articles had to be excluded due to the inability to access the full-texts. A further limitation includes the insufficient exploration of the negative consequences of adaptation to the transition to teletherapy. While adaptation is necessary and beneficial, the consequences of this adaptation need to be explored further.

### **Practical Implications**

Similar to the work of Fish and Mittal (2021), this rapid review showed that while psychotherapists adapted to the difficult circumstances, it is evident that further training and development are needed to enhance teletherapy work. Similarly, rigorous planning is needed for technological support, capabilities and network stability, to ensure that all sectors of the population are able to receive mental health care.

In promoting training programmes, we cannot neglect focus on improving organisational and peer support. This is critical to preventing clinician burnout and to ensure that an appropriate and supportive milieu is created for psychotherapists to provide the levels of congruence and warmth that Carl Rogers (1961) advised. Finally, it is important for psychotherapists to be aware how these three needs can influence self-determined behaviour, depending on whether or not they have been met.

### **Recommendations for future research**

Through this research process, significant gaps were identified that should be explored. Research studies included in this review were conducted mainly in global North countries. Little to no research regarding psychotherapists' motivations to shift to teletherapy has been conducted in the global South, specifically Africa, and especially in public health facilities catering to less fortunate communities. It is crucial that research conducted in local contexts is used to identify challenges and inform appropriate policy development. Evidence has shown that clinicians in

public sector facilities in South Africa struggled with access to the required technological support during COVID-19, seriously disadvantaging already deprived communities (Pillay & Kramers-Olen, 2021).

### **Author Contribution**

Indira Pillay undertook this study as part of the requirements of her Master of Social Science degree in Clinical Psychology and wrote the first draft of the manuscript; Dr Nel supervised the Masters project, assisted with the conceptualisation, methods and analysis, and edited the drafts of the paper.

### **Declarations**

The authors declare no competing interests with regard to this research.

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### **SECTION 3: CRITICAL REFLECTION AND CONCLUSION**

This section provides a critical reflection on the process of conducting this rapid review research study, for the partial fulfilment of the Master of Social Science Degree in Clinical Psychology.

#### **Critical Reflection on the Research Process**

During the research process, the researcher had both positive and negative experiences. Positives included the transition through ethics clearance into the data collection. Since this research involved secondary data collection, there were very few challenges experienced in the ethics clearance process. The researcher was able to respond to and rectify concerns quite easily following feedback from both the departmental and institutional ethics committees. However, ensuring that the data collection and analysis were conducted in a trustworthy and credible manner took a concerted effort, with the researcher making sure to bracket out personal thoughts on the subject and avoid contamination. This was done to the researcher's best ability under the close guidance of her supervisor.

Hurdles experienced in the research process included, the difficulty in accessing articles due to full-text unavailability. This challenge was perhaps the most significant since the limited access to articles meant that some of the research studies, which might have benefitted the review, could not have been included. Despite this, the researcher was able to gain access to 12 articles that met all the inclusion criteria and were equally relevant to this study. A further challenge, perhaps a result of being a novice researcher, was to occasionally go back to the research aims and the theoretical framework, to ensure that the aims were being met and the coding was conducted correctly. Hiccups did occur but, with supervision, the researcher was able to keep on track and ensure the trustworthiness of the study.

#### **Data Collection**

Data was collected using the rigorous procedures necessary to conduct a rapid review. These procedures assist in understanding the process and reflecting on progress at the end of each step. It provided structure in conducting the research study, which was needed as this was the first

occasion that I undertook a rapid review study. To complete this rapid review, the steps proposed by Onwuegbuzie and Frels (2012), as cited by Du Toit and De Klerk (2022), were followed. The first step was stating the aim of the rapid review and formulating the research question. Next, setting the eligibility criteria was done with regards to the inclusion and exclusion criteria. The third step involved formulating the search strategy which included sifting through a large number of articles for relevant and appropriate data. When this was done, the included articles were verified by my research supervisor, Dr L Nel, and articles that did not entirely meet the inclusion criteria were excluded. To ensure that only relevant, high-quality studies were chosen, the Joanna Briggs Institute scientific appraisal tool was used. This tool assisted in assessing the reliability, relevance and outcomes of included articles (The Joanna Briggs Institute, 2017).

### **Data Analysis and Interpretation**

Once the appraisal process was completed, I began the analysis, which was a daunting process that took longer than expected. I chose to use Thematic Analysis as the analytic tool, as set out by Braun and Clark (2006), which looks at identifying, examining and discussing patterns common across data samples. During this process, discussions occurred between my supervisor and me to ensure that themes were not ignored and all the important areas were addressed. During this process of analysis and interpretation, I experienced challenges in making sure not to over-interpret and to ensure cognitive and researcher bias did not filter into the interpretation stage of the research. The Thematic Analysis approach was helpful as it focused on identifying overarching themes applicable across the articles, as opposed to identifying solely lived experiences. A challenge faced during this stage of the research process was encountered while using a deductive analysis approach. In order to ensure researcher bias does not filter through this study, the researcher and her supervisor ensured that data collected was not analysed prematurely so as to fit the Basic Psychological Needs Theory (BPNT). Rather, analysed data was agreed upon by both the researcher and her supervisor.

## **Strengths and Limitations of the study**

Through this research process, a few key strengths were evident. The first is that the rapid review approach is an efficient, time-saving and cost-effective type of review. While acknowledging my naivety in time management, it is interesting to reflect on how ‘rapid’ this review process can be, producing information in a timely manner. Exploring the transition to teletherapy in the manner that we did, allows the reader to reflect on psychotherapists’ experiences of the shift to teletherapy and the factors that influenced the decision to make the transition. At face value, it may be over-simplistic to believe that the motives were solely for financial gain, but unpacking the narratives in the research articles reviewed, the findings revealed the care and concern that psychotherapists had for their patients’ wellbeing, as well as the ways in which they discharged their ethical and professional obligations.

Additional strengths of this study include the understanding that when placed in distressing circumstances such as the COVID-19 pandemic and lockdown, psychotherapists were able to look at the positives and find innovative ways to overcome the challenges. They added and developed new skills to their existing repertoire, and worked towards ensuring that the essence of the therapeutic relationship was not lost.

Limitations of this study include not having access to many full text articles which may have provided ‘thicker’ descriptions and understandings of the experiences and motivations of psychotherapists. Additionally, the possibility of researcher bias filtering into the review process must be considered. While it is understood that rapid reviews are a shortened, expedited version of a systematic review, the researcher put into place strategies to strengthen the rigour of the work. Lastly, as with other methods of research, the possibility of overinterpretation is a consideration, but having this research supervised by a senior academic and researcher, provided some ‘protection’ in this respect.

## **Practical implications**

The initial stage of the COVID-19 pandemic saw psychotherapists experiencing some hesitance toward the shift to online therapy. One of the reasons was the lack of training and experience with this medium. As a result of the COVID-19 experience and the evident value

of teletherapy, it is now necessary for training programmes to begin including this form of psychotherapy – and the present study provides valuable insights that can inform such training modules. In addition to the basic training of psychotherapy professionals, it will be helpful to have continuing education courses that include interventions such as teletherapy. This may be beneficial for existing practitioners, as part of the profession's Continuous Professional Development (CPD) requirements.

As we reflect on the changes in climate and increase in the prevalence of disasters, psychotherapists must be encouraged to prepare for, and anticipate the next pandemic and the mental health and other challenges that it will bring. Similarly, the need for rigorous planning is needed for technological support, capabilities and network stability, to ensure that all sectors of the population are able to receive mental health care.

In promoting training programmes, we cannot neglect focus on improving organisational and peer support. This is critical to prevent clinician burnout and to ensure that an appropriate and supportive milieu is created for psychotherapists to provide the levels of congruence and warmth that Carl Rogers (1961) advised. Keeping in mind that the relationship is the key ingredient in psychotherapy, it is vital that we plan ahead appropriately.

### **Future research based on this review's findings**

While gaps in this research included the fact that articles meeting the inclusion criteria were mainly studies conducted in the global North, it is interesting to note that one article from the African continent made it through to the final stages, but had to be excluded due to no full-text access. It is, therefore, clear that research findings must adequately reflect the global context, while taking cognisance of regional and sociocultural complexities. Decisions and policies cannot be developed globally based on just data from higher income countries. Findings may differ in under-resourced settings due to likely instability of technological infrastructure and the lack of organisational support for the transition to teletherapy especially in poorer countries.

Related to the disparity between rich and poor nations, the global community has to learn from the COVID-19 pandemic and especially the value of technology in meeting mental health care needs – teletherapy being one example. The advances and developments in artificial intelligence (AI) must also be factored into health systems and leveraged for the best

possible outcomes for all. Ensuring that poorer communities benefit from these advances must be high on the agenda to ensure that they are not left behind, as past experiences have demonstrated across the world. There is also a need for more research using BPNT, considering that it can be directly linked to behaviour change.

## **Conclusion**

On reflection, conducting this research turned out to be more challenging than I initially envisaged, but this was perhaps due to me being a relatively novice researcher. When I began the research, I intended for it to be an overview of how healthcare workers who provide psychotherapy coped during the COVID-19 pandemic, the challenges they experienced, and also their motivation to continue providing services to vulnerable individuals in distress. Something I learned quickly during my clinical psychology internship and earlier anthropology Master's research into mental health care provision, is that an invisible hierarchy system pervades health care services. While on the surface there is acknowledgement of the role of the multidisciplinary team, biomedical dominance has seen greater focus on the experiences of medical health care professionals, with little attention given to those providing psychotherapeutic care, during the pandemic. Relatively little research has been conducted on the latter group.

The use of Self-Determination Theory and the Basic Psychological Needs (sub)Theory in this research has allowed for the examination of an individual's motivation to persevere despite distressing circumstances. It has been an interesting research process in that the researcher has engaged with the included articles and literature to determine how these basic psychological needs influenced the continuation of psychotherapy. In addition, the psychological constructs of adaptability, resilience and determination also featured strongly.

Through this process, my knowledge and insight regarding the intrinsic motivation required for clinicians providing psychotherapy to continue working grew significantly. I also learned more about their perceptions of the impact their discipline would make on the heightened levels of anxiety, uncertainty and other emotions that individuals across the globe were experiencing. Mental health care is considerably more than biomedical treatment, and it has been encouraging to see how psychotherapy providers were able to motivate themselves to continue providing

services in a sector of healthcare that is too often overlooked. On the positive side, COVID-19 taught the world about the importance of mental health and its care.

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## Appendix A



### GENERAL/HUMAN RESEARCH ETHICS COMMITTEE (GHREC)

02-Jul-2023

Dear Ms Indira Pillay

#### Application Approved

Research Project Title:

**Psychotherapists' self-determined motivations and experiences in shifting to online psychotherapy during the COVID-19 pandemic: A rapid review.**

Ethical Clearance number:

**UFS-HSD2023/0972**

We are pleased to inform you that your application for ethical clearance has been approved. Your ethical clearance is valid for twelve (12) months from the date of issue. We request that any changes that may take place during the course of your study/research project be submitted to the ethics office to ensure ethical transparency. Furthermore, you are requested to submit the final report of your study/research project to the ethics office. Should you require more time to complete this research, please apply for an extension. Thank you for submitting your proposal for ethical clearance; we wish you the best of luck and success with your research.

Yours sincerely

**Dr Adri Du Plessis**

**Chairperson: General/Human Research Ethics Committee**

Adri  
Du  
Plessis

Digitally  
signed by Adri  
Du Plessis  
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# Appendix B



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[REV: 20220217]

# Appendix C

Article

## Qualitative Investigation into Therapists' Experiences of Online Therapy: Implications for Working Clients

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**Abstract:** Online therapy has increasingly been utilised during the COVID-19 pandemic by many, including working populations. However, few qualitative studies have explored how online therapy is experienced in practice and discussed its implications for those working clients. Semi-structured interviews attended by nine integrative psychotherapists practising in California, the United States, were conducted. Thematic analysis of the transcripts identified three themes: (i) 'Positive experiences of online therapy', (ii) 'Challenges experienced by therapists and clients in online therapy', and (iii) 'Preparation and training for online therapy'. Online therapy was assessed as being helpful, particularly in terms of mitigating against previous geographical and temporal barriers to uptake. However, due to technological disruptions and potential blurring of professional boundaries, online therapy may detract from the emotional salience of therapy, negatively impacting the therapeutic relationship and containment. Considering these positive experiences, participants expected that the demand for online therapy would continue to increase. Particularly in the occupational context, online therapy can offer interventions without fostering shame regarding mental health. The findings provide preliminary qualitative evidence that online therapy can be a useful adjunct to traditional forms of face-to-face therapy. However, therapists require more explicit training in implementing online therapy. Results are discussed in particular regarding the utility of this therapy for working clients.

**Keywords:** online therapy; COVID-19; qualitative; therapeutic relationship; thematic analysis; workplace mental health

### 1. Introduction

#### 1.1. Emergence of Online Therapy

In 2013, the American Psychological Association published 'Guidelines for the Practice of Telepsychology'. Analogous to this, within the UK, the British Association for Counselling and Psychotherapy (BACP) recently published good practice guidance for therapeutic working online [1]. Both developments underscore the rising interest in online therapy in the counselling and psychotherapy professions. They have paved the way for formal recognition of 'telepsychology', also known internationally as online therapy, e-therapy, e-counselling, computerised cognitive behavioural therapy (cCBT) and electronic cognitive behavioural therapy (eCBT) [2]. The term 'online therapy' (online therapy) in this paper predominantly refers to live video therapy. However, we also acknowledge that this term can include other online and integrative therapeutic support types, including asynchronous (email) and synchronous (instant messaging) communication, alongside live video therapy. Additionally, the terms 'psychological therapist' and 'counsellor' are used

## Frontline experiences of delivering remote mental health supports during the COVID-19 pandemic in Scotland: innovations, insights and lessons learned from mental health workers

Bethany Griffith, Heather Archbold, Isabel Sáez Berruga, Samantha Smith, Karen Deakin, Nicola Cogan, Gary Tanner & Paul Flowers

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Original Paper

## Integration of Online Treatment Into the “New Normal” in Mental Health Care in Post–COVID-19 Times: Exploratory Qualitative Study

Joyce J P A Bierbooms<sup>1,2</sup>, PhD; Monique van Haaren<sup>2</sup>, MSc; Wijnand A IJsselsteijn<sup>3</sup>, Prof Dr; Yvonne A W de Kort<sup>3</sup>, Prof Dr; Milou Feijt<sup>3</sup>, MSc; Inge M B Bongers<sup>1,2</sup>, Prof Dr

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*Abstract*

**Background:** The COVID-19 pandemic has necessitated an immediate and large-scale uptake of online treatment for mental health care. However, there is uncertainty about what the “new normal” in mental health care will be like in post–COVID-19 times. To what extent will the experiences gained during the pandemic influence a sustainable adoption and implementation of online mental health care treatment in the future?

**Objective:** In this paper, we aim to formulate expectations with regard to the sustainability of online mental health care after COVID-19.

**Methods:** In an interview study, 11 mental health care professionals were asked about their experiences and expectations for the future. Participants were recruited from a mental health care organization in the Netherlands. The interviews took place between April 7–30, 2020, at the peak of the COVID-19 crisis in the Netherlands. The data were analyzed using a thematic coding method.

**Results:** From the interviews, we learn that the new normal in mental health care will most likely consist of more blended treatments. Due to skill enhancement and (unexpected) positive experiences with online treatment, an increase in adoption is likely to take place. However, not all experiences promise a successful and sustainable upscaling of online treatment in the future. Mental health care professionals are learning that not all clients are able to benefit from this type of treatment.

**Conclusions:** Sustainable upscaling of online mental health care requires customized solutions, investments in technology, and flexibility of mental health care providers. Online treatment could work for those who are open to it, but many factors influence whether it will work in specific situations. There is work to be done before online treatment is inherently part of mental health care.

(*JMIR Form Res* 2020;4(10):e21344) doi: [10.2196/21344](https://doi.org/10.2196/21344)

**KEYWORDS**

online treatment; sustainability; mental health care; COVID-19



Commentary

## Mental Health Providers During COVID-19: Essential to the US Public Health Workforce and in Need of Support

Jessica N. Fish, PhD<sup>1,2</sup> ; and Mona Mittal, PhD<sup>1</sup>

In 2015, the combined disease burden of mental health and substance use disorders in the United States was higher than that of any other health condition.<sup>1</sup> Given the mental health effects of isolation, stress, and economic strain, researchers forecast a devastating increase in poor mental health as a result of the coronavirus disease 2019 (COVID-19) pandemic<sup>2,3</sup>—estimating an additional 75 000 deaths as a result of substance abuse and suicide in the United States.<sup>4</sup> People with chronic and severe mental health conditions and people with substance use disorders will not only struggle to gain access to the services they need, but pandemic-related stressors are likely exacerbating these preexisting vulnerabilities.<sup>5</sup> The increase in mental health need will burden an already strapped mental health care system<sup>6</sup> and challenge the capacity of our mental health workforce to serve clients' needs in a mutually safe manner and with limited resources and supports. Furthermore, mental health providers (eg, therapists, counselors, psychologists) will also bear the primary responsibility of adapting and learning new modalities of service delivery while managing their own pandemic-related stressors.

### Effect of the COVID-19 Pandemic on Mental Health Providers

Although much attention has been given to the health of frontline medical workers, the pandemic will soon also compromise the services and health of mental health providers. Mental health providers—although not typically considered frontline workers—will face the immediate challenge of addressing the mounting mental health crisis in the United States. Given widespread physical distancing measures, mental health providers swiftly responded by adopting teletherapy as the primary platform for delivering mental health services. For most of the mental health workforce, the shift to teletherapy was immediate, and it fundamentally challenged the way mental health providers are accustomed to delivering services.

Compassion and empathy form the foundation of a strong therapeutic relationship between mental health providers and their clients, and they are essential elements for providing good clinical care. However, the ability to cultivate and convey these feelings requires that mental health providers engage in and maintain their own self-care. The ubiquity of the pandemic, however, not only increases the stressors and needs of clients but also limits the emotional and material resources of the mental health providers committed to helping them. Mental health providers are also not impervious to personal challenges, loss, and stressors related to the pandemic, which are compounded by their responsibility to hold space for their clients on these very same issues. In other words, mental health providers are having to process both their own and their clients' stressors related to the pandemic, which is uniquely challenging.

We conducted a brief online survey focused on the impact of COVID-19 on mental health providers' work and mental health ( $n = 137$ ) in June–July 2020. The survey was targeted to US-based mental health providers (eg, licensed social workers, marriage and family therapists, counseling psychologists) and included 5 open-ended response questions asking participants to reflect on their experiences offering mental health care during the early months of the pandemic in the United States:

1. How has the COVID-19 pandemic impacted your client's ability to access services?
2. How has the COVID-19 pandemic impacted your ability to serve clients?

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## “Each Week Feels Like a Mountain”: The Impact of COVID-19 on Mental Health Providers’ Well-Being and Clinical Work

Mona Mittal<sup>1</sup>, Amy A. Morgan<sup>1</sup>, Jingshuai Du<sup>1</sup>, Jessica Jiang<sup>1, 2</sup>, Bradley Boekeloo<sup>3, 4</sup>, and Jessica N. Fish<sup>1, 3</sup>

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The SARS-CoV-2 (COVID-19) pandemic has placed a tremendous strain on health care providers. Although there is a burgeoning body of literature on how COVID-19 has impacted frontline health care workers (i.e., providers treating COVID-19 patients), little attention has been dedicated to second-line workers (i.e., providers treating the mental health of people impacted by COVID-19). In this article, we present findings from a thematic analysis of open-text responses ( $n = 136$ ) examining how COVID-19 shaped both the well-being of second-line workers, specifically mental health providers, as well as their clinical work in the early months of the COVID-19 pandemic in the United States. Results indicated that mental health providers were experiencing significant COVID-19-related burnout and poor physical and mental health outcomes. Participants described diminished negative effects on the quality of their clinical care from the burnout and trauma associated with COVID-19. Many also demonstrated resilience, identifying the duality of both negative (e.g., exhaustion) and positive (e.g., pride in helping others) meaning derived from their second-line work experiences. We conclude with recommendations for preventing and addressing burnout among mental health professionals in the era of COVID-19 and subsequent health emergencies.

### Public Significance Statement

Given the long-term nature of the COVID-19 pandemic, it is imperative we identify and address the needs of mental health care providers as they serve their communities during the pandemic. This article describes the psychological burnout, trauma, and exhaustion experienced by mental health providers in the United States, as well as the meaning derived from being part of the COVID-19 public health response. Based on these findings, we offer recommendations to support mental health care providers to prevent and address burnout, promote personal wellness, and foster sustainable work practices.

**Keywords:** COVID-19, teletherapy, mental health provider, second-line workers, burnout

This article was published Online First December 19, 2022.

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MONA MITTAL received her PhD in marriage and family therapy from Texas Tech University and a masters in clinical investigation from the University of Rochester. She is currently an associate professor in the Department of Family Science and core faculty in the couple and family therapy master’s program, at the University of Maryland School of Public Health. Her research focuses on mental health and traumatic stress, particularly interpersonal violence, and sexual and reproductive health outcomes among populations that experience health disparities.

AMY A. MORGAN received her master’s degree in family science: marriage and family therapy from the University of New Hampshire in 2012, and her PhD in human development and family science: marriage and family therapy in 2020 from Virginia Tech. She is currently an assistant professor in the Department of Family Science, and core faculty in the couple and family therapy master’s program, at the University of Maryland’s School of Public Health. Her research focuses on the health and well-being of people reentering communities and families following incarceration, as well as mental health providers’ experiences working in an underresourced health care system.

JINGSHUAI DU received her master’s degree in social work (MSW) from Peking University in China in 2014, and MS in couple and family therapy

from Kansas State University in 2019. She is currently a PhD candidate in the Department of Family Science at the University of Maryland. Her area of research interests includes the impacts of stressful experiences (e.g., discrimination, intimate partner violence), couple relationship functioning, and Asian American mental health.

JESSICA JIANG received a BS in neurobiology and physiology and a BA in public policy from the University of Maryland College Park. She is currently a first-year medical student at the Georgetown University School of Medicine. Her research interests include examining how social and structural determinants of health affect disease pathology and equitable health outcomes for marginalized populations.

BRADLEY BOEKELOO received his ScM and PhD from the Johns Hopkins Bloomberg School of Public Health in behavioral sciences. He is currently a professor of Behavioral and Community Health at the University of Maryland School of Public Health with a joint appointment in the University of Maryland School of Medicine. His research focuses on sensitive patient-provider communications and clinical trials of behavioral interventions regarding sexual risks, sexuality, and substance use.

JESSICA N. FISH received her MS in couple and family therapy from the University of Purdue Northwester (formerly Calumet) and her PhD in family and child sciences from Florida State University. She is currently an assistant professor of family health and well-being in the

*continued*

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article

## Bodies on the line: how telepsychology brought about new relationalities between therapists and their clients during the COVID-19 pandemic

Leanne Downing, [l.downing@unsw.edu.au](mailto:l.downing@unsw.edu.au)  
University of New South Wales, Australia

This article explores a series of psychosocial and embodied relationalities that emerged between registered solo-practice psychologists and their clients during the COVID-19 social lockdowns that took place in Australia between June and August 2020. Drawing on findings from a larger qualitative research project into Australian psychologists' experiences of maintaining therapeutic relationships via teleconferencing technologies during the pandemic, I explore the ways in which the relational and embodied experiences of taking therapy online resulted in new ways of working with clients over digital media interfaces such as Zoom, Skype and Facetime. Central to this discussion is an exploration of the ways in which embodied attunement, fears of risk and contagion, and concerns around trust and privacy were negotiated to create new, 'more-than-human' relationships between therapists, clients and the spaces and technologies that brought them together.

**Key words** telepsychology • more-than-human-theory • psychosocial studies • COVID-19

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### Introduction

Since its initial detection in late 2019, the SARS-CoV-2 (COVID-19) virus has brought with it a series of embodied and psychosocial implications that cannot be sufficiently articulated within a biomedical paradigm. From business closures and government-imposed curfews, through to widespread job losses, home-schooling requirements and stay-at-home mandates, the COVID-19 crisis has emerged not just as a virus, but also as a profoundly *social* and *psychological* phenomenon in which an ever-expanding entanglement of humans, places, spaces, objects and technologies is enmeshed.

In numerous countries, infection control directives have required people to not only change many of their social behaviours, but also actively adjust and pay attention to their own embodiment. To prevent infection, people have been asked to adhere to

## Mental Health Care Goes Online: Practitioners' Experiences of Providing Mental Health Care During the COVID-19 Pandemic

Milou Feijt, MSc,<sup>1</sup> Yvonne de Kort, PhD,<sup>1</sup> Inge Bongers, PhD,<sup>2,3</sup> Joyce Bierbooms, PhD,<sup>2,3</sup>  
 Joyce Westerink, PhD,<sup>1,4</sup> and Wijnand IJsselstein, PhD<sup>1</sup>

### Abstract

The outbreak of the COVID-19 pandemic has necessitated sudden and radical changes in mental health care delivery, as strict social distancing and lockdown measures were imposed in the early phases of the pandemic. Almost overnight, practitioners were forced to transfer their face-to-face care practice to online means. To understand the implications of this drastic change for mental health care, and to improve the online care offerings, an online qualitative survey was held among mental health care professionals in Netherlands ( $n = 51$ ). Our findings indicate that technological and usability problems pose a significant challenge, as do difficulties to establish rapport with clients. Moreover, not all mental health issues and treatment forms are equally amenable to online interaction. In contrast, in many instances, practitioners were positive about the effectiveness of treatment, and reported flexibility, a lower threshold for contact, and lack of travel time as advantages. Their most prominent needs concern better technological, organizational, and logistical support. It is critical that these needs are acted upon by institutions and governments. In addition, current results inform future research on the improvement of e-mental health technologies.

**Keywords:** online psychological treatment, mental health care, teletherapy, e-health, COVID-19, practitioners' experiences

### Introduction

OVER THE PAST DECADES, a growing number of technological tools for remote psychological treatment have been developed. Technology-mediated psychological treatment has shown a level of efficacy comparable with that of unmediated treatment,<sup>1,2</sup> and research has pointed out several unique benefits, such as increased convenience, flexibility, and accessibility of mental health care, and higher self-disclosure and active involvement of clients.<sup>3,4</sup> Despite this, mental health care professionals and organizations in the field have been relatively slow in adopting these tools.<sup>5,6</sup>

Recently, with the outbreak of COVID-19, the state of affairs in mental health care has drastically changed. The pandemic has far-reaching consequences; it not only poses a serious threat to people's physical health, but it also has grave impact on our psychological well-being, in several

ways. The pandemic is associated with fear and rumination over contamination risks, experiences of severe and debilitating illness, and the potential or actual loss of life. Moreover, the implementation of extensive social and physical restrictions, including social distancing measures and mass quarantine measures (i.e., lockdown), has led to further increases in psychological stress and lower access to usual means of support.<sup>7-9</sup> Therein, we face an urgent but very complicated situation: the current circumstances put people without pre-existing mental health problems at risk of developing them, whereas the conditions of people who are already suffering from mental health care issues are likely to worsen. At the same time, the accessibility and the standard way of providing mental health care are highly disrupted.

Where the adoption of e-mental health tools was relatively low before COVID-19, for a variety of reasons,<sup>10,11</sup> these tools now offer a potential solution to continue high-quality

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<sup>4</sup>Philips Research, Eindhoven, Netherlands.

## A qualitative exploration of psychologists' experiences of teletherapy within the Irish Public Mental Health System

Katie Reilly<sup>1</sup> | Michael Maher<sup>1</sup> | Elaine Smith<sup>2</sup> | Elaine Coyne<sup>3</sup> | Síle Murphy<sup>3</sup> | Charlotte Wilson<sup>1</sup>

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### Funding information

No funding was received for this study.

### Abstract

**Objective:** The current qualitative study aimed to investigate psychologists' experiences of teletherapy throughout the COVID-19 pandemic, with a particular focus on teletherapy's impact on therapeutic relationships.

**Method:** Fifteen participants, consisting of clinical and counselling psychologists employed by the Health Service Executive (HSE) in Ireland, participated in semi-structured interviews conducted via telephone.

**Results:** Constructionist thematic analysis yielded three prominent themes: (i) psychologists experienced a lack of control over therapeutic boundaries with their clients, such as the setting and time in which sessions take place. Teletherapy also encroaches on psychologists' personal boundaries from having aspects of their home lives becoming associated with clients' trauma; (ii) psychologists have to work much harder to make the connection with clients due to the substantial loss of information, including non-verbal cues, transmitted across teletherapeutic platforms; and (iii) psychologists themselves feel uncontained from being insufficiently supported by the HSE, which impacts on their ability to contain high-risk clients via teletherapy.

**Conclusions:** Various aspects of the therapeutic relationship, including therapeutic boundaries between psychologists and their clients, and psychologists' ability to make the connection and foster containment with their clients, were impacted by teletherapy. Psychologists need to feel heard, supported and appreciated to ensure optimal delivery of teletherapy in future.

### KEYWORDS

boundaries, connection, containment, COVID-19, teletherapy, therapeutic relationship

## 1 | LITERATURE REVIEW

The turbulent advent of COVID-19 resulted in the introduction of a number of restrictions with the aim of reducing contagion, and psychologists worldwide have been forced to adopt new methods

of delivering therapy in a way that greatly limits in-person contact. *Teletherapy*, which involves delivering therapy through technological media such as video-based sessions and telephone calls, has become the 'new normal' and enables psychologists to see/hear their clients remotely in lieu of in-person therapy (Rosen et al., 2020). When

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“It made me a more resilient therapist”: a qualitative study on practitioners’ experience of providing mental health services during the pandemic

#### Abstract

The COVID-19 pandemic has necessitated sudden and radical changes in mental health care delivery where practitioners unavoidably engaged in remote working. As remote care is likely to become increasingly common, perhaps routine, in this study, we aimed to explore practitioners’ experiences of delivering online therapy during a unique moment in history. Semi-structured online interviews were conducted with 5 participants. 3 main themes were developed using Thematic Analysis: 1) Moving services online: practical challenges and opportunities; 2) Intimacy and distance in online connections; and 3) We’re all in this together: a collective experience. This study highlighted participants’ flexibility, digital and relational connectedness, and ability to reframe negative experiences as potential for growth. Findings demonstrate that the existence of both challenges and opportunities for online therapy constitutes just the start of an exciting journey for practitioners when delivering mental health services in the future.

#### Introduction

Due to the COVID-19 pandemic, therapists were forced to pivot from face-to-face care practice with immediate and large-scale uptake of remote online treatment, intervention, and support (Bierbooms et al., 2020). The clients’ perspective as they adjusted to this new modality of service delivery has been briefly explored in the literature. Clients’ reported technological concerns with the new paradigm of mental health services (Feijt et al., 2020). Clients who may not always have had the required infrastructure, resources, privacy, or digital skills to effectively engage in online therapy found themselves at risk of being disconnected from the care they needed (Feijt et al., 2020). However, until the present day, some clients expressed enthusiasm for these ongoing flexible arrangements and increased convenience, finding it less stressful to attend appointments without the anxiety of commuting, giving some clients a stronger sense of power and control (Hardy et al., 2021; Venville et al., 2021).

Technical glitches, insufficient internet literacy, or the challenges of assuring confidentiality online have been some of the main concerns for therapists working remotely (Hanley, 2021; Barker & Barker, 2022). However, many viewed this transition positively and reported confidence in their abilities to deliver services via these new platforms, perceiving their clients’ willingness to schedule remote sessions better than in-person services (Sklar et al., 2021). With respect to the therapeutic interaction, some therapists miss the richness of nonverbal cues that are important to their therapeutic encounters (Geller, 2021; Gullo et al., 2022). Some reported feeling less confident in their skills for building rapport with their clients (Feijt et al., 2020). The clients’ emotional reactions to the sudden switch could not be processed with the therapist in the same room, and the therapeutic space that may have allowed the clients to self-regulate was abruptly lost (Kashyap et al, 2020). Clients’ responses to the loss of space, as well as therapists’ thoughts on them, were crucial to the working

## Psychotherapy in the Age of Coronavirus: A Reflection on Collective Discomfort

Brittany Wade, M.S.W., LICSW

I am a psychotherapist at a major hospital in rural New England. I work with individuals hospitalized for chronic and acute illnesses. In other words, I work in the business of discomfort. One of the most common narratives I hear is that of anxiety and depression related to illness, isolation, and loss. Many of my patients struggle to leave their homes because of pain, exhaustion, physical limitations, and immunocompromised states. Cue isolation: friends and family members jump ship because it is too difficult to cope with the discomfort that results from witnessing a loved one suffer. Enter loss—of identity, agency, relationships, careers, hobbies, hopes, dreams, purpose, dignity, and time.

I can't help but reflect on the stories of my patients amid the coronavirus pandemic. I watch a sea of social media posts that lament the boring and isolating lifestyle of sheltering in place and the losses—of employment, income, routine, long-awaited celebrations, that “big 5-0” trip to the South Pacific. We are all either sick with coronavirus or afraid of getting sick with coronavirus. How interesting that the illness, isolation, and loss that color my patients' worlds are now woven together with our current dominant cultural narrative. We are in a collective state of discomfort.

Recently, I wrote an e-mail to my supervisor about the discomfort I felt in transitioning my work to telehealth. I call patients on the phone and try to create some semblance of a trusting and authentic therapeutic relationship amid their medical crises. I cannot see the physical manifestations of their illnesses or injuries, the machines, the tubes, the wires, the wounds. I cannot rely on the nonverbal communication that so deeply guides my practice: body language, affect, eye contact. Therapeutic silence no longer facilitates reflection or encourages patient dialogue; instead, it elicits, “Hello? Are you still there? Did I lose you?” Meanwhile, my partner and I are cooped up in the house with our rambunctious dogs barking at melting snow falling in thuds off the roof; it is, after all, “spring in New England.” I fight off cognitive distortions with all my might, perhaps almost as mightily as I am prepared to fight my partner for the last piece of chocolate fudge cake, because *who knows when the flour I used to make it will be stocked again? I am a bad therapist. I am not doing high-quality work. I am not helping anyone. Now I really need that last slice of cake.* Cue maladaptive coping:

*What kind of therapist am I? I should be practicing what I preach. I'm so self-critical. I should be gentle with myself. Maybe I should meditate.* For those who have ever looked at their therapists and wondered how they were so high functioning, I'll let you in on a secret: We are not. I digress.

So here I sit, at my little ramshackle home desk, in complete discomfort, reflecting on the irony that the very illness anxiety, isolation, and loss that erode the mental health of my patients are now the main characters on my emotional stage. The most integral lesson I've learned is that to be a therapist is to be willing to tolerate discomfort in the service of bearing witness to the experience of a fellow human. But nobody taught me how to be a therapist in the midst of a global pandemic, when my patients and I are simultaneously grappling with the same source of discomfort, and we all are acutely aware of it.

I remember in graduate school when nothing felt more forbidden than self-disclosure. I vividly recall the first time a patient asked me whether I was married or had children. I sat perspiring in panic. I have since come to understand that a healthy dose of self-disclosure is an invaluable tool in building transformative therapeutic relationships. During this coronavirus pandemic, I cannot think of a more powerful therapeutic tool. I have the opportunity to model for my patients how to sit with discomfort gracefully and to normalize the anxiety and fear that we are collectively sitting with. I can empower my patients by asking them to share what they have learned in sitting with illness, isolation, and loss and to learn from them. I can ask them to reflect on how they feel now that suddenly the entire country is experiencing their day-to-day lifestyle: being unable to leave their homes, struggling with anxiety and depression, feeling isolated, facing financial stress, and depending on public assistance. And I have the opportunity to ask how it feels now that their emotional pain is so widely shared.

In my opinion, one of the most harmful cultural narratives posits emotion as weakness. Emotional experiences become private events, thus leading us to believe that others are not suffering as we are. A colleague of mine once shared a reflection on suicide: *Some people are just too tender for this world.* It struck me so deeply. There is an incongruence between our personal experience and our cultural narrative



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## New Skills for Distance Regulation: Therapists' Experiences of Remote Psychotherapy Following the COVID-19 Pandemic

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Social distancing during the COVID-19 pandemic forced many therapists to shift from in-person sessions to the use of communication technology. This shift actualizes the issue of for whom and when remote therapy is suitable and how the therapeutic technique should be adjusted. Our study explored therapists' long-term experiences of remote psychotherapy after this transition. Data were collected about 2 years after World Health Organization's (WHO's) declaration of the COVID-19 pandemic. Semistructured interviews with 10 therapists with different treatment orientations were analyzed, applying the qualitative method of inductive experiential thematic analysis. The therapists said that the use of communication technology implied a new and different in-session interaction, inclusive of changed relational dynamics and the need to adjust their way of working. All therapists experienced possibilities and advantages as well as difficulties and challenges with remote psychotherapy. As time went on, they gained both positive and negative new experiences of the distinctive features of remote therapy and became more comfortable with remote communication. Above all, they acquired new technical and relational skills. Taken together, the therapists' experiences illustrate the need to develop new skills for negotiating setting alternations and distance regulation and to adapt therapeutic interventions when shifting between in-person settings and remote sessions.

### Public Health Significance Statement

Shifting between in-person and remote settings has a strong impact on the patient–therapist interplay, forcing therapists to develop new and advanced therapeutic skills. These skills include the therapist's sensitivity to both participants' ways of balancing the needs of togetherness and of autonomy, ongoing negotiation of different aspects of setting alternations, as well as developing a new repertoire of teleinterventions. Psychotherapy training and supervision need to encompass the challenges of teletherapy.

**Keywords:** therapeutic relationship, therapeutic technique, communication technology, teleinterventions, therapist perspective

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Interview data are not shared due to privacy and ethical restrictions.

Andrzej Werbart served as lead for conceptualization, funding acquisition, methodology, project administration, and writing–review and editing and served in a supporting

role for resources. David Forsström contributed equally to conceptualization, methodology, and writing–review and editing. Andrzej Werbart, Martin Jonsson, and David Forsström contributed equally to data curation. Andrzej Werbart, Martin Jonsson, Bartosz Jankowski, and David Forsström contributed equally to investigation and formal analysis. Andrzej Werbart and David Forsström contributed equally to supervision and validation. Martin Jonsson and Bartosz Jankowski contributed equally to writing–original draft.

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## **A NONPROFIT'S TRANSITION TO TELETHERAPY DUE TO THE COVID-19 CRISIS: LEARNING HOW TO ADAPT**

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CLAUDIA HERRERA

CASSANDRA CACACE

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*Due to the state of the COVID-19 in Florida, a community-based agency serving children and families had to transition abruptly to teletherapy. This agency adapted to pandemic-related challenges by transitioning from in-person to virtual therapy, which played a key role in safely serving community members. This article explores the unique benefits and difficulties of the transition to teletherapy under those circumstances. The agency clinical staff utilized their brief therapy skills and strengths-oriented perspective to aid in this abrupt transition, as illustrated by a case study. Ultimately, the agency's transition was a successful one as evidenced by a survey of both agency clinicians and clients, and by uninterrupted services at the same volume of cases and level of care. Suggestions are made for other providers seeking to cope with similar transitions.*

*Keywords:* brief therapy, strengths-oriented, COVID-19, community-based, teletherapy

With the onset of the coronavirus pandemic (COVID-19), delivering counseling services online became a necessity for our community-based agency serving children and families. The agency is located in south Florida, where the COVID-19 infection rate was among the highest in the nation. The transition was abrupt, and agency clinicians had mixed emotions. Agency clinicians expressed concerns about confidentiality and privacy. Many did not consider themselves “tech savvy.” Agency clinicians were accustomed to delivering services in office and home environments, with art and play activities offered to child and teen clients. Clients discussed with

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## Appendix D

### Language Editing Certificate

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Clinical Psychologist

19-266 Middleton Rd, Albany, WA 6330, Australia

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4 December 2024

To whom it concerns,

**PSYCHOTHERAPISTS' SELF-DETERMINED MOTIVATIONS AND EXPERIENCES IN SHIFTING TO ONLINE PSYCHOTHERAPY DURING THE COVID-19 PANDEMIC: A RAPID REVIEW**

This is to confirm that I have read and edited the academic work prepared and emailed to me by Indira Pillay. The document is a dissertation, titled "Psychotherapists' self-determined motivations and experiences in shifting to online psychotherapy during the COVID-19 pandemic: A rapid review".

As a clinical psychologist, experienced in reviewing and editing academic papers in psychology and an author of scholarly articles, I am familiar with academic standards, and have edited the abovementioned dissertation accordingly. I have corrected the work for language and grammar to ensure it complies with academic writing standards.

*P. Naidoo*

Dr Pragash Naidoo

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## Appendix E

Themes	Tertiary Codes	Secondary Codes	Primary Codes	Excerpts
Enemy of change	Shifts in therapeutic relationship	Shifting to new medium of therapy	Changes with shifting patients online	<ul style="list-style-type: none"> <li>• <i>“Practitioners find it more difficult to connect with their client or clearly communicate their intended message.”</i> (Fejit et al., 2020)</li> <li>• <i>“online treatment is less suitable for treating trauma, family therapy, for clients with psychotic symptoms, severe anxiety, and generally those who are vulnerable to crisis and a sudden exacerbation of symptoms.”</i> (Fejit et al., 2020)</li> <li>• <i>“patients differ in their suitability for remote work”</i> (Werbart et al., 2023)</li> <li>• <i>“Furthermore, the therapists recounted that returning to the traditional in-person setting could have a noticeable impact on the relational dynamics, positive when working with some patients and negative with others. Thus, from the therapists’ perspective, setting alternations”</i> (Werbart et al., 2023)</li> <li>• <i>“A core underlying theme in the therapists’ narratives was the loss of contact and emotional closeness with their patients, as if psychotherapy at a distance gave rise to increased distance in the therapeutic relationship”</i> (Werbart et al., 2023)</li> <li>• <i>“All therapists experienced that the remote contact in some cases could make the patients more relaxed and contributed to more engaging and empathetic intimacy in the therapeutic relationship, bringing about more joy in the work”</i> (Werbart et al., 2023)</li> <li>• <i>“the limited nonverbal communication, and the lack of input in the form of bodily expressions were experienced as negatively influencing their therapeutic stance, which slowed down alliance-building and obstructed the interpersonal attunement”</i> (Werbart et al., 2023)</li> <li>• <i>“The bodily absence hindered access to emotional perception and subtle impressions of the patient’s body language”</i> (Werbart et al., 2023)</li> </ul>

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|--|--|--|--|---|
|  |  |  |  | <ul style="list-style-type: none"> <li>• <i>“One respondent predicted that because clients are now experiencing the benefits of online treatment, there is a significant chance that they will continue to ask for it, which will to a large extent determine whether online treatment options will be integrated into the new normal.” (Bierbooms et al., 2020)</i></li> <li>• <i>“Participants found increased access to therapy significant for clients who preferred online sessions, or for those with specific needs could now be a possibility, offering them more independence and power of choice” (Brandon &amp; Fragkiadaki, 2023)</i></li> <li>• <i>“This, in turn, leads to more frequent, shorter consultations, which adds to a higher level of connectedness between client and therapist” (Bierbooms et al., 2020)</i></li> <li>• <i>“Some participants experienced initial disruptions to sessions due to their lack of experience with technology and the format, impacting their confidence in providing online therapy” (Brandon &amp; Fragkiadaki, 2023)</i></li> <li>• <i>“Participants also expressed concern that relying on work from home would make guaranteeing client safety more difficult, particularly managing the risk of violence between clients and their partners, which might obstruct access for some clients” (Brandon &amp; Fragkiadaki, 2023)</i></li> <li>• <i>“Practitioners experienced the consequences of the lack of consistency and clients not feeling supported by them” (Brandon &amp; Fragkiadaki, 2023)</i></li> <li>• <i>“Additionally, for some participants remote working was advantageous for specific conditions such as anxiety disorders, as it increased accessibility” (Brandon &amp; Fragkiadaki, 2023)</i></li> <li>• <i>“participants raised concerns over clients’ access to resources that would enable them to appropriately utilise these services. They expressed their concerns about their inability to assure client safety, as well as their belief that the process of risk assessment is more difficult online” (Brandon &amp; Fragkiadaki, 2023)</i></li> <li>• <i>“Clients from lower socioeconomic communities were more disadvantaged in terms of accessing technology, as they may lack equipment or have a poor internet connection. Additionally, because some clients did not have the</i></li> </ul> |
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				<p><i>necessary devices, they may become vulnerable to exclusion and unable to receive services.” (Brandon &amp; Fragkiadaki, 2023)</i></p> <ul style="list-style-type: none"> <li>• <i>“absence of nonverbal communication and the lack of a designated safe space for therapy were identified as challenges participants faced with the changes to mental health provision. Yet, practitioners spoke of solutions to maintain a therapeutic space suitable for their sessions.” (Brandon &amp; Fragkiadaki, 2023)</i></li> <li>• <i>“All participants felt their view of client’s bodies, the totality of non-verbal communication and their ability to discern non-verbal communication through the digital space, were compromised.” (Brandon &amp; Fragkiadaki, 2023)</i></li> <li>• <i>“Participants, along with their clients shared the experiences of a global crisis during the pandemic, coping with the resulting emotional and psychological impacts in parallel. These processes influenced the development of the therapeutic relationships as the participants and clients were on an equal status, and the notion that this “humanised” the practitioner was prevalent throughout the data” (Brandon &amp; Fragkiadaki, 2023)</i></li> <li>• <i>“inability to secure a secluded, quiet space when providing online therapy as another challenge”. (Brandon &amp; Fragkiadaki, 2023)</i></li> <li>• <i>“Participants commented that offering online therapy during the pandemic has reduced the stigma of receiving therapy. Communication also appeared to be more open and honest and that genuine empathic contact was indeed possible in remote communication” (Brandon &amp; Fragkiadaki, 2023)</i></li> <li>• <i>“challenges caused by the blending of the home environment and the digital therapeutic space, which include disruptions from family members during therapy sessions, other technological interruptions (phones, laptops, tablets), lack of private space, and client behaviours that would not ordinarily occur during physical (face-to-face) sessions” (Kotera et al., 2021)</i></li> <li>• <i>“online therapy is not suitable for clients who suffer from severe psychopathology or mental health distress (e.g., trauma or personality disorders) (T2-4: Severe psychopathology), because they require greater</i></li> </ul>
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				<p><i>contact and containment that cannot be facilitated via online mediums” (Kotera et al., 2021)</i></p> <ul style="list-style-type: none"> <li>• <i>“Technological problems, including a lack of digital skills in therapists and/or clients, are among them. An unstable internet connection can disrupt the flow in a therapy session, negatively impacting the therapeutic relationship and outcomes.” (Kotera et al., 2021)</i></li> <li>• <i>“Numerous participants agreed that ‘it’s quite containing having a boundary between home and work life’, and that ‘a level of differentiation’ between the two allows them to transition between working and relaxing (P13); however, they now have no way of escaping their work life as their home has now become ‘a therapy room almost’ (P3).” (Rielly et al., 2022)</i></li> <li>• <i>“The absence of physical presence and inability to perceive non-verbal cues such as eye contact can make participants feel more comfortable in ‘bringing the therapy to a deeper level’ (P8) over the telephone and can facilitate further exploration; as one participant said, ‘I often say to a client on the phone now, you know, “I’m just wondering about this, or I was wondering about that.” I wonder more on the phone with a client than I wonder face to face’ (P10).” (Rielly et al., 2022)</i></li> <li>• <i>“Participants have to trust that their clients were truthfully disclosing their location as, ‘the combination of not knowing where they were, not being able to control the environment, were they in a place that was safe for them to speak or private’” (Rielly et al., 2022)</i></li> <li>• <i>“Participants also had to re-establish the boundaries of the therapeutic relationship, as clients began to treat their encounter ‘less formally than, you know, coming in for your therapy session, people were treating it like I think maybe a call from a friend” (Rielly et al., 2022)</i></li> <li>• <i>“Some participants also expressed that ‘people have access to my email now, people have access to my work mobile, things that I wouldn’t have given to clients routinely before’ (P6), as participants need alternative ways of contacting their clients should the call drop. Numerous clients are now contacting participants out of hours as a ‘mechanism to offload’, which jeopardises the boundary of the therapeutic relationship” (Rielly et al., 2022)</i></li> </ul>
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				<ul style="list-style-type: none"> <li>• <i>“concerns around privacy risks arose, with several of our respondents expressing concern that their clients did not have a safe or private space within which to attend the session. Therapeutic consultations in cars, bedrooms and broom cupboards quickly became commonplace as clients sought out private spaces away from cohabitants during social lockdowns. This issue was especially pressing for clients who lived in a shared house, or with elderly family members and/or children who were prone to interrupting”</i> (Downing, 2021)</li> <li>• <i>“new relationalities depended on the therapist adjusting their physical gestures to match the realities of a two-dimensional screen and the needs of their individual clients.”</i> (Downing, 2021)</li> <li>• <i>“Correspondingly, some therapists reported relying on exaggerated facial expressions rather than body gestures in order to account for the limitations of the screen: ‘I use less subtle cues to guide clients ... for example the tone in encouraging ‘mmhm’s’. I am also aware not to cross my arms on the desk as it can appear as a block to the other. I am relying less on subtle facial cues, though they still exist naturally for me.”</i> (Downing, 2021)</li> <li>• <i>“Fears of contagion and the rapid uptake of teleconferencing platforms have, in this way, created a new range of therapeutic relationalities in which therapists have renegotiated how they experience their bodies as sensing tools. In the absence of a material consultation space in which issues of mutual trust and understanding can be explored and validated via embodied presence, the therapists that we surveyed were working hard to re-evaluate therapeutic relationships and embodied relationalities over teleconferencing technologies.”</i> (Downing, 2021)</li> </ul>
			Patient/ Therapeutic Match	<ul style="list-style-type: none"> <li>• <i>“mental health care professionals come to understand that much more is possible in online treatment than what they had initially expected”</i> (Bierbooms et al., 2020)</li> <li>• <i>“One respondent predicted that because clients are now experiencing the benefits of online treatment, there is a significant chance that they will continue to ask for it, which will to a large extent determine whether online treatment options will be integrated into the new normal.”</i> (Bierbooms et al., 2020)</li> </ul>

				<ul style="list-style-type: none"> <li>• <i>“Additionally, for some participants remote working was advantageous for specific conditions such as anxiety disorders, as it increased accessibility” (Brandon &amp; Fragkiadaki, 2023)</i></li> <li>• <i>“Participants also expressed concern that relying on work from home would make guaranteeing client safety more difficult, particularly managing the risk of violence between clients and their partners, which might obstruct access for some clients” (Brandon &amp; Fragkiadaki, 2023)</i></li> <li>• <i>“Participants found increased access to therapy significant for clients who preferred online sessions, or for those with specific needs could now be a possibility, offering them more independence and power of choice” (Brandon &amp; Fragkiadaki, 2023)</i></li> <li>• <i>“Clients from lower socioeconomic communities were more disadvantaged in terms of accessing technology, as they may lack equipment or have a poor internet connection. Additionally, because some clients did not have the necessary devices, they may become vulnerable to exclusion and unable to receive services.” (Brandon &amp; Fragkiadaki, 2023)</i></li> <li>• <i>“participants raised concerns over clients’ access to resources that would enable them to appropriately utilise these services. They expressed their concerns about their inability to assure client safety, as well as their belief that the process of risk assessment is more difficult online” (Brandon &amp; Fragkiadaki, 2023)</i></li> <li>• <i>“Participants, along with their clients shared the experiences of a global crisis during the pandemic, coping with the resulting emotional and psychological impacts in parallel. These processes influenced the development of the therapeutic relationships as the participants and clients were on an equal status, and the notion that this “humanised” the practitioner was prevalent throughout the data” (Brandon &amp; Fragkiadaki, 2023)</i></li> <li>• <i>“participants found themselves on equal terms with their clients, sitting together and sharing the reality of the pandemic. It appears that as a result, they found that it deepened and strengthened the therapeutic relationship” (Brandon &amp; Fragkiadaki, 2023)</i></li> </ul>
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|  |  |  |  | <ul style="list-style-type: none"> <li>• <i>“Participants commented that offering online therapy during the pandemic has reduced the stigma of receiving therapy. Communication also appeared to be more open and honest and that genuine empathic contact was indeed possible in remote communication” (Brandon &amp; Fragkiadaki, 2023)</i></li> <li>• <i>“Such regulation has to be adjusted to the individual patient’s needs and to the specific patient–therapist match.” (Werbart et al., 2023)</i></li> <li>• <i>“patients differ in their suitability for remote work. However, in making this judgment, the therapists focused on different patient characteristics. Positive features could include high motivation, independence, orderliness, affect tolerance, and being younger, whereas specific difficulties... could be experienced as hindering” (Werbart et al., 2023)</i></li> <li>• <i>“Generally, the therapists experienced that the transition to remote therapy changed the therapist – patient interaction in different ways, regarding patient suitability and the therapeutic boundaries” (Werbart et al., 2023)</i></li> <li>• <i>“Still, one of their general conclusions was that “different folks need different strokes,” (Werbart et al., 2023)</i></li> <li>• <i>“This struggle seemed to have different expressions in different patient–therapist constellations, thus raising the issue of the patient–therapist match in relation to participant’s needs for both a relationship and autonomy” (Werbart et al., 2023)</i></li> <li>• <i>“Therapists reflected on how the remote format might promote avoidance for patients with social problems: “and if the person doesn’t have to put himself in difficult [social] situations and can get away if you intervene, it’s bad for the patient.” (Werbart et al., 2023)</i></li> <li>• <i>“Thus, the therapists felt that different patients, and potentially different therapists too, had different needs when it comes to distance and closeness in the therapeutic relationship” (Werbart et al., 2023)</i></li> <li>• <i>“Despite such experiences reported by the therapists, they still preferred to meet their patients in-person, and the optimal distance for patient and therapist did not always match” (Werbart et al., 2023)</i></li> <li>• <i>“In more general terms, it is a matter of developing specific interventions tailored to different interpersonal patterns to facilitate telepresence” (Werbart et al., 2023)</i></li> </ul> |
|--|--|--|--|--|

				<ul style="list-style-type: none"> <li>• <i>“online therapy is not suitable for clients who suffer from severe psychopathology or mental health distress (e.g., trauma or personality disorders) (T2-4: Severe psychopathology), because they require greater contact and containment that cannot be facilitated via online mediums” (Kotera et al., 2021)</i></li> <li>• <i>“Issues around the emotional depth of therapy surfaced regularly in these comments, with some therapists saying that they deliberately kept therapy ‘lighter’ as they were unable to create a safe physical space for the session.” (Downing, 2021)</i></li> <li>• <i>“found that teletherapies had also ‘opened up’ access for client groups who struggled with physical accessibility” (Griffith et al., 2023)</i></li> <li>• <i>“Moreover, MHWs believed virtual therapeutic spaces to have protective qualities for SUs with social anxiety or avoidance, as they have ‘more control” (Griffith et al., 2023)</i></li> <li>• <i>“increased services’ flexibility which MHWs thought to improve comfort and access for SUs with impaired mobility” (Griffith et al., 2023)</i></li> </ul>
			Physical presence/absence	<ul style="list-style-type: none"> <li>• <i>“Some participants reported that the perceived absence of boundaries in teletherapy makes them feel ‘freer’ and can enable them to ask questions that they would not normally ask in person:” (Rielly et al., 2022)</i></li> <li>• <i>“Regarding the mediated nature of communication, the most frequently reported challenge concerns the lack of nonverbal signals that practitioners normally use in face-to-face communication, such as posture and hand movements, but also general demeanor, including smell” (Fejit et al., 2020)</i></li> <li>• <i>“Furthermore, practitioners reported to miss the ability to do exercises that require physical presence such as role play, or collaboratively drawing models on a whiteboard.” (Fejit et al., 2020)</i></li> <li>• <i>“Furthermore, the therapists recounted that returning to the traditional in-person setting could have a noticeable impact on the relational dynamics, positive when working with some patients and negative with others. Thus, from the therapists’ perspective, setting alternations” (Werbart et al., 2023)</i></li> <li>• <i>“Furthermore, the shift to remote sessions confronted both the patients and the therapists with the task of creating a new physical space for therapy</i></li> </ul>

				<p><i>sessions when the bodily presence at the same location was no longer possible.” (Werbart et al., 2023)</i></p> <ul style="list-style-type: none"> <li>• <i>“Despite such experiences reported by the therapists, they still preferred to meet their patients in-person, and the optimal distance for patient and therapist did not always match” (Werbart et al., 2023)</i></li> <li>• <i>“The narratives of therapists in our study revealed, regardless of their therapeutic orientation, their struggle with the closeness–distance coregulation and their insecurity regarding how to achieve an adequate balance after the transition to remote sessions” (Werbart et al., 2023)</i></li> <li>• <i>“All therapists described the shortcomings when using communication technology, such as problems with internet connection or the poor quality of phone calls. They could miss the patient’s bodily presence, not be able to see the whole person on the screen or become negatively self-aware of themselves and the patient on screen” (Werbart et al., 2023)</i></li> <li>• <i>“However, some patients seemed to be more comfortable with remote sessions, allowing them to open up more in therapy and opening new areas for therapeutic work” (Werbart et al., 2023)</i></li> <li>• <i>“All therapists experienced that the remote contact in some cases could make the patients more relaxed and contributed to more engaging and empathetic intimacy in the therapeutic relationship, bringing about more joy in the work” (Werbart et al., 2023)</i></li> <li>• <i>“The bodily absence hindered access to emotional perception and subtle impressions of the patient’s body language” (Werbart et al., 2023)</i></li> <li>• <i>“Participants found increased access to therapy significant for clients who preferred online sessions, or for those with specific needs could now be a possibility, offering them more independence and power of choice” (Brandon &amp; Fragkiadaki, 2023)</i></li> <li>• <i>“the limited nonverbal communication, and the lack of input in the form of bodily expressions were experienced as negatively influencing their therapeutic stance, which slowed down alliance-building and obstructed the interpersonal attunement” (Werbart et al., 2023)</i></li> </ul>
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				<ul style="list-style-type: none"> <li>• <i>“mental health care professionals come to understand that much more is possible in online treatment than what they had initially expected”</i> (Bierbooms et al., 2020)</li> <li>• <i>“Mental health care professionals also report that their clients tend to be more open when they are in their home environment and that genuine empathic contact is indeed possible in remote communication”</i> (Bierbooms et al., 2020)</li> <li>• <i>“Practitioners experienced the consequences of the lack of consistency and clients not feeling supported by them”</i> (Brandon &amp; Fragkiadaki, 2023)</li> <li>• <i>“Additionally, for some participants remote working was advantageous for specific conditions such as anxiety disorders, as it increased accessibility”</i> (Brandon &amp; Fragkiadaki, 2023)</li> <li>• <i>“participants raised concerns over clients’ access to resources that would enable them to appropriately utilise these services. They expressed their concerns about their inability to assure client safety, as well as their belief that the process of risk assessment is more difficult online”</i> (Brandon &amp; Fragkiadaki, 2023)</li> <li>• <i>“absence of nonverbal communication and the lack of a designated safe space for therapy were identified as challenges participants faced with the changes to mental health provision. Yet, practitioners spoke of solutions to maintain a therapeutic space suitable for their sessions.”</i> (Brandon &amp; Fragkiadaki, 2023)</li> <li>• <i>“All participants felt their view of client’s bodies, the totality of non-verbal communication and their ability to discern non-verbal communication through the digital space, were compromised.”</i> (Brandon &amp; Fragkiadaki, 2023)</li> <li>• <i>“I cannot rely on the nonverbal communication that so deeply guides my practice: body language, affect, eye contact.”</i> (Wade, 2020)</li> <li>• <i>“patients differ in their suitability for remote work. However, in making this judgment, the therapists focused on different patient characteristics. Positive features could include high motivation, independence, orderliness, affect tolerance, and being younger, whereas specific difficulties... could be experienced as hindering”</i> (Werbart et al., 2023)</li> </ul>
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|  |  |  |  | <ul style="list-style-type: none"> <li>• <i>“online therapy is not suitable for clients who suffer from severe psychopathology or mental health distress (e.g., trauma or personality disorders) (T2-4: Severe psychopathology), because they require greater contact and containment that cannot be facilitated via online mediums” (Kotera et al., 2021)</i></li> <li>• <i>“The absence of physical presence and inability to perceive non-verbal cues such as eye contact can make participants feel more comfortable in ‘bringing the therapy to a deeper level’ (P8) over the telephone and can facilitate further exploration; as one participant said, ‘I often say to a client on the phone now, you know, “I’m just wondering about this, or I was wondering about that.” I wonder more on the phone with a client than I wonder face to face’ (P10).” (Rielly et al., 2022)</i></li> <li>• <i>“Participants have to trust that their clients were truthfully disclosing their location as, ‘the combination of not knowing where they were, not being able to control the environment, were they in a place that was safe for them to speak or private’” (Rielly et al., 2022)</i></li> <li>• <i>“Physical presence’ is conducive to facilitating a collaborative, therapeutic relationship with a client; one participant claimed that, ‘the boundary of the room creates a sense of collaboration, we’re both here together working on this’ and that doing therapy remotely doesn’t feed into this sense of collaboration and active stance’” (Rielly et al., 2022)</i></li> <li>• <i>“Similarly, another respondent reported that the absence of a physical consulting space made it ‘harder to provide comfort’ when a client became distressed or expressed suicidal ideation.” (Downing, 2021)</i></li> <li>• <i>“new relationalities depended on the therapist adjusting their physical gestures to match the realities of a two-dimensional screen and the needs of their individual clients.” (Downing, 2021)</i></li> <li>• <i>“Fears of contagion and the rapid uptake of teleconferencing platforms have, in this way, created a new range of therapeutic relationalities in which therapists have renegotiated how they experience their bodies as sensing tools. In the absence of a material consultation space in which issues of mutual trust and understanding can be explored and validated via embodied presence, the therapists that we surveyed were working hard to re-evaluate</i></li> </ul> |
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				<p><i>therapeutic relationships and embodied relationalities over teleconferencing technologies.” (Downing, 2021)</i></p> <ul style="list-style-type: none"> <li>• <i>“found that teletherapies had also ‘opened up’ access for client groups who struggled with physical accessibility” (Griffith et al., 2023)</i></li> <li>•</li> </ul>
	Learning the hard way	Unexpectedness		<ul style="list-style-type: none"> <li>• <i>“...desensitised to the crisis ‘in order to survive’...” (Rielly et al., 2022)</i></li> <li>• <i>“participants talked about having to transition the mental health services they provided online on short notice” (Brandon &amp; Fragkiadaki, 2023)</i></li> <li>• <i>“absence of nonverbal communication and the lack of a designated safe space for therapy were identified as challenges participants faced with the changes to mental health provision. Yet, practitioners spoke of solutions to maintain a therapeutic space suitable for their sessions.” (Brandon &amp; Fragkiadaki, 2023)</i></li> <li>• <i>“the unexpected shift to remote sessions initially left insufficient time and space for preparation for the changed therapeutic setting. The therapists’ primary focus was on finding new ways to interact with the patients, maintaining the therapeutic alliance” (Werbart et al., 2023)</i></li> <li>• <i>“Some participants experienced initial disruptions to sessions due to their lack of experience with technology and the format, impacting their confidence in providing online therapy” (Brandon &amp; Fragkiadaki, 2023)</i></li> <li>• <i>“Clients from lower socioeconomic communities were more disadvantaged in terms of accessing technology, as they may lack equipment or have a poor internet connection. Additionally, because some clients did not have the necessary devices, they may become vulnerable to exclusion and unable to receive services.” (Brandon &amp; Fragkiadaki, 2023)</i></li> <li>• <i>“inability to secure a secluded, quiet space when providing online therapy as another challenge”. (Brandon &amp; Fragkiadaki, 2023)</i></li> <li>• <i>“Participants, along with their clients shared the experiences of a global crisis during the pandemic, coping with the resulting emotional and psychological impacts in parallel. These processes influenced the development of the therapeutic relationships as the participants and clients were on an equal status, and the notion that this “humanised” the</i></li> </ul>

			<p><i>practitioner was prevalent throughout the data” (Brandon &amp; Fragkiadaki, 2023)</i></p> <ul style="list-style-type: none"> <li>• <i>“Some of the issues identified in training for online therapy include a) lack of documents, surveys and scales for online sessions; b) lack of technological guidance (for both clients and therapists); and c) lack of guidance on how therapeutic relationships and outcomes can be addressed in online therapy” (Kotera et al., 2021)</i></li> <li>• <i>“Similarly, I wish I have been taught the ground rules more from the beginning to asking about the address, you know, those tips like: make sure you check with the clients that they’re in a private space, that they do not have any distractions, even other screens, phones, things like that.” (Kotera et al., 2021)</i></li> <li>• <i>“it was believed that teletherapy was ‘brought in in a crisis and eh people were forced into it and I guess that’s not a good way to introduce anything’” (Rielly et al., 2022)</i></li> <li>• <i>“Numerous participants agreed that ‘it’s quite containing having a boundary between home and work life’, and that ‘a level of differentiation’ between the two allows them to transition between working and relaxing (P13); however, they now have no way of escaping their work life as their home has now become ‘a therapy room almost’ (P3).” (Rielly et al., 2022)</i></li> <li>• <i>“Some participants also expressed that ‘people have access to my email now, people have access to my work mobile, things that I wouldn’t have given to clients routinely before’ (P6), as participants need alternative ways of contacting their clients should the call drop. Numerous clients are now contacting participants out of hours as a ‘mechanism to offload’, which jeopardises the boundary of the therapeutic relationship” (Rielly et al., 2022)</i></li> <li>• <i>“Participants now experience a lack of perceived control over the boundaries of therapy when delivering teletherapy. The usual boundaries of therapy that naturally ensue during in-person therapy, such as the setting and time at which it occurs, and the ensured confidentiality and safety that are rendered to participants are outside of their control” (Rielly et al., 2022)</i></li> </ul>
	Therapeutic rupture	Disharmony with patients	<ul style="list-style-type: none"> <li>• <i>“Furthermore, the therapists recounted that returning to the traditional in-person setting could have a noticeable impact on the relational dynamics,</i></li> </ul>

				<p><i>positive when working with some patients and negative with others. Thus, from the therapists' perspective, setting alternations" (Werbart et al., 2023)</i></p> <ul style="list-style-type: none"> <li>• <i>"The bodily absence hindered access to emotional perception and subtle impressions of the patient's body language" (Werbart et al., 2023)</i></li> <li>• <i>"the limited nonverbal communication, and the lack of input in the form of bodily expressions were experienced as negatively influencing their therapeutic stance, which slowed down alliance-building and obstructed the interpersonal attunement" (Werbart et al., 2023)</i></li> <li>• <i>"All therapists described the shortcomings when using communication technology, such as problems with internet connection or the poor quality of phone calls. They could miss the patient's bodily presence, not be able to see the whole person on the screen or become negatively self-aware of themselves and the patient on screen" (Werbart et al., 2023)</i></li> <li>• <i>"patients differ in their suitability for remote work. However, in making this judgment, the therapists focused on different patient characteristics. Positive features could include high motivation, independence, orderliness, affect tolerance, and being younger, whereas specific difficulties... could be experienced as hindering" (Werbart et al., 2023)</i></li> <li>• <i>"the unexpected shift to remote sessions initially left insufficient time and space for preparation for the changed therapeutic setting. The therapists' primary focus was on finding new ways to interact with the patients, maintaining the therapeutic alliance" (Werbart et al., 2023)</i></li> <li>• <i>"participants raised concerns over clients' access to resources that would enable them to appropriately utilise these services. They expressed their concerns about their inability to assure client safety, as well as their belief that the process of risk assessment is more difficult online" (Brandon &amp; Fragkiadaki, 2023)</i></li> <li>• <i>"Practitioners experienced the consequences of the lack of consistency and clients not feeling supported by them" (Brandon &amp; Fragkiadaki, 2023)</i></li> <li>• <i>"inability to secure a secluded, quiet space when providing online therapy as another challenge". (Brandon &amp; Fragkiadaki, 2023)</i></li> </ul>
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				<ul style="list-style-type: none"> <li>• <i>“The most significant limitation of online therapy identified by all participants is limited physical contact and body language, both of which can be further diminished by technological disruptions” (Kotera et al., 2021)</i></li> <li>• <i>“challenges caused by the blending of the home environment and the digital therapeutic space, which include disruptions from family members during therapy sessions, other technological interruptions (phones, laptops, tablets), lack of private space, and client behaviours that would not ordinarily occur during physical (face-to-face) sessions” (Kotera et al., 2021)</i></li> <li>• <i>“Technological problems, including a lack of digital skills in therapists and/or clients, are among them. An unstable internet connection can disrupt the flow in a therapy session, negatively impacting the therapeutic relationship and outcomes.” (Kotera et al., 2021)</i></li> <li>• <i>“Teletherapy posed a threat to some participants' sense of competency as psychologists. For those doubtful of its therapeutic capacity, this could have negatively impacted their ability to form healthy therapeutic relationships.” (Rielly et al., 2022)</i></li> <li>• <i>“One participant reported having woken up on a Monday morning to a ‘rake-load of texts from a client... she was making all these disclosures, so it was very very unboundaried’ (P6), which resulted in them having to remind their client that they ‘don't have the capacity to respond to those types of communications’ outside of their scheduled weekly appointment (P6). Having to remedy these ruptures in the therapeutic relationship boundaries places additional strain on participants as they have to prevent clients from interpreting their relationship to be a colloquial one.” (Rielly et al., 2022)</i></li> <li>• <i>“Fears of contagion and the rapid uptake of teleconferencing platforms have, in this way, created a new range of therapeutic relationalities in which therapists have renegotiated how they experience their bodies as sensing tools. In the absence of a material consultation space in which issues of mutual trust and understanding can be explored and validated via embodied presence, the therapists that we surveyed were working hard to re-evaluate therapeutic relationships and embodied relationalities over teleconferencing technologies.” (Downing, 2021)</i></li> </ul>
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		Feelings of incompetence	Unpreparedness	<ul style="list-style-type: none"> <li>• <i>“As many practitioners were first-time users of online treatment tools, this is likely associated with a steep learning curve, and the technological skill set of practitioners will probably become more sophisticated with experience over time”</i> (Fejit et al., 2020)</li> <li>• <i>“A possible explanation for this could be that the transition to online treatment was very sudden and the necessary technological infrastructure and support mechanisms were not fully in place”</i> (Fejit et al., 2020)</li> <li>• <i>“Participants also expressed concern that relying on work from home would make guaranteeing client safety more difficult, particularly managing the risk of violence between clients and their partners, which might obstruct access for some clients”</i> (Brandon &amp; Fragkiadaki, 2023)</li> <li>• <i>“Insufficient technological structure”</i> (Fejit et al., 2020)</li> <li>• <i>“online treatment is less suitable for treating trauma, family therapy, for clients with psychotic symptoms, severe anxiety, and generally those who are vulnerable to crisis and a sudden exacerbation of symptoms.”</i> (Fejit et al., 2020)</li> <li>• <i>“These learning experiences contributed to increased security and a more positive view of remote therapeutic work, which could help the therapists to give the patients a feeling of security when starting treatment: “Over time, I have built up trust in remote therapy, so I think I can now convey a kind of confidence in the format, early in the therapy process.”</i> (Werbart et al., 2023)</li> <li>• <i>“Initially, the therapists were convinced that remote psychotherapy would not function as well as traditional in-person sessions, and they were not prepared to adapt their way of working to the new circumstances”</i> (Werbart et al., 2023)</li> <li>• <i>“the unexpected shift to remote sessions initially left insufficient time and space for preparation for the changed therapeutic setting. The therapists’ primary focus was on finding new ways to interact with the patients, maintaining the therapeutic alliance”</i> (Werbart et al., 2023)</li> <li>• <i>“It is possible that the therapists’ initial negative expectations and lack of training and time for preparation for remote communication, together with technical obstacles, contributed to the therapists’ attribution of the lack of</i></li> </ul>
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				<p><i>contact and loss of closeness in the therapeutic relationship to the forced transition from in-person to remote sessions.” (Werbart et al., 2023)</i></p> <ul style="list-style-type: none"> <li>• <i>“Some participants experienced initial disruptions to sessions due to their lack of experience with technology and the format, impacting their confidence in providing online therapy” (Brandon &amp; Fragkiadaki, 2023)</i></li> <li>• <i>“Practitioners experienced the consequences of the lack of consistency and clients not feeling supported by them” (Brandon &amp; Fragkiadaki, 2023)</i></li> <li>• <i>“participants raised concerns over clients’ access to resources that would enable them to appropriately utilise these services. They expressed their concerns about their inability to assure client safety, as well as their belief that the process of risk assessment is more difficult online” (Brandon &amp; Fragkiadaki, 2023)</i></li> <li>• <i>“Clients from lower socioeconomic communities were more disadvantaged in terms of accessing technology, as they may lack equipment or have a poor internet connection. Additionally, because some clients did not have the necessary devices, they may become vulnerable to exclusion and unable to receive services.” (Brandon &amp; Fragkiadaki, 2023)</i></li> <li>• <i>“absence of nonverbal communication and the lack of a designated safe space for therapy were identified as challenges participants faced with the changes to mental health provision. Yet, practitioners spoke of solutions to maintain a therapeutic space suitable for their sessions.” (Brandon &amp; Fragkiadaki, 2023)</i></li> <li>• <i>“inability to secure a secluded, quiet space when providing online therapy as another challenge”. (Brandon &amp; Fragkiadaki, 2023)</i></li> <li>• <i>“Some of the issues identified in training for online therapy include a) lack of documents, surveys and scales for online sessions; b) lack of technological guidance (for both clients and therapists); and c) lack of guidance on how therapeutic relationships and outcomes can be addressed in online therapy” (Kotera et al., 2021)</i></li> <li>• <i>“Similarly, I wish I have been taught the ground rules more from the beginning to asking about the address, you know, those tips like: make sure you check with the clients that they’re in a private space, that they do not</i></li> </ul>
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				<p><i>have any distractions, even other screens, phones, things like that.” (Kotera et al., 2021)</i></p> <ul style="list-style-type: none"> <li>• <i>“Technological problems, including a lack of digital skills in therapists and/or clients, are among them. An unstable internet connection can disrupt the flow in a therapy session, negatively impacting the therapeutic relationship and outcomes.” (Kotera et al., 2021)</i></li> <li>• <i>“The vast majority of participants anticipated that teletherapy was going to be a temporary solution to the upheaval of the pandemic and that its efficacy was incomparable to that of in-person treatment” (Rielly et al., 2022)</i></li> <li>• <i>“Numerous participants agreed that ‘it’s quite containing having a boundary between home and work life’, and that ‘a level of differentiation’ between the two allows them to transition between working and relaxing (P13); however, they now have no way of escaping their work life as their home has now become ‘a therapy room almost’ (P3).” (Rielly et al., 2022)</i></li> <li>• <i>“Some participants also expressed that ‘people have access to my email now, people have access to my work mobile, things that I wouldn’t have given to clients routinely before’ (P6), as participants need alternative ways of contacting their clients should the call drop. Numerous clients are now contacting participants out of hours as a ‘mechanism to offload’, which jeopardises the boundary of the therapeutic relationship” (Rielly et al., 2022)</i></li> <li>• <i>“Participants now experience a lack of perceived control over the boundaries of therapy when delivering teletherapy. The usual boundaries of therapy that naturally ensue during in-person therapy, such as the setting and time at which it occurs, and the ensured confidentiality and safety that are rendered to participants are outside of their control” (Rielly et al., 2022)</i></li> <li>• <i>“the sudden shift to using online teleconferencing platforms such as Zoom, Skype and Facetime resulted in the need for an entirely different relational skillset – one in which the therapist’s reading of the client was often limited to their head and shoulders” (Downing, 2021)</i></li> <li>• <i>“The uncertainty of early lock-downs, transitioning to tele-appointments only, reduction in hours, increase in client distress and symptom management concerns, difficulty in finding professional resources (e.g., consultation groups) as well as unpacking personally and professionally the concept of</i></li> </ul>
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			<p><i>systemic racism have created a very challenging environment to provide useful and helpful psychotherapy” (Mittal et al., 2023)</i></p> <ul style="list-style-type: none"> <li>• <i>“They shared, “I don’t feel connected to my clients, I have an increased sense of imposter syndrome, and a decreased sense of efficacy as a clinician,” “It’s (the pandemic) made it harder to concentrate and focus. It’s left me distracted and less engaged. It’s made it harder to access empathy at times,” and “I’m more anxious. I’m less present with clients or I have to force it, draining more energy.” (Mittal et al., 2023)</i></li> </ul>
	Blurred boundaries	New insights about patients	<ul style="list-style-type: none"> <li>• <i>“Another advantage concerns the ability to see more of the clients’ home environments and their behavior outside the therapy room, which can lead to new information that is valuable for treatment.” (Fejit et al., 2020)</i></li> <li>• <i>“challenges caused by the blending of the home environment and the digital therapeutic space, which include disruptions from family members during therapy sessions, other technological interruptions (phones, laptops, tablets), lack of private space, and client behaviours that would not ordinarily occur during physical (face-to-face) sessions” (Kotera et al., 2021)</i></li> <li>• <i>“many participants found that their clients were doing teletherapy sessions in inappropriate or unconventional places such as their cars, on the bus, or while doing jobs around the house, which participants may have ‘taken for granted when somebody’s in the office with you’” (Rielly et al., 2022)</i></li> <li>• <i>“Participants also had to re-establish the boundaries of the therapeutic relationship, as clients began to treat their encounter ‘less formally than, you know, coming in for your therapy session, people were treating it like I think maybe a call from a friend” (Rielly et al., 2022)</i></li> </ul>
		Self-disclosure	<ul style="list-style-type: none"> <li>• <i>“I’ve probably been even more open and transparent with my thoughts and concerns with her just based on the technology” (Werbart et al., 2023)</i></li> <li>• <i>“I have since come to understand that a healthy dose of self-disclosure is an invaluable tool in building transformative therapeutic relationships. During this coronavirus pandemic, I cannot think of a more powerful therapeutic tool. I have the opportunity to model for my patients how to sit with discomfort gracefully and to normalize the anxiety and fear that we are collectively sitting with” (Wade, 2020)</i></li> </ul>

				<ul style="list-style-type: none"> <li>• <i>“Because I’m less motivated and somewhat lonely, I’m worried that I may be inappropriately disclosing with clients. I haven’t, but [I am] concerned about possibility” (Mittal et al., 2023)</i></li> <li>• <i>“I feel less able to hold boundaries and less focused in session,” “[I have to be mindful of] feelings of vulnerability at times around my own sadness or anxiety. Also, an urge to self-disclose that I keep an eye on, just related to us all being in the same boat,” (Mittal et al., 2023)</i></li> </ul>
		Perceived change in the relationship		<ul style="list-style-type: none"> <li>• <i>“Some participants reported that the perceived absence of boundaries in teletherapy makes them feel ‘freer’ and can enable them to ask questions that they would not normally ask in person:” (Rielly et al., 2022)</i></li> <li>• <i>“Practitioners find it more difficult to connect with their client or clearly communicate their intended message.” (Fejit et al., 2020)</i></li> <li>• <i>“Moreover, sessions are sometimes shorter and more efficient, because the conversations tend to focus more on the content. (Fejit et al., 2020)</i></li> <li>• <i>“The new ways of interacting affected the relational dynamics and led to changed patient and therapist roles, as well as an altered power balance in the therapeutic relationship.” (Werbart et al., 2023)</i></li> <li>• <i>“Participants, along with their clients shared the experiences of a global crisis during the pandemic, coping with the resulting emotional and psychological impacts in parallel. These processes influenced the development of the therapeutic relationships as the participants and clients were on an equal status, and the notion that this “humanised” the practitioner was prevalent throughout the data” (Brandon &amp; Fragkiadaki, 2023)</i></li> <li>• <i>“However, some patients seemed to be more comfortable with remote sessions, allowing them to open up more in therapy and opening new areas for therapeutic work” (Werbart et al., 2023)</i></li> <li>• <i>“the limited nonverbal communication, and the lack of input in the form of bodily expressions were experienced as negatively influencing their therapeutic stance, which slowed down alliance-building and obstructed the interpersonal attunement” (Werbart et al., 2023)</i></li> </ul>

				<ul style="list-style-type: none"> <li>• <i>“mental health care professionals come to understand that much more is possible in online treatment than what they had initially expected” (Bierbooms et al., 2020)</i></li> <li>• <i>“Some participants experienced initial disruptions to sessions due to their lack of experience with technology and the format, impacting their confidence in providing online therapy” (Brandon &amp; Fragkiadaki, 2023)</i></li> <li>• <i>“Practitioners experienced the consequences of the lack of consistency and clients not feeling supported by them” (Brandon &amp; Fragkiadaki, 2023)</i></li> <li>• <i>“Participants commented that offering online therapy during the pandemic has reduced the stigma of receiving therapy. Communication also appeared to be more open and honest and that genuine empathic contact was indeed possible in remote communication” (Brandon &amp; Fragkiadaki, 2023)</i></li> <li>• <i>“Generally, the therapists experienced that the transition to remote therapy changed the therapist – patient interaction in different ways, regarding patient suitability and the therapeutic boundaries” (Werbart et al., 2023)</i></li> <li>• <i>“All therapists experienced that the remote contact in some cases could make the patients more relaxed and contributed to more engaging and empathetic intimacy in the therapeutic relationship, bringing about more joy in the work” (Werbart et al., 2023)</i></li> <li>• <i>“The absence of physical presence and inability to perceive non-verbal cues such as eye contact can make participants feel more comfortable in ‘bringing the therapy to a deeper level’ (P8) over the telephone and can facilitate further exploration; as one participant said, ‘I often say to a client on the phone now, you know, “I’m just wondering about this, or I was wondering about that.” I wonder more on the phone with a client than I wonder face to face’ (P10).” (Rielly et al., 2022)</i></li> <li>• <i>“It is important to establish boundaries early in therapy and ‘get all of that right from the outset’ (P2), and, in an attempt to re-establish these boundaries in this new teletherapeutic space, participants laid out explicit guidelines to keep it similar to meeting in-person such as setting aside 50 minutes to do the session and making sure that they are in a confidential space where they would not be overheard and would not be disturbed, as this communicates to the client that, ‘I very much care about this, you’re</i></li> </ul>
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				<p><i>important to me, your issues are important to me' (P1). Re-establishing these therapeutic boundaries provided participants with the prerequisite foundation for nurturing a strong therapeutic relationship similar to how they would have in person, albeit through an unfamiliar, virtual medium.” (Rielly et al., 2022)</i></p> <ul style="list-style-type: none"> <li>• <i>“many participants found that their clients were doing teletherapy sessions in inappropriate or unconventional places such as their cars, on the bus, or while doing jobs around the house, which participants may have ‘taken for granted when somebody’s in the office with you ’” (Rielly et al., 2022)</i></li> <li>• <i>“Participants have to trust that their clients were truthfully disclosing their location as, ‘the combination of not knowing where they were, not being able to control the environment, were they in a place that was safe for them to speak or private ’” (Rielly et al., 2022)</i></li> <li>• <i>“Participants also had to re-establish the boundaries of the therapeutic relationship, as clients began to treat their encounter ‘less formally than, you know, coming in for your therapy session, people were treating it like I think maybe a call from a friend” (Rielly et al., 2022)</i></li> <li>• <i>“Some participants also expressed that ‘people have access to my email now, people have access to my work mobile, things that I wouldn’t have given to clients routinely before’ (P6), as participants need alternative ways of contacting their clients should the call drop. Numerous clients are now contacting participants out of hours as a ‘mechanism to offload’, which jeopardises the boundary of the therapeutic relationship” (Rielly et al., 2022)</i></li> <li>• <i>“new relationalities depended on the therapist adjusting their physical gestures to match the realities of a two-dimensional screen and the needs of their individual clients.” (Downing, 2021)</i></li> <li>• <i>“Fears of contagion and the rapid uptake of teleconferencing platforms have, in this way, created a new range of therapeutic relationalities in which therapists have renegotiated how they experience their bodies as sensing tools. In the absence of a material consultation space in which issues of mutual trust and understanding can be explored and validated via embodied presence, the therapists that we surveyed were working hard to re-evaluate</i></li> </ul>
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				<p><i>therapeutic relationships and embodied relationalities over teleconferencing technologies.</i>” (Downing, 2021)</p> <ul style="list-style-type: none"> <li>• <i>“They shared, “I don’t feel connected to my clients, I have an increased sense of imposter syndrome, and a decreased sense of efficacy as a clinician,” “It’s (the pandemic) made it harder to concentrate and focus. It’s left me distracted and less engaged. It’s made it harder to access empathy at times,” and “I’m more anxious. I’m less present with clients or I have to force it, draining more energy.” (Mittal et al., 2023)</i></li> <li>• <i>“how recounting complex traumas could feel ‘quite shameful’ for SUs in face-to-face sessions: teletherapy was thought to ease this process, as ‘over the phone people can’t see your face’” (Griffith et al., 2023)</i></li> </ul>
		<p>Changes in control</p>	<p>Shifts in control over therapeutic relationship</p>	<ul style="list-style-type: none"> <li>• <i>“Some practitioners reported to lack sufficient support from their organization to help them work with the available software or devices, and guidelines about which tools meet privacy regulations, such as the General Data Protection Regulation.” (Fejit et al., 2020)</i></li> <li>• <i>“Sometimes the client’s home environment does not offer the required privacy needed for online treatment.” (Fejit et al., 2020)</i></li> <li>• <i>“Participants also offered some interesting reflections about having more control over the therapeutic situation and being less affected by potentially difficult and/or negative therapeutic experiences with clients” (Kotera et al., 2021)</i></li> <li>• <i>“challenges caused by the blending of the home environment and the digital therapeutic space, which include disruptions from family members during therapy sessions, other technological interruptions (phones, laptops, tablets), lack of private space, and client behaviours that would not ordinarily occur during physical (face-to-face) sessions” (Kotera et al., 2021)</i></li> <li>• <i>“online therapy is not suitable for clients who suffer from severe psychopathology or mental health distress (e.g., trauma or personality disorders) (T2-4: Severe psychopathology), because they require greater contact and containment that cannot be facilitated via online mediums” (Kotera et al., 2021)</i></li> <li>• <i>“what about privacy? Containment in the room?” (Kotera et al., 2021)</i></li> </ul>

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|  |  |  |  | <ul style="list-style-type: none"> <li>• “Technological problems, including a lack of digital skills in therapists and/or clients, are among them. An unstable internet connection can disrupt the flow in a therapy session, negatively impacting the therapeutic relationship and outcomes.” (Kotera et al., 2021)</li> <li>• <i>“Furthermore, the therapists recounted that returning to the traditional in-person setting could have a noticeable impact on the relational dynamics, positive when working with some patients and negative with others. Thus, from the therapists’ perspective, setting alternations”</i> (Werbart et al., 2023)</li> <li>• <i>“Generally, the therapists felt uncertain and uncomfortable when confronted with major limitations in the application of core elements of their therapeutic work”</i> (Werbart et al., 2023)</li> <li>• <i>“It became harder to sense the patient’s mood and to regulate affects, which contributed to feelings of insecurity”</i> (Werbart et al., 2023)</li> <li>• <i>“patients differ in their suitability for remote work. However, in making this judgment, the therapists focused on different patient characteristics. Positive features could include high motivation, independence, orderliness, affect tolerance, and being younger, whereas specific difficulties... could be experienced as hindering”</i> (Werbart et al., 2023)</li> <li>• <i>“the limited nonverbal communication, and the lack of input in the form of bodily expressions were experienced as negatively influencing their therapeutic stance, which slowed down alliance-building and obstructed the interpersonal attunement”</i> (Werbart et al., 2023)</li> <li>• <i>“Some participants experienced initial disruptions to sessions due to their lack of experience with technology and the format, impacting their confidence in providing online therapy”</i> (Brandon &amp; Fragkiadaki, 2023)</li> <li>• <i>“Practitioners experienced the consequences of the lack of consistency and clients not feeling supported by them”</i> (Brandon &amp; Fragkiadaki, 2023)</li> <li>• <i>“participants raised concerns over clients’ access to resources that would enable them to appropriately utilise these services. They expressed their concerns about their inability to assure client safety, as well as their belief that the process of risk assessment is more difficult online”</i> (Brandon &amp; Fragkiadaki, 2023)</li> </ul> |
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				<ul style="list-style-type: none"> <li>• <i>“Participants also expressed concern that relying on work from home would make guaranteeing client safety more difficult, particularly managing the risk of violence between clients and their partners, which might obstruct access for some clients” (Brandon &amp; Fragkiadaki, 2023)</i></li> <li>• <i>“Clients from lower socioeconomic communities were more disadvantaged in terms of accessing technology, as they may lack equipment or have a poor internet connection. Additionally, because some clients did not have the necessary devices, they may become vulnerable to exclusion and unable to receive services.” (Brandon &amp; Fragkiadaki, 2023)</i></li> <li>• <i>“All participants felt their view of client’s bodies, the totality of non-verbal communication and their ability to discern non-verbal communication through the digital space, were compromised.” (Brandon &amp; Fragkiadaki, 2023)</i></li> <li>• <i>“inability to secure a secluded, quiet space when providing online therapy as another challenge”. (Brandon &amp; Fragkiadaki, 2023)</i></li> <li>• <i>“It is important to establish boundaries early in therapy and ‘get all of that right from the outset’ (P2), and, in an attempt to re-establish these boundaries in this new teletherapeutic space, participants laid out explicit guidelines to keep it similar to meeting in-person such as setting aside 50 minutes to do the session and making sure that they are in a confidential space where they would not be overheard and would not be disturbed, as this communicates to the client that, ‘I very much care about this, you’re important to me, your issues are important to me’ (P1). Re-establishing these therapeutic boundaries provided participants with the prerequisite foundation for nurturing a strong therapeutic relationship similar to how they would have in person, albeit through an unfamiliar, virtual medium.” (Rielly et al., 2022)</i></li> <li>• <i>“many participants found that their clients were doing teletherapy sessions in inappropriate or unconventional places such as their cars, on the bus, or while doing jobs around the house, which participants may have ‘taken for granted when somebody’s in the office with you ’” (Rielly et al., 2022)</i></li> </ul>
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|  |  |  |  | <ul style="list-style-type: none"> <li>• <i>“Participants also experienced a lack of control over their own personal boundaries while delivering teletherapy, with the merging of their personal and professional lives.” (Rielly et al., 2022)</i></li> <li>• <i>“Participants have to trust that their clients were truthfully disclosing their location as, ‘the combination of not knowing where they were, not being able to control the environment, were they in a place that was safe for them to speak or private’” (Rielly et al., 2022)</i></li> <li>• <i>“Participants also had to re-establish the boundaries of the therapeutic relationship, as clients began to treat their encounter ‘less formally than, you know, coming in for your therapy session, people were treating it like I think maybe a call from a friend” (Rielly et al., 2022)</i></li> <li>• <i>“Some participants also expressed that ‘people have access to my email now, people have access to my work mobile, things that I wouldn't have given to clients routinely before’ (P6), as participants need alternative ways of contacting their clients should the call drop. Numerous clients are now contacting participants out of hours as a ‘mechanism to offload’, which jeopardises the boundary of the therapeutic relationship” (Rielly et al., 2022)</i></li> <li>• <i>“Participants now experience a lack of perceived control over the boundaries of therapy when delivering teletherapy. The usual boundaries of therapy that naturally ensue during in-person therapy, such as the setting and time at which it occurs, and the ensured confidentiality and safety that are rendered to participants are outside of their control” (Rielly et al., 2022)</i></li> <li>• <i>“When these spaces and the bodies within them suddenly came to represent fears around contagion and disease, a significant layer of complexity was added to the therapeutic encounter” (Downing, 2021)</i></li> <li>• <i>“concerns around privacy risks arose, with several of our respondents expressing concern that their clients did not have a safe or private space within which to attend the session. Therapeutic consultations in cars, bedrooms and broom cupboards quickly became commonplace as clients sought out private spaces away from cohabitants during social lockdowns. This issue was especially pressing for clients who lived in a shared house, or with elderly family members and/or children who were prone to interrupting” (Downing, 2021)</i></li> </ul> |
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				<ul style="list-style-type: none"> <li>• <i>“I center myself on that purpose during this pandemic and it helps me channel my own feelings of helplessness. I am appreciating the additional time at home with family and hobbies now that I don’t have a commute. I focus on that rather than the ambiguity of the situation and the lack of control.”</i> (Mittal et al., 2023)</li> <li>• <i>“Moreover, MHWs believed virtual therapeutic spaces to have protective qualities for SUs with social anxiety or avoidance, as they have ‘more control’”</i> (Griffith et al., 2023)</li> <li>• <i>“This was especially troubling for those handling upsetting calls who, were unable to draw support from their colleagues and had ‘nobody to check in with’”</i> (Griffith et al., 2023)</li> </ul>
		“Empathic Contact”	Possibility to create therapeutic relationship	<ul style="list-style-type: none"> <li>• <i>“Mental health care professionals also report that their clients tend to be more open when they are in their home environment and that genuine empathic contact is indeed possible in remote communication”</i> (Bierbooms et al., 2020)</li> <li>• <i>“One respondent predicted that because clients are now experiencing the benefits of online treatment, there is a significant chance that they will continue to ask for it, which will to a large extent determine whether online treatment options will be integrated into the new normal.”</i> (Bierbooms et al., 2020)</li> <li>• <i>“Participants found increased access to therapy significant for clients who preferred online sessions, or for those with specific needs could now be a possibility, offering them more independence and power of choice”</i> (Brandon &amp; Fragkiadaki, 2023)</li> <li>• <i>“absence of nonverbal communication and the lack of a designated safe space for therapy were identified as challenges participants faced with the changes to mental health provision. Yet, practitioners spoke of solutions to maintain a therapeutic space suitable for their sessions.”</i> (Brandon &amp; Fragkiadaki, 2023)</li> <li>• <i>“participants found themselves on equal terms with their clients, sitting together and sharing the reality of the pandemic. It appears that as a result, they found that it deepened and strengthened the therapeutic relationship”</i> (Brandon &amp; Fragkiadaki, 2023)</li> </ul>

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|  |  |  |  | <ul style="list-style-type: none"> <li>• <i>“Participants commented that offering online therapy during the pandemic has reduced the stigma of receiving therapy. Communication also appeared to be more open and honest and that genuine empathic contact was indeed possible in remote communication” (Brandon &amp; Fragkiadaki, 2023)</i></li> <li>• <i>“described experiences of positive surprise and exceeded expectations regarding remote therapy.” (Werbart et al., 2023)</i></li> <li>• <i>“The absence of physical presence and inability to perceive non-verbal cues such as eye contact can make participants feel more comfortable in ‘bringing the therapy to a deeper level’ (P8) over the telephone and can facilitate further exploration; as one participant said, ‘I often say to a client on the phone now, you know, “I’m just wondering about this, or I was wondering about that.” I wonder more on the phone with a client than I wonder face to face’ (P10).” (Rielly et al., 2022)</i></li> <li>• <i>“It is important to establish boundaries early in therapy and ‘get all of that right from the outset’ (P2), and, in an attempt to re-establish these boundaries in this new teletherapeutic space, participants laid out explicit guidelines to keep it similar to meeting in-person such as setting aside 50 minutes to do the session and making sure that they are in a confidential space where they would not be overheard and would not be disturbed, as this communicates to the client that, ‘I very much care about this, you’re important to me, your issues are important to me’ (P1). Re-establishing these therapeutic boundaries provided participants with the prerequisite foundation for nurturing a strong therapeutic relationship similar to how they would have in person, albeit through an unfamiliar, virtual medium.” (Rielly et al., 2022)</i></li> <li>• <i>“Some participants reported that the perceived absence of boundaries in teletherapy makes them feel ‘freer’ and can enable them to ask questions that they would not normally ask in person:” (Rielly et al., 2022)</i></li> <li>• <i>“therapists reported feeling worried about how they were relating to clients online as they could not see each other’s full bodies. As one respondent said: ‘The lack of visual information on client’s body impacts on my ability to accurately pick up on emotional states.” (Downing, 2021)</i></li> </ul> |
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				<ul style="list-style-type: none"> <li>• <i>“another respondent worried that it was harder to pick up on subtle emotions over a two-dimensional screen: ‘Reading subtle emotional cues is difficult. I have to rely much more on the verbal components of therapy’ (Downing, 2021)</i></li> </ul>
	Consequences of inadequate training programs	Lack of training	Little to no training or support	<ul style="list-style-type: none"> <li>• <i>“Lack of organizational and procedural support” (Fejit et al., 2020)</i></li> <li>• <i>“Some practitioners reported to lack sufficient support from their organization to help them work with the available software or devices, and guidelines about which tools meet privacy regulations, such as the General Data Protection Regulation.” (Fejit et al., 2020)</i></li> <li>• <i>“Also, sessions with children, groups, and clients with cognitive impairments are more challenging. Some clients lack the digital skills to work with the software,” (Fejit et al., 2020)</i></li> <li>• <i>“It is possible that the therapists’ initial negative expectations and lack of training and time for preparation for remote communication, together with technical obstacles, contributed to the therapists” (Kotera et al., 2021)</i></li> <li>• <i>“[Online therapy] was not part of my master’s program or my supervision. It’s something that I’ve learnt more about, now that I’m doing it since COVID. . . . and it works! And it’s better than I thought it was going to be.” (Kotera, et al., 2021)</i></li> <li>• <i>“Some of the issues identified in training for online therapy include a) lack of documents, surveys and scales for online sessions; b) lack of technological guidance (for both clients and therapists); and c) lack of guidance on how therapeutic relationships and outcomes can be addressed in online therapy” (Kotera et al., 2021)</i></li> <li>• <i>“Similarly, I wish I have been taught the ground rules more from the beginning to asking about the address, you know, those tips like: make sure you check with the clients that they’re in a private space, that they do not have any distractions, even other screens, phones, things like that.” (Kotera et al., 2021)</i></li> <li>• <i>“The lack of training on online therapy delivery had a detrimental impact on both their clients, themselves as practitioners as well as the therapy process” (Brandon &amp; Fragkiadaki, 2023)</i></li> </ul>

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|  |  |  |  | <ul style="list-style-type: none"> <li>• <i>“Both clients and practitioners experienced 'internet glitches' have disrupted conversations and have had an impact on the therapeutic work” (Brandon &amp; Fragkiadaki, 2023)</i></li> <li>• <i>“Some participants experienced initial disruptions to sessions due to their lack of experience with technology and the format, impacting their confidence in providing online therapy” (Brandon &amp; Fragkiadaki, 2023)</i></li> <li>• <i>“participants raised concerns over clients’ access to resources that would enable them to appropriately utilise these services. They expressed their concerns about their inability to assure client safety, as well as their belief that the process of risk assessment is more difficult online” (Brandon &amp; Fragkiadaki, 2023)</i></li> <li>• <i>“Participants also expressed concern that relying on work from home would make guaranteeing client safety more difficult, particularly managing the risk of violence between clients and their partners, which might obstruct access for some clients” (Brandon &amp; Fragkiadaki, 2023)</i></li> <li>• <i>“absence of nonverbal communication and the lack of a designated safe space for therapy were identified as challenges participants faced with the changes to mental health provision. Yet, practitioners spoke of solutions to maintain a therapeutic space suitable for their sessions.” (Brandon &amp; Fragkiadaki, 2023)</i></li> <li>• <i>“It is possible that the therapists’ initial negative expectations and lack of training and time for preparation for remote communication, together with technical obstacles, contributed to the therapists’ attribution of the lack of contact and loss of closeness in the therapeutic relationship to the forced transition from in-person to remote sessions.” (Werbart et al., 2023)</i></li> <li>• <i>“A colleague of mine once shared a reflection on suicide: Some people are just too tender for this world. It struck me so deeply. There is an incongruence between our personal experience and our cultural narrative that is fueling suicide. Our patients are ending their lives because they have been made to feel that the universal human experience of having emotions is abnormal.” (Wade, 2020)</i></li> <li>• <i>“Although mental health providers and their professional organizations are adapting to the demands of the pandemic on their profession and clinical</i></li> </ul> |
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				<p><i>practice, the pandemic also challenges us to rethink aspects of clinical training and mental health workforce development” (Fish &amp; Mittal, 2021)</i></p> <ul style="list-style-type: none"> <li>• <i>“In order to mitigate the lack of training and experience in online therapy, some participants joined an online community of therapists; however, more support is needed” (Kotera et al., 2021)</i></li> <li>• <i>“Taken together, the participants did not feel that they had had enough training (T3-1), nor that helpful guidance was available (T3-2). Though some of them accessed an online community of therapists, more support was needed” (Kotera et al., 2021)</i></li> <li>• <i>“Psychologists themselves feel uncontained from being insufficiently supported by the HSE, “(Rielly et al., 2022)</i></li> <li>• <i>“Numerous participants agreed that ‘it's quite containing having a boundary between home and work life’, and that ‘a level of differentiation’ between the two allows them to transition between working and relaxing (P13); however, they now have no way of escaping their work life as their home has now become ‘a therapy room almost’ (P3).” (Rielly et al., 2022)</i></li> <li>• <i>“It is important to establish boundaries early in therapy and ‘get all of that right from the outset’ (P2), and, in an attempt to re-establish these boundaries in this new teletherapeutic space, participants laid out explicit guidelines to keep it similar to meeting in-person such as setting aside 50 minutes to do the session and making sure that they are in a confidential space where they would not be overheard and would not be disturbed, as this communicates to the client that, ‘I very much care about this, you're important to me, your issues are important to me’ (P1). Re-establishing these therapeutic boundaries provided participants with the prerequisite foundation for nurturing a strong therapeutic relationship similar to how they would have in person, albeit through an unfamiliar, virtual medium.” (Rielly et al., 2022)</i></li> <li>• <i>“Some participants also expressed that ‘people have access to my email now, people have access to my work mobile, things that I wouldn't have given to clients routinely before’ (P6), as participants need alternative ways of contacting their clients should the call drop. Numerous clients are now</i></li> </ul>
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				<p><i>contacting participants out of hours as a ‘mechanism to offload’, which jeopardises the boundary of the therapeutic relationship” (Rielly et al., 2022)</i></p> <ul style="list-style-type: none"> <li>• <i>“Participants now experience a lack of perceived control over the boundaries of therapy when delivering teletherapy. The usual boundaries of therapy that naturally ensue during in-person therapy, such as the setting and time at which it occurs, and the ensured confidentiality and safety that are rendered to participants are outside of their control” (Rielly et al., 2022)</i></li> <li>• <i>“They reported feeling lost, vulnerable, stressed, overwhelmed, and emotionally burned out. Participants also stated that they felt isolated, lonely, worried, anxious, and depressed. They shared, “it highlighted my own loneliness, isolation and need for meaningful connections” and “There are some days when I feel particularly drained from multiple telehealth sessions and lack of social contact with my colleagues.” (Mittal et al., 2023)</i></li> <li>• <i>“The racism in my personal life is replicated in the workplace and this has been stressful. Racism has increased since COVID-19 toward Black, Brown communities. I manage racial battle fatigue and race-related stress sufficiently such that it doesn’t negatively affect my clinical practice, but I do not anticipate staying in my organization long-term.” (Mittal et al., 2023)</i></li> <li>• <i>“Mental health providers reported that the pandemic-related stressors had significantly impacted their satisfaction with work. Study participants shared, “Extremely unsatisfying for me as a clinician as I am limited in providing services and doing what I love,” “[I] have not enjoyed my job as much as I used to,” and “Increased isolation “(mine) has decreased “informal” times to reach out to colleagues during the day, therefore increasing stress and decreasing satisfaction found in the work environment.” Several other participants talked about losing motivation and questioning the meaningfulness of their work.” (Mittal et al., 2023)</i></li> <li>• <i>“This was especially troubling for those handling upsetting calls who, were unable to draw support from their colleagues and had ‘nobody to check in with’” (Griffith et al., 2023)</i></li> <li>• <i>“Without peer debriefs, MHWs had to ‘deal with’ their emotions alone and could no longer ‘go home and leave it [work] behind” (Griffith et al., 2023)</i></li> </ul>
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Time waits for no one	Professional Growth and Development	New Opportunities	<ul style="list-style-type: none"> <li>• <i>“Some participants reported that the perceived absence of boundaries in teletherapy makes them feel ‘freer’ and can enable them to ask questions that they would not normally ask in person:” (Rielly et al., 2022)</i></li> <li>• <i>“Therapists reflected on how the remote format might promote avoidance for patients with social problems: “and if the person doesn’t have to put himself in difficult [social] situations and can get away if you intervene, it’s bad for the patient.” (Werbart et al., 2023)</i></li> <li>• <i>“On the other hand, the remote format and a deliberate choice of communication channels (e.g., solely audio) could give new and increased opportunities to intervene.” (Werbart et al., 2023)</i></li> <li>• <i>“As the pandemic continued, the therapists in our study became more comfortable with conducting remote psychotherapy, and they seemed to continuously renegotiate the altered therapeutic setting” (Werbart et al., 2023)</i></li> <li>• <i>“In the long term, they became surprised at how well the remote therapy could function, and that the very essence of therapy could be preserved” (Werbart et al., 2023)</i></li> <li>• <i>“the new ways of interacting affected the relational dynamics and led to changed patient and therapist roles, as well as an altered power balance in the therapeutic relationship.” (Werbart et al., 2023)</i></li> <li>• <i>“The transition triggered their creativity and they adapted to the new circumstances, finding new ways of working, developing new skills, and learning how to calibrate the therapeutic distance in remote sessions.” (Werbart et al., 2023)</i></li> <li>• <i>“In sum, the changes that followed the transition to remote psychotherapy generated a shift in the therapists’ attitude over time.” (Werbart et al., 2023)</i></li> <li>• <i>“described experiences of positive surprise and exceeded expectations regarding remote therapy.” (Werbart et al., 2023)</i></li> <li>• <i>“Generally, the therapists experienced that the transition to remote therapy changed the therapist – patient interaction in different ways, regarding patient suitability and the therapeutic boundaries” (Werbart et al., 2023)</i></li> <li>• <i>“Moreover, they could discover and explore new sides of themselves as therapists” (Werbart et al., 2023)</i></li> </ul>
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|  |  |  |  | <ul style="list-style-type: none"> <li>• <i>“On the other hand, the remote format and a deliberate choice of communication channels (e.g., solely audio) could give new and increased opportunities to intervene.” (Werbart et al., 2023)</i></li> <li>• <i>“several advantages and new possibilities when working remotely, such as facilitating the therapeutic exchanges in some cases. They were surprised how well the format worked; they felt that the very essence of therapy remained unchanged and could be particularly beneficial for some patients.” (Werbart et al., 2023)</i></li> <li>• <i>“At the same time, as practitioners’ digital skill sets improve and their online experiences diversify, the acceptability and use of online treatment may persistently increase toward more blended forms of treatment.” (Fejit et al., 2020)</i></li> <li>• <i>“As many practitioners were first-time users of online treatment tools, this is likely associated with a steep learning curve, and the technological skill set of practitioners will probably become more sophisticated with experience over time” (Fejit et al., 2020)</i></li> <li>• <i>“Multiple practitioners reported that online treatment works sufficiently well and that clients are satisfied” (Fejit et al., 2020)</i></li> <li>• <i>“Practical advantages concern convenience for the client and/or the therapist. Because there is no travel time, scheduling appointments becomes more flexible. Moreover, sessions are sometimes shorter and more efficient, because the conversations tend to focus more on the content.” (Fejit et al., 2020)</i></li> <li>• <i>“absence of nonverbal communication and the lack of a designated safe space for therapy were identified as challenges participants faced with the changes to mental health provision. Yet, practitioners spoke of solutions to maintain a therapeutic space suitable for their sessions.” (Brandon &amp; Fragkiadaki, 2023)</i></li> <li>• <i>“On the one hand, the results suggest that because important barriers such as a lack of skills and experience have now been lowered, online treatment will be used more frequently” (Bierbooms et al., 2020)</i></li> </ul> |
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|  |  |  |  | <ul style="list-style-type: none"> <li>• <i>“mental health care professionals come to understand that much more is possible in online treatment than what they had initially expected” (Bierbooms et al., 2020)</i></li> <li>• <i>“Mental health care professionals also report that their clients tend to be more open when they are in their home environment and that genuine empathic contact is indeed possible in remote communication” (Bierbooms et al., 2020)</i></li> <li>• <i>“One respondent predicted that because clients are now experiencing the benefits of online treatment, there is a significant chance that they will continue to ask for it, which will to a large extent determine whether online treatment options will be integrated into the new normal.” (Bierbooms et al., 2020)</i></li> <li>• <i>“added value include the reduction in travel time, an increase in self-efficacy and activation in clients, more openness by clients when they are in their home environment, and increased accessibility to treatment due to flexibilities in time and place.” (Bierbooms et al., 2020)</i></li> <li>• <i>“It also contributed to a better schedule and work – life balance for practitioners” (Brandon &amp; Fragkiadaki, 2023)</i></li> <li>• <i>“Additionally, for some participants remote working was advantageous for specific conditions such as anxiety disorders, as it increased accessibility” (Brandon &amp; Fragkiadaki, 2023)</i></li> <li>• <i>“Participants found increased access to therapy significant for clients who preferred online sessions, or for those with specific needs could now be a possibility, offering them more independence and power of choice” (Brandon &amp; Fragkiadaki, 2023)</i></li> <li>• <i>“participants learned something new by delivering therapy online alongside becoming more open minded and adaptable with the use of the medium. Remote work for them required resilience, flexibility, and a rapid adaptation to change to enable the development of robust therapeutic relationships” (Brandon &amp; Fragkiadaki, 2023)</i></li> <li>• <i>“challenge their beliefs and expectations from therapy, the way they were trained to work and adjust in a strange and unusual online environment. This</i></li> </ul> |
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				<p><i>had a great impact on the way they perceive themselves as therapists and their work.” (Brandon &amp; Fragkiadaki, 2023)</i></p> <ul style="list-style-type: none"> <li>• <i>“participants spoke positively and of an acceptance to the paradigm shift found in the delivery of online mental health services. Participants expected that clients will more frequently consider online treatment as an alternative now that they are aware of its potential value” (Brandon &amp; Fragkiadaki, 2023)</i></li> <li>• <i>“Participants commented that offering online therapy during the pandemic has reduced the stigma of receiving therapy. Communication also appeared to be more open and honest and that genuine empathic contact was indeed possible in remote communication” (Brandon &amp; Fragkiadaki, 2023)</i></li> <li>• <i>“[Online therapy] was not part of my master’s program or my supervision. It’s something that I’ve learnt more about, now that I’m doing it since COVID. . . . and it works! And it’s better than I thought it was going to be.” (Kotera, et al., 2021)</i></li> <li>• <i>“I see [online therapy] as an adequate substitution. It seems to be working okay, and in that sense, I feel really grateful that I can keep working” (Kotera et al., 2021)</i></li> <li>• <i>“So, there’s that—the shifting in landscape where therapy is becoming more mundane, more accessible. Online therapy has accelerated it.” (Kotera et al., 2021)</i></li> <li>• <i>“I’ve had to make certain documents online because they previously [didn’t exist] [ . . . ] for example, certain anxiety, depression, relationship, satisfaction, mood surveys that I would typically do as a check-in just before the session with the clients to get the baseline of their functioning.” (Kotera et al., 2021)</i></li> <li>• <i>“Online therapy can offer access to treatment for these shame-sensitive employees, as they can access therapy from home without any time and costs associated with physically accessing a therapy room.” (Kotera et al., 2021)</i></li> <li>• <i>“during the pandemic was gratifying and it gave them a sense of pride and meaning as they were able to help people under this stressful time. “I feel proud that I have been able to help people when they need it most” and “Helping people has helped my mental health. It has helped me to keep</i></li> </ul>
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				<p><i>working” are examples of the positive impact of being a clinician during the pandemic. Several participants expressed gratitude toward their profession and its sustainability. (Mittal et al., 2023)</i></p> <ul style="list-style-type: none"> <li>• <i>“Some others shared that the stressors that they were experiencing during the pandemic had some positive effects on their clinical practice. They shared that they felt more connected with their clients and greater empathy toward them. “In some unexpected ways it has deepened the work with many of my clients,” (Mittal et al., 2023)</i></li> <li>• <i>“However, with time, most of the MHWs came to support the use of virtual communications, stating how it was a ‘life-line’ for SUs during COVID-19 lockdowns. MHWs felt that this adaptation displayed how ‘flexible’ and ‘resourceful’ the mental health sector could be and noted the benefits of teletherapy for their productivity: where in-person therapy ‘would be an afternoon, gone, for one meeting’, teletherapy was typically ‘an hour and [MHWs] can get on with other stuff’ (Griffith et al., 2023)</i></li> <li>• <i>“found that teletherapies had also ‘opened up’ access for client groups who struggled with physical accessibility” (Griffith et al., 2023)</i></li> <li>• <i>“Moreover, MHWs believed virtual therapeutic spaces to have protective qualities for SUs with social anxiety or avoidance, as they have ‘more control’” (Griffith et al., 2023)</i></li> <li>• <i>“how recounting complex traumas could feel ‘quite shameful’ for SUs in face-to-face sessions: teletherapy was thought to ease this process, as ‘over the phone people can’t see your face’” (Griffith et al., 2023)</i></li> </ul>
		Potential for growth		<ul style="list-style-type: none"> <li>• <i>“At the same time, as practitioners’ digital skill sets improve and their online experiences diversify, the acceptability and use of online treatment may persistently increase toward more blended forms of treatment.” (Fejit et al., 2020)</i></li> <li>• <i>“Multiple practitioners reported that online treatment works sufficiently well and that clients are satisfied” (Fejit et al., 2020)</i></li> <li>• <i>“Participants commented that offering online therapy during the pandemic has reduced the stigma of receiving therapy. Communication also appeared to be more open and honest and that genuine empathic contact was indeed possible in remote communication” (Brandon &amp; Fragkiadaki, 2023)</i></li> </ul>

				<ul style="list-style-type: none"> <li>• <i>“As many practitioners were first-time users of online treatment tools, this is likely associated with a steep learning curve, and the technological skill set of practitioners will probably become more sophisticated with experience over time” (Fejit et al., 2020)</i></li> <li>• <i>“several advantages and new possibilities when working remotely, such as facilitating the therapeutic exchanges in some cases. They were surprised how well the format worked; they felt that the very essence of therapy remained unchanged and could be particularly beneficial for some patients.” (Werbart et al., 2023)</i></li> <li>• <i>“As the pandemic continued, the therapists in our study became more comfortable with conducting remote psychotherapy, and they seemed to continuously renegotiate the altered therapeutic setting” (Werbart et al., 2023)</i></li> <li>• <i>“In the long term, they became surprised at how well the remote therapy could function, and that the very essence of therapy could be preserved” (Werbart et al., 2023)</i></li> <li>• <i>“described experiences of positive surprise and exceeded expectations regarding remote therapy.” (Werbart et al., 2023)</i></li> <li>• <i>“The transition triggered their creativity and they adapted to the new circumstances, finding new ways of working, developing new skills, and learning how to calibrate the therapeutic distance in remote sessions.” (Werbart et al., 2023)</i></li> <li>• <i>“In sum, the changes that followed the transition to remote psychotherapy generated a shift in the therapists’ attitude over time.” (Werbart et al., 2023)</i></li> <li>• <i>“Moreover, they could discover and explore new sides of themselves as therapists” (Werbart et al., 2023)</i></li> <li>• <i>“Typically, the therapists felt that they had adapted to remote relating and learned to handle technical, relational, and personal challenges.” (Werbart et al., 2023)</i></li> <li>• <i>“As they gained more experience, both positive and negative, of the distinctive features of remote therapy, they became more comfortable with the technical communication aids, but above all with their modified therapeutic stance. (Werbart et al., 2023)</i></li> </ul>
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|  |  |  |  | <ul style="list-style-type: none"> <li>• <i>“On the other hand, the remote format and a deliberate choice of communication channels (e.g., solely audio) could give new and increased opportunities to intervene.” (Werbart et al., 2023)</i></li> <li>• <i>“the new ways of interacting affected the relational dynamics and led to changed patient and therapist roles, as well as an altered power balance in the therapeutic relationship.” (Werbart et al., 2023)</i></li> <li>• <i>“participants in this study who were already experienced online practitioners were more confident about the continuation of online treatment in the future compared to others” (Bierbooms et al., 2020)</i></li> <li>• <i>“participants spoke positively and of an acceptance to the paradigm shift found in the delivery of online mental health services. Participants expected that clients will more frequently consider online treatment as an alternative now that they are aware of its potential value” (Brandon &amp; Fragkiadaki, 2023)</i></li> <li>• <i>“On the one hand, the results suggest that because important barriers such as a lack of skills and experience have now been lowered, online treatment will be used more frequently” (Bierbooms et al., 2020)</i></li> <li>• <i>“mental health care professionals come to understand that much more is possible in online treatment than what they had initially expected” (Bierbooms et al., 2020)</i></li> <li>• <i>“Participants had to find alternative ways to build empathy and establish rapport.”(Brandon &amp; Fragkiadaki, 2023)</i></li> <li>• <i>“participants learned something new by delivering therapy online alongside becoming more open minded and adaptable with the use of the medium. Remote work for them required resilience, flexibility, and a rapid adaptation to change to enable the development of robust therapeutic relationships” (Brandon &amp; Fragkiadaki, 2023)</i></li> <li>• <i>“One respondent predicted that because clients are now experiencing the benefits of online treatment, there is a significant chance that they will continue to ask for it, which will to a large extent determine whether online treatment options will be integrated into the new normal.” (Bierbooms et al., 2020)</i></li> </ul> |
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				<ul style="list-style-type: none"> <li>• <i>“participants found themselves on equal terms with their clients, sitting together and sharing the reality of the pandemic. It appears that as a result, they found that it deepened and strengthened the therapeutic relationship”</i> (Brandon &amp; Fragkiadaki, 2023)</li> <li>• <i>“added value include the reduction in travel time, an increase in self-efficacy and activation in clients, more openness by clients when they are in their home environment, and increased accessibility to treatment due to flexibilities in time and place.”</i> (Bierbooms et al., 2020)</li> <li>• <i>“Additionally, for some participants remote working was advantageous for specific conditions such as anxiety disorders, as it increased accessibility”</i> (Brandon &amp; Fragkiadaki, 2023)</li> <li>• <i>“Participants found increased access to therapy significant for clients who preferred online sessions, or for those with specific needs could now be a possibility, offering them more independence and power of choice”</i> (Brandon &amp; Fragkiadaki, 2023)</li> <li>• <i>“absence of nonverbal communication and the lack of a designated safe space for therapy were identified as challenges participants faced with the changes to mental health provision. Yet, practitioners spoke of solutions to maintain a therapeutic space suitable for their sessions.”</i> (Brandon &amp; Fragkiadaki, 2023)</li> <li>• <i>“Remote work for all participants made it difficult or delayed the ability to engage with a client, respond to communication cues, and engage in conversation that allowed for a relationship to develop. Relying on non – verbal communication to enhance their understanding of their clients was very important for the participants and hence one of the things they feel they lose in remote working”</i> (Brandon &amp; Fragkiadaki, 2023)</li> <li>• <i>“challenge their beliefs and expectations from therapy, the way they were trained to work and adjust in a strange and unusual online environment. This had a great impact on the way they perceive themselves as therapists and their work.”</i> (Brandon &amp; Fragkiadaki, 2023)</li> <li>• <i>“Mental health providers also need to be trained in self-care, strategies and in identifying signs of compassion fatigue, burnout, and secondary traumatic stress”</i> (Fish &amp; Mittal, 2021)</li> </ul>
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|  |  |  |  | <ul style="list-style-type: none"> <li>• “[Online therapy] was not part of my master’s program or my supervision. It’s something that I’ve learnt more about, now that I’m doing it since COVID. . . . and it works! And it’s better than I thought it was going to be.” (Kotera, et al., 2021)</li> <li>• “So, there’s that—the shifting in landscape where therapy is becoming more mundane, more accessible. Online therapy has accelerated it.” (Kotera et al., 2021)</li> <li>• “I’ve had to make certain documents online because they previously [didn’t exist] [ . . . ] for example, certain anxiety, depression, relationship, satisfaction, mood surveys that I would typically do as a check-in just before the session with the clients to get the baseline of their functioning.” (Kotera et al., 2021)</li> <li>• “It is important to establish boundaries early in therapy and ‘get all of that right from the outset’ (P2), and, in an attempt to re-establish these boundaries in this new teletherapeutic space, participants laid out explicit guidelines to keep it similar to meeting in-person such as setting aside 50 minutes to do the session and making sure that they are in a confidential space where they would not be overheard and would not be disturbed, as this communicates to the client that, ‘I very much care about this, you’re important to me, your issues are important to me’ (P1). Re-establishing these therapeutic boundaries provided participants with the prerequisite foundation for nurturing a strong therapeutic relationship similar to how they would have in person, albeit through an unfamiliar, virtual medium.” (Rielly et al., 2022)</li> <li>• “during the pandemic was gratifying and it gave them a sense of pride and meaning as they were able to help people under this stressful time. “I feel proud that I have been able to help people when they need it most” and “Helping people has helped my mental health. It has helped me to keep working” are examples of the positive impact of being a clinician during the pandemic. Several participants expressed gratitude toward their profession and its sustainability. (Mittal et al., 2023)</li> <li>• “Some others shared that the stressors that they were experiencing during the pandemic had some positive effects on their clinical practice. They shared</li> </ul> |
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				<p><i>that they felt more connected with their clients and greater empathy toward them. “In some unexpected ways it has deepened the work with many of my clients,” (Mittal et al., 2023)</i></p> <ul style="list-style-type: none"> <li>• <i>“However, with time, most of the MHWs came to support the use of virtual communications, stating how it was a ‘life-line’ for SUs during COVID-19 lockdowns. MHWs felt that this adaptation displayed how ‘flexible’ and ‘resourceful’ the mental health sector could be and noted the benefits of teletherapy for their productivity: where in-person therapy ‘would be an afternoon, gone, for one meeting’, teletherapy was typically ‘an hour and [MHWs] can get on with other stuff’ (Griffith et al., 2023)</i></li> <li>• <i>“found that teletherapies had also ‘opened up’ access for client groups who struggled with physical accessibility” (Griffith et al., 2023)</i></li> </ul>
Humans are inherently social beings	Lack of Organizational Support	Expectation to continue working	Working despite concerns	<ul style="list-style-type: none"> <li>• <i>“Clients from lower socioeconomic communities were more disadvantaged in terms of accessing technology, as they may lack equipment or have a poor internet connection. Additionally, because some clients did not have the necessary devices, they may become vulnerable to exclusion and unable to receive services.” (Brandon &amp; Fragkiadaki, 2023)</i></li> <li>• <i>“challenge their beliefs and expectations from therapy, the way they were trained to work and adjust in a strange and unusual online environment. This had a great impact on the way they perceive themselves as therapists and their work.” (Brandon &amp; Fragkiadaki, 2023)</i></li> <li>• <i>“I’ve had to make certain documents online because they previously [didn’t exist] [ . . . ] for example, certain anxiety, depression, relationship, satisfaction, mood surveys that I would typically do as a check-in just before the session with the clients to get the baseline of their functioning.” (Kotera et al., 2021)</i></li> <li>• <i>“Numerous participants agreed that ‘it’s quite containing having a boundary between home and work life’, and that ‘a level of differentiation’ between the two allows them to transition between working and relaxing (P13); however, they now have no way of escaping their work life as their home has now become ‘a therapy room almost’ (P3).” (Rielly et al., 2022)</i></li> <li>• <i>“Participants now experience a lack of perceived control over the boundaries of therapy when delivering teletherapy. The usual boundaries of therapy that</i></li> </ul>

				<p><i>naturally ensue during in-person therapy, such as the setting and time at which it occurs, and the ensured confidentiality and safety that are rendered to participants are outside of their control” (Rielly et al., 2022)</i></p> <ul style="list-style-type: none"> <li>• <i>“They reported feeling lost, vulnerable, stressed, overwhelmed, and emotionally burned out. Participants also stated that they felt isolated, lonely, worried, anxious, and depressed. They shared, “it highlighted my own loneliness, isolation and need for meaningful connections” and “There are some days when I feel particularly drained from multiple telehealth sessions and lack of social contact with my colleagues.” (Mittal et al., 2023)</i></li> <li>• <i>“The racism in my personal life is replicated in the workplace and this has been stressful. Racism has increased since COVID-19 toward Black, Brown communities. I manage racial battle fatigue and race-related stress sufficiently such that it doesn’t negatively affect my clinical practice, but I do not anticipate staying in my organization long-term.” (Mittal et al., 2023)</i></li> <li>• <i>“noting instances of compromised confidentiality, where she had ‘realised that there are other people there’. Due to the complexities of individuals’ backgrounds, she stated how these experiences felt ‘unnerving’ and ‘unsafe’. The culmination of these stressors was found to affect MHWs’ mental wellbeing” (Griffith et al., 2023)</i></li> </ul>
		<p>Technological Challenges</p>		<ul style="list-style-type: none"> <li>• <i>“Either way, to support successful online therapeutic options, there is a need for commitment on an institutional and governmental level with investments in user-friendly technology and fundamental infrastructural resources and organizational support” (Fejit et al., 2020)</i></li> <li>• <i>“the needs of practitioners also primarily concern technological improvements. The majority of participants reported that the availability of a stable Internet connection and proper devices and software on both therapist and client sides is essential. Regarding software, a very user-friendly video call tool that adheres to the mandatory privacy standards is needed, as are supplementary features such as the ability to jointly work on a digital whiteboard, transfer files securely, and support group sessions.” (Fejit et al., 2020)</i></li> </ul>

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|  |  |  |  | <ul style="list-style-type: none"> <li>• <i>“A possible explanation for this could be that the transition to online treatment was very sudden and the necessary technological infrastructure and support mechanisms were not fully in place” (Fejit et al., 2020)</i></li> <li>• <i>“Mediated communication issues” (Fejit et al., 2020)</i></li> <li>• <i>“Some practitioners reported to lack sufficient support from their organization to help them work with the available software or devices, and guidelines about which tools meet privacy regulations, such as the General Data Protection Regulation.” (Fejit et al., 2020)</i></li> <li>• <i>“Also, sessions with children, groups, and clients with cognitive impairments are more challenging. Some clients lack the digital skills to work with the software” (Fejit et al., 2020)</i></li> <li>• <i>“All therapists described the shortcomings when using communication technology, such as problems with internet connection or the poor quality of phone calls. They could miss the patient’s bodily presence, not be able to see the whole person on the screen or become negatively self-aware of themselves and the patient on screen” (Werbart et al., 2023)</i></li> <li>• <i>“absence of nonverbal communication and the lack of a designated safe space for therapy were identified as challenges participants faced with the changes to mental health provision. Yet, practitioners spoke of solutions to maintain a therapeutic space suitable for their sessions.” (Brandon &amp; Fragkiadaki, 2023)</i></li> <li>• <i>“Therapeutic silence no longer facilitates reflection or encourages patient dialogue; instead, it elicits, “Hello? Are you still there? Did I lose you?”” (Wade, 2020)</i></li> <li>• <i>“The most significant limitation of online therapy identified by all participants is limited physical contact and body language, both of which can be further diminished by technological disruptions” (Kotera et al., 2021)</i></li> <li>• <i>“what about privacy? Containment in the room?” (Kotera et al., 2021)</i></li> <li>• <i>“Technological problems, including a lack of digital skills in therapists and/or clients, are among them. An unstable internet connection can disrupt the flow in a therapy session, negatively impacting the therapeutic relationship and outcomes.” (Kotera et al., 2021)</i></li> </ul> |
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				<ul style="list-style-type: none"> <li>• <i>“Participants now experience a lack of perceived control over the boundaries of therapy when delivering teletherapy. The usual boundaries of therapy that naturally ensue during in-person therapy, such as the setting and time at which it occurs, and the ensured confidentiality and safety that are rendered to participants are outside of their control” (Rielly et al., 2022)</i></li> <li>• <i>“glitches with technology can result in me missing subtle physical cues or important verbal information.” (Downing, 2021)</i></li> <li>• <i>“I’m also filling the space with words rather than sitting in a companionable silence of understanding. There’s an awkwardness with video lag which results in us speaking over each other and it’s harder to pick up on very subtly facial gestures.” (Downing, 2021)</i></li> <li>• <i>“working around family members meant that many MHWs were lacking a confidential therapeutic space” (Griffith et al., 2023)</i></li> </ul>
	Shared feelings in therapeutic relationship	Lack of energy, Motivation, Training & Fear	Need for survival	<ul style="list-style-type: none"> <li>• <i>“...desensitised to the crisis ‘in order to survive’...” (Rielly et al., 2022)</i></li> <li>• <i>“Teletherapy posed a threat to some participants' sense of competency as psychologists. For those doubtful of its therapeutic capacity, this could have negatively impacted their ability to form healthy therapeutic relationships.” (Rielly et al., 2022)</i></li> <li>• <i>“It is possible that the therapists’ initial negative expectations and lack of training and time for preparation for remote communication, together with technical obstacles, contributed to the therapists” (Kotera et al., 2021)</i></li> <li>• <i>“Meanwhile, my partner and I are cooped up in the house with our rambunctious dogs barking at melting snow falling in thuds off the roof; it is, after all, “spring in New England.” I fight off cognitive distortions with all my might” (Wade, 2023)</i></li> <li>• <i>“I am a bad therapist. I am not doing high-quality work. I am not helping anyone” (Wade, 2023)</i></li> <li>• <i>“maladaptive coping: What kind of therapist am I? I should be practicing what I preach. I’m so self-critical. I should be gentle with myself. Maybe I should meditate. For those who have ever looked at their therapists and wondered how they were so high functioning, I’ll let you in on a secret: We are not.” (Wade, 2020)</i></li> </ul>

				<ul style="list-style-type: none"> <li>• <i>“Given that there was less distinction between work and home environments while working online, some participants struggled to maintain the work – life balance on a cognitive and emotional level as home needed to be transformed to work and then home again.” (Brandon &amp; Fragkiadaki, 2023)</i></li> <li>• <i>“challenge their beliefs and expectations from therapy, the way they were trained to work and adjust in a strange and unusual online environment. This had a great impact on the way they perceive themselves as therapists and their work.” (Brandon &amp; Fragkiadaki, 2023)</i></li> <li>• <i>“Mental health providers are also not impervious to personal challenges, loss, and stressors related to the pandemic, which are compounded by their responsibility to hold space for their clients on these very same issues” (Fish &amp; Mittal, 2021)</i></li> <li>• <i>“health providers susceptible to compassion fatigue, burnout, and secondary traumatic stress” (Fish &amp; Mittal, 2021)</i></li> <li>• <i>“Survey respondents also discussed emotional and physical health implications of these stressors. They described feeling distressed, depressed, anxious, isolated, and fearful. Several respondents shared that they were not sleeping well, feeling physically exhausted, and having more migraines than usual. Several respondents shared their struggles with their own mental health; one respondent noted, “As [the pandemic] has gone on, I have become more distracted and fatigued conducting telehealth, especially without having a transition to home from work and having the two spaces blend together.” Another respondent said, “Stress is up, anxiety is up.” (Fish &amp; Mittal, 2021)</i></li> <li>• <i>“teletherapy fatigue, and many disclosed feeling dissatisfied with work or questioning the meaningfulness of their work” (Fish &amp; Mittal, 2021)</i></li> <li>• <i>“I have an increased sense of imposter syndrome and a decreased sense of efficacy as a clinician.” (Fish &amp; Mittal, 2021)</i></li> <li>• <i>“clinicians have disclosed that they are experiencing elevated levels of empathic distress—an emotional state that affects people’s capacity to bear witness and tolerate another person’s pain and suffering—and at times feeling distracted and less engaged with their clients. Several respondents suggested that the</i></li> </ul>
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				<p><i>“[pandemic has] made it harder to access empathy at times.” (Fish &amp; Mittal, 2021)</i></p> <ul style="list-style-type: none"> <li>• <i>“Similar to the calls to protect our frontline workers, mental health providers need protection and support as they tackle the mental health wave of this pandemic and prepare for future events” (Fish &amp; Mittal, 2021)</i></li> <li>• <i>“Numerous participants agreed that ‘it’s quite containing having a boundary between home and work life’, and that ‘a level of differentiation’ between the two allows them to transition between working and relaxing (P13); however, they now have no way of escaping their work life as their home has now become ‘a therapy room almost’ (P3).” (Rielly et al., 2022)</i></li> <li>• <i>“have to be super alert to the client’s body movement/facial expressions when undertaking telehealth ... two of my clients have noted that they feel more “distant”. It contributes to fatigue” (Downing, 2021)</i></li> <li>• <i>“the COVID-19 crisis puts us in tension with our own corporeality and demands that we perpetually reassess and confront issues of uncertainty, risk and trust in our day-to-day social interactions” (Downing, 2021)</i></li> <li>• <i>“They reported feeling lost, vulnerable, stressed, overwhelmed, and emotionally burned out. Participants also stated that they felt isolated, lonely, worried, anxious, and depressed. They shared, “it highlighted my own loneliness, isolation and need for meaningful connections” and “There are some days when I feel particularly drained from multiple telehealth sessions and lack of social contact with my colleagues.” (Mittal et al., 2023)</i></li> <li>• <i>“An overwhelming number of participants commented on their</i></li> <li>• <i>stress levels being compounded because of “mirrored experiences” related to COVID-19 between themselves and their clients. They stated, “I am finding myself a bit burned out holding the collective trauma of my clients it is taking a toll on my emotional/mental/relational health,” (Mittal et al., 2023)</i></li> <li>• <i>“Teletherapy fatigue was another common experience that was shared by many participants. Overall, they reported that seeing clients online was more tiring than face-to-face. They shared, “I find it much more exhausting to provide care via telehealth, going from video chat to video chat with both patients and meetings” and “I find doing telehealth more draining and tiring</i></li> </ul>
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				<p><i>and not as enjoyable as in person work feel more isolated and anxious.”</i> (Mittal et al., 2023)</p> <ul style="list-style-type: none"> <li>• <i>“They shared feeling stressed out about the safety of their loved ones, loss of loved ones due to COVID-19, financial stress because of income uncertainty, and stress related to racism and the political climate.”</i> (Mittal et al., 2023)</li> <li>• <i>“I center myself on that purpose during this pandemic and it helps me channel my own feelings of helplessness. I am appreciating the additional time at home with family and hobbies now that I don’t have a commute. I focus on that rather than the ambiguity of the situation and the lack of control.”</i> (Mittal et al., 2023)</li> <li>• <i>“Coupled with compromised mental health, isolation, and burnout, many clinicians also reported negative general health outcomes, such as headaches, trouble sleeping, poor appetite, back pain, eye strain, and so on. One participant shared that “The adjustment to looking at a screen all day was particularly rough on me. I had headaches and felt more fatigued, until I figured out how to set blue blocking on my computer.”</i> (Mittal et al., 2023)</li> <li>• <i>“The economic impact has been even worse- I had a job offer rescinded and still do not have a plan for where I will work or live one month from now, I’m paying monthly rent for a private practice office that I can’t use right now.”</i> (Mittal et al., 2023)</li> <li>• <i>“It’s been additionally trying to manage my caseload and personal mental health with the social unrest and news cycle that amplifies polarizing views and uncertainty in our world.”</i> (Mittal et al., 2023)</li> <li>• <i>“Not all the participants reported that being a mental health provider during the pandemic had bad implications for their mental and physical health. A few participants shared that being a mental health clinician during the pandemic was both a difficult and rewarding experience”</i> (Mittal et al., 2023)</li> <li>• <i>“The racism in my personal life is replicated in the workplace and this has been stressful. Racism has increased since COVID-19 toward Black, Brown communities. I manage racial battle fatigue and race-related stress sufficiently such that it doesn’t negatively affect my clinical practice, but I do not anticipate staying in my organization long-term.”</i> (Mittal et al., 2023)</li> </ul>
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|  |  |  |  | <ul style="list-style-type: none"> <li>• <i>“A few clinicians highlighted additional stressors that they were facing as a result of practicing from home and being responsible for other members in the household. The following quotes demonstrate their thoughts and feelings, “Working from home has had its challenges and made practicing optimally more difficult. I find myself more distracted in my home environment.” The stress has been high as my 2 children were home from school for the past 3 months. Trying to do telehealth while home-schooling 2 kids was a mess and at times impossible. The stress has made me distracted,” (Mittal et al., 2023)</i></li> <li>• <i>“I am fortunate-I am not alone, nor am I having to work while taking care of and home -schooling children. I am older and my husband and I find that our lives have not changed terribly significantly other than not being able to see friends and family in person-but we’re finding lots of ways to keep in touch. (Mittal et al., 2023)</i></li> <li>• <i>“Mental health providers reported that the pandemic-related stressors had significantly impacted their satisfaction with work. Study participants shared, “Extremely unsatisfying for me as a clinician as I am limited in providing services and doing what I love,” “[I] have not enjoyed my job as much as I used to,” and “Increased isolation “(mine) has decreased “informal” times to reach out to colleagues during the day, therefore increasing stress and decreasing satisfaction found in the work environment.” Several other participants talked about losing motivation and questioning the meaningfulness of their work.” (Mittal et al., 2023)</i></li> <li>• <i>“Because I’m less motivated and somewhat lonely, I’m worried that I may be inappropriately disclosing with clients. I haven’t, but [I am] concerned about possibility” (Mittal et al., 2023)</i></li> <li>• <i>“I feel less able to hold boundaries and less focused in session,” “[I have to be mindful of] feelings of vulnerability at times around my own sadness or anxiety. Also, an urge to self-disclose that I keep an eye on, just related to us all being in the same boat,” (Mittal et al., 2023)</i></li> <li>• <i>“They attributed their experience of not feeling additional stress to having work–life balance or being in a different life and relationship stage” (Mittal et al., 2023)</i></li> </ul> |
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				<ul style="list-style-type: none"> <li>• <i>“main difficulty reported was MHWs’ inability to separate themselves from work within their homes. Having round-the-clock access to work equipment often led to ‘exhaustion’” (Griffith et al., 2023)</i></li> <li>• <i>“‘never really had a proper day off’” (Griffith et al., 2023)</i></li> <li>• <i>“This was especially troubling for those handling upsetting calls who, were unable to draw support from their colleagues and had ‘nobody to check in with’” (Griffith et al., 2023)</i></li> <li>• <i>“Without peer debriefs, MHWs had to ‘deal with’ their emotions alone and could no longer ‘go home and leave it [work] behind’” (Griffith et al., 2023)</i></li> <li>• <i>“remote working as ‘an invasion of your space . . . especially in crisis situations’, as the traumatic experiences recounted by SUs became associated with MHWs’ private spaces” (Griffith et al., 2023)</i></li> <li>• <i>“noting instances of compromised confidentiality, where she had ‘realised that there are other people there’. Due to the complexities of individuals’ backgrounds, she stated how these experiences felt ‘unnerving’ and ‘unsafe’. The culmination of these stressors was found to affect MHWs’ mental wellbeing” (Griffith et al., 2023)</i></li> </ul>
		Sharing feelings	Shared emotions	<ul style="list-style-type: none"> <li>• <i>“The new ways of interacting affected the relational dynamics and led to changed patient and therapist roles, as well as an altered power balance in the therapeutic relationship.” (Werbart et al., 2023)</i></li> <li>• <i>“The most integral lesson I’ve learned is that to be a therapist is to be willing to tolerate discomfort in the service of bearing witness to the experience of a fellow human. But nobody taught me how to be a therapist in the midst of a global pandemic, when my patients and I are simultaneously grappling with the same source of discomfort, and we all are acutely aware of it.” (Wade, 2020)</i></li> <li>• <i>“Participants, along with their clients shared the experiences of a global crisis during the pandemic, coping with the resulting emotional and psychological impacts in parallel. These processes influenced the development of the therapeutic relationships as the participants and clients were on an equal status, and the notion that this “humanised” the practitioner was prevalent throughout the data” (Brandon &amp; Fragkiadaki, 2023)</i></li> </ul>

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|  |  |  |  | <ul style="list-style-type: none"> <li>• <i>“participants found themselves on equal terms with their clients, sitting together and sharing the reality of the pandemic. It appears that as a result, they found that it deepened and strengthened the therapeutic relationship” (Brandon &amp; Fragkiadaki, 2023)</i></li> <li>• <i>“We are in a collective state of discomfort.” (Wade, 2020)</i></li> <li>• <i>“I have since come to understand that a healthy dose of self-disclosure is an invaluable tool in building transformative therapeutic relationships. During this coronavirus pandemic, I cannot think of a more powerful therapeutic tool. I have the opportunity to model for my patients how to sit with discomfort gracefully and to normalize the anxiety and fear that we are collectively sitting with” (Wade, 2020)</i></li> <li>• <i>“Survey respondents also discussed emotional and physical health implications of these stressors. They described feeling distressed, depressed, anxious, isolated, and fearful. Several respondents shared that they were not sleeping well, feeling physically exhausted, and having more migraines than usual. Several respondents shared their struggles with their own mental health; one respondent noted, “As [the pandemic] has gone on, I have become more distracted and fatigued conducting telehealth, especially without having a transition to home from work and having the two spaces blend together.” Another respondent said, “Stress is up, anxiety is up.” (Fish &amp; Mittal, 2021)</i></li> <li>• <i>“They shared feeling stressed out about the safety of their loved ones, loss of loved ones due to COVID-19, financial stress because of income uncertainty, and stress related to racism and the political climate.” (Mittal et al., 2023)</i></li> <li>• <i>“The economic impact has been even worse- I had a job offer rescinded and still do not have a plan for where I will work or live one month from now, I’m paying monthly rent for a private practice office that I can’t use right now.” (Mittal et al., 2023)</i></li> <li>• <i>“Some others shared that the stressors that they were experiencing during the pandemic had some positive effects on their clinical practice. They shared that they felt more connected with their clients and greater empathy toward them. “In some unexpected ways it has deepened the work with many of my clients,” (Mittal et al., 2023)</i></li> </ul> |
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				<ul style="list-style-type: none"> <li>• <i>“They shared, “I don’t feel connected to my clients, I have an increased sense of imposter syndrome, and a decreased sense of efficacy as a clinician,” “It’s (the pandemic) made it harder to concentrate and focus. It’s left me distracted and less engaged. It’s made it harder to access empathy at times,” and “I’m more anxious. I’m less present with clients or I have to force it, draining more energy.” (Mittal et al., 2023)</i></li> <li>• <i>“Because I’m less motivated and somewhat lonely, I’m worried that I may be inappropriately disclosing with clients. I haven’t, but [I am] concerned about possibility” (Mittal et al., 2023)</i></li> <li>• <i>“I feel less able to hold boundaries and less focused in session,” “[I have to be mindful of] feelings of vulnerability at times around my own sadness or anxiety. Also, an urge to self-disclose that I keep an eye on, just related to us all being in the same boat,” (Mittal et al., 2023)</i></li> </ul>
I am what I choose to be	Shifting the landscape	Containing clients	Difficulty to provide safety and holding environment	<ul style="list-style-type: none"> <li>• <i>“online treatment is less suitable for treating trauma, family therapy, for clients with psychotic symptoms, severe anxiety, and generally those who are vulnerable to crisis and a sudden exacerbation of symptoms.” (Fejit et al., 2020)</i></li> <li>• <i>“Generally, the therapists felt uncertain and uncomfortable when confronted with major limitations in the application of core elements of their therapeutic work” (Werbart et al., 2023)</i></li> <li>• <i>“It became harder to sense the patient’s mood and to regulate affects, which contributed to feelings of insecurity” (Werbart et al., 2023)</i></li> <li>• <i>“Practitioners experienced the consequences of the lack of consistency and clients not feeling supported by them” (Brandon &amp; Fragkiadaki, 2023)</i></li> <li>• <i>“participants raised concerns over clients’ access to resources that would enable them to appropriately utilise these services. They expressed their concerns about their inability to assure client safety, as well as their belief that the process of risk assessment is more difficult online” (Brandon &amp; Fragkiadaki, 2023)</i></li> <li>• <i>“Participants also expressed concern that relying on work from home would make guaranteeing client safety more difficult, particularly managing the risk of violence between clients and their partners, which might obstruct access for some clients” (Brandon &amp; Fragkiadaki, 2023)</i></li> </ul>

				<ul style="list-style-type: none"> <li>• <i>“absence of nonverbal communication and the lack of a designated safe space for therapy were identified as challenges participants faced with the changes to mental health provision. Yet, practitioners spoke of solutions to maintain a therapeutic space suitable for their sessions.” (Brandon &amp; Fragkiadaki, 2023)</i></li> <li>• <i>“online therapy is not suitable for clients who suffer from severe psychopathology or mental health distress (e.g., trauma or personality disorders) (T2-4: Severe psychopathology), because they require greater contact and containment that cannot be facilitated via online mediums” (Kotera et al., 2021)</i></li> <li>• <i>“what about privacy? Containment in the room?” (Kotera et al., 2021)</i></li> <li>• <i>“Participants have to trust that their clients were truthfully disclosing their location as, ‘the combination of not knowing where they were, not being able to control the environment, were they in a place that was safe for them to speak or private’” (Rielly et al., 2022)</i></li> <li>• <i>“Participants now experience a lack of perceived control over the boundaries of therapy when delivering teletherapy. The usual boundaries of therapy that naturally ensue during in-person therapy, such as the setting and time at which it occurs, and the ensured confidentiality and safety that are rendered to participants are outside of their control” (Rielly et al., 2022)</i></li> <li>• <i>“another respondent worried that it was harder to pick up on subtle emotions over a two-dimensional screen: ‘Reading subtle emotional cues is difficult. I have to rely much more on the verbal components of therapy’ (Downing, 2021)</i></li> <li>• <i>“concerns around privacy risks arose, with several of our respondents expressing concern that their clients did not have a safe or private space within which to attend the session. Therapeutic consultations in cars, bedrooms and broom cupboards quickly became commonplace as clients sought out private spaces away from cohabitants during social lockdowns. This issue was especially pressing for clients who lived in a shared house, or with elderly family members and/or children who were prone to interrupting” (Downing, 2021)</i></li> </ul>
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			<ul style="list-style-type: none"> <li>• <i>“a number of respondents indicating that they found it harder to work with clients who self-harmed and/or were victims of domestic abuse. Issues around the emotional depth of therapy surfaced regularly in these comments, with some therapists saying that they deliberately kept therapy ‘lighter’ as they were unable to create a safe physical space for the session”</i> (Downing, 2021)</li> <li>• <i>“They shared, “I don’t feel connected to my clients, I have an increased sense of imposter syndrome, and a decreased sense of efficacy as a clinician,” “It’s (the pandemic) made it harder to concentrate and focus. It’s left me distracted and less engaged. It’s made it harder to access empathy at times,” and “I’m more anxious. I’m less present with clients or I have to force it, draining more energy.”</i> (Mittal et al., 2023)</li> <li>• <i>“Moreover, MHWs believed virtual therapeutic spaces to have protective qualities for SUs with social anxiety or avoidance, as they have ‘more control’”</i> (Griffith et al., 2023)</li> <li>• <i>“This was especially troubling for those handling upsetting calls who, were unable to draw support from their colleagues and had ‘nobody to check in with’”</i> (Griffith et al., 2023)</li> <li>• <i>“working around family members meant that many MHWs were lacking a confidential therapeutic space”</i> (Griffith et al., 2023)</li> <li>• <i>“noting instances of compromised confidentiality, where she had ‘realised that there are other people there’. Due to the complexities of individuals’ backgrounds, she stated how these experiences felt ‘unnerving’ and ‘unsafe’. The culmination of these stressors was found to affect MHWs’ mental wellbeing”</i> (Griffith et al., 2023)</li> </ul>
	“Empathic Accuracy”	Possibility of empathic contact despite perceived expectations	<ul style="list-style-type: none"> <li>• <i>“professionals also expect that they, or their colleagues, will revert to regular face-to-face treatment as soon as possible, since a number of professionals and clients perceive regular face-to-face treatment as the only way to create a therapeutic alliance.”</i> (Bierbooms et al., 2020)</li> <li>• <i>“mental health care professionals come to understand that much more is possible in online treatment than what they had initially expected”</i> (Bierbooms et al., 2020)</li> <li>• <i>“Participants commented that offering online therapy during the pandemic has reduced the stigma of receiving therapy. Communication also appeared</i></li> </ul>

				<p><i>to be more open and honest and that genuine empathic contact was indeed possible in remote communication” (Brandon &amp; Fragkiadaki, 2023)</i></p> <ul style="list-style-type: none"> <li>• <i>“Mental health care professionals also report that their clients tend to be more open when they are in their home environment and that genuine empathic contact is indeed possible in remote communication” (Bierbooms et al., 2020)</i></li> <li>• <i>“Additionally, for some participants remote working was advantageous for specific conditions such as anxiety disorders, as it increased accessibility” (Brandon &amp; Fragkiadaki, 2023)</i></li> <li>• <i>“absence of nonverbal communication and the lack of a designated safe space for therapy were identified as challenges participants faced with the changes to mental health provision. Yet, practitioners spoke of solutions to maintain a therapeutic space suitable for their sessions.” (Brandon &amp; Fragkiadaki, 2023)</i></li> <li>• <i>“participants learned something new by delivering therapy online alongside becoming more open minded and adaptable with the use of the medium. Remote work for them required resilience, flexibility, and a rapid adaptation to change to enable the development of robust therapeutic relationships” (Brandon &amp; Fragkiadaki, 2023)</i></li> <li>• <i>“participants spoke positively and of an acceptance to the paradigm shift found in the delivery of online mental health services. Participants expected that clients will more frequently consider online treatment as an alternative now that they are aware of its potential value” (Brandon &amp; Fragkiadaki, 2023)</i></li> <li>• <i>“described experiences of positive surprise and exceeded expectations regarding remote therapy.” (Werbart et al., 2023)</i></li> <li>• <i>“Generally, the therapists felt uncertain and uncomfortable when confronted with major limitations in the application of core elements of their therapeutic work” (Werbart et al., 2023)</i></li> <li>• <i>“The absence of physical presence and inability to perceive non-verbal cues such as eye contact can make participants feel more comfortable in ‘bringing the therapy to a deeper level’ (P8) over the telephone and can facilitate further exploration; as one participant said, ‘I often say to a client on the</i></li> </ul>
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				<p><i>phone now, you know, “I’m just wondering about this, or I was wondering about that.” I wonder more on the phone with a client than I wonder face to face’ (P10).” (Rielly et al., 2022)</i></p> <ul style="list-style-type: none"> <li>• <i>“It is important to establish boundaries early in therapy and ‘get all of that right from the outset’ (P2), and, in an attempt to re-establish these boundaries in this new teletherapeutic space, participants laid out explicit guidelines to keep it similar to meeting in-person such as setting aside 50 minutes to do the session and making sure that they are in a confidential space where they would not be overheard and would not be disturbed, as this communicates to the client that, ‘I very much care about this, you’re important to me, your issues are important to me’ (P1). Re-establishing these therapeutic boundaries provided participants with the prerequisite foundation for nurturing a strong therapeutic relationship similar to how they would have in person, albeit through an unfamiliar, virtual medium.” (Rielly et al., 2022)</i></li> <li>• <i>“therapists reported feeling worried about how they were relating to clients online as they could not see each other’s full bodies. As one respondent said: ‘The lack of visual information on client’s body impacts on my ability to accurately pick up on emotional states.’” (Downing, 2021)</i></li> <li>• <i>“another respondent worried that it was harder to pick up on subtle emotions over a two-dimensional screen: ‘Reading subtle emotional cues is difficult. I have to rely much more on the verbal components of therapy” (Downing, 2021)</i></li> </ul>
		Positives of Teletherapy	Job satisfaction	<ul style="list-style-type: none"> <li>• <i>“Practitioners also reported positive experiences with online treatment. Practical advantages concern convenience for the client and/or the therapist. Because there is no travel time, scheduling appointments becomes more flexible. Moreover, sessions are sometimes shorter and more efficient because the conversations tend to focus more on the content.” (Fejit et al., 2020)</i></li> <li>• <i>“Multiple practitioners reported that online treatment works sufficiently well and that clients are satisfied” (Fejit et al., 2020)</i></li> <li>• <i>“Furthermore, the therapists recounted that returning to the traditional in-person setting could have a noticeable impact on the relational dynamics,</i></li> </ul>

				<p><i>positive when working with some patients and negative with others. Thus, from the therapists' perspective, setting alternations</i>" (Werbart et al., 2023)</p> <ul style="list-style-type: none"> <li>• <i>"several advantages and new possibilities when working remotely, such as facilitating the therapeutic exchanges in some cases. They were surprised how well the format worked; they felt that the very essence of therapy remained unchanged and could be particularly beneficial for some patients."</i> (Werbart et al., 2023)</li> <li>• <i>"These learning experiences contributed to increased security and a more positive view of remote therapeutic work, which could help the therapists to give the patients a feeling of security when starting treatment: "Over time, I have built up trust in remote therapy, so I think I can now convey a kind of confidence in the format, early in the therapy process."</i> (Werbart et al., 2023)</li> <li>• <i>"As the pandemic continued, the therapists in our study became more comfortable with conducting remote psychotherapy, and they seemed to continuously renegotiate the altered therapeutic setting"</i> (Werbart et al., 2023)</li> <li>• <i>"In the long term, they became surprised at how well the remote therapy could function, and that the very essence of therapy could be preserved"</i> (Werbart et al., 2023)</li> <li>• <i>"The transition triggered their creativity and they adapted to the new circumstances, finding new ways of working, developing new skills, and learning how to calibrate the therapeutic distance in remote sessions."</i> (Werbart et al., 2023)</li> <li>• <i>"on the other hand, they discovered several positive aspects of remote psychotherapy and they felt that they had developed as"</i> (Werbart et al., 2023)</li> <li>• <i>"In sum, the changes that followed the transition to remote psychotherapy generated a shift in the therapists' attitude over time."</i> (Werbart et al., 2023)</li> <li>• <i>"However, some patients seemed to be more comfortable with remote sessions, allowing them to open up more in therapy and opening new areas for therapeutic work"</i> (Werbart et al., 2023)</li> <li>• <i>"Moreover, they could discover and explore new sides of themselves as therapists"</i> (Werbart et al., 2023)</li> </ul>
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|  |  |  |  | <ul style="list-style-type: none"> <li>• <i>“participants in this study who were already experienced online practitioners were more confident about the continuation of online treatment in the future compared to others” (Bierbooms et al., 2020)</i></li> <li>• <i>“On the one hand, the results suggest that because important barriers such as a lack of skills and experience have now been lowered, online treatment will be used more frequently” (Bierbooms et al., 2020)</i></li> <li>• <i>“added value include the reduction in travel time, an increase in self-efficacy and activation in clients, more openness by clients when they are in their home environment, and increased accessibility to treatment due to flexibilities in time and place.” (Bierbooms et al., 2020)</i></li> <li>• <i>“Many participants perceived the good side of this paradigm and highlighted the greater flexibility and convenience it created in their work. Online service delivery was an efficient approach to mitigate barriers to in-person counselling services, such as travel constraints, which enhanced flexibility.” (Brandon &amp; Fragkiadaki, 2023)</i></li> <li>• <i>“It also contributed to a better schedule and work – life balance for practitioners” (Brandon &amp; Fragkiadaki, 2023)</i></li> <li>• <i>“Participants found increased access to therapy significant for clients who preferred online sessions, or for those with specific needs could now be a possibility, offering them more independence and power of choice” (Brandon &amp; Fragkiadaki, 2023)</i></li> <li>• <i>“some technological benefits were acknowledged for the quality assurance, including supervision as well as the development and sharing of therapeutic knowledge within therapists’ professional network and training” (Kotera et al., 2021)</i></li> <li>• <i>“Online therapy is the only option for some clients due to geographical limitations (e.g., lack of available counsellors and therapists or time spent travelling) or other circumstances (such as illness or caretaking/parenting responsibilities). These aspects are particularly important for clients in employment who, in the past, did not have time or lacked geographical proximity to attend face-to-face therapy” (Kotera et al., 2021)</i></li> </ul> |
|--|--|--|--|---|

				<ul style="list-style-type: none"> <li>• <i>“So, there’s that—the shifting in landscape where therapy is becoming more mundane, more accessible. Online therapy has accelerated it.” (Kotera et al., 2021)</i></li> <li>• <i>“Online therapy can offer access to treatment for these shame-sensitive employees, as they can access therapy from home without any time and costs associated with physically accessing a therapy room.” (Kotera et al., 2021)</i></li> <li>• <i>“participant interestingly reported teletherapy to be ‘85% as good as the real thing’. (Rielly et al., 2022)</i></li> <li>• <i>“Some participants reported that the perceived absence of boundaries in teletherapy makes them feel ‘freer’ and can enable them to ask questions that they would not normally ask in person:” (Rielly et al., 2022)</i></li> <li>• <i>“Not all the participants reported that being a mental health provider during the pandemic had bad implications for their mental and physical health. A few participants shared that being a mental health clinician during the pandemic was both a difficult and rewarding experience” (Mittal et al., 2023)</i></li> <li>• <i>“during the pandemic was gratifying and it gave them a sense of pride and meaning as they were able to help people under this stressful time. “I feel proud that I have been able to help people when they need it most” and “Helping people has helped my mental health. It has helped me to keep working” are examples of the positive impact of being a clinician during the pandemic. Several participants expressed gratitude toward their profession and its sustainability. (Mittal et al., 2023)</i></li> <li>• <i>“Mental health providers reported that the pandemic-related stressors had significantly impacted their satisfaction with work. Study participants shared, “Extremely unsatisfying for me as a clinician as I am limited in providing services and doing what I love,” “[I] have not enjoyed my job as much as I used to,” and “Increased isolation “(mine) has decreased “informal” times to reach out to colleagues during the day, therefore increasing stress and decreasing satisfaction found in the work environment.” Several other participants talked about losing motivation and questioning the meaningfulness of their work.” (Mittal et al., 2023)</i></li> <li>• <i>“Some others shared that the stressors that they were experiencing during the pandemic had some positive effects on their clinical practice. They shared</i></li> </ul>
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				<p><i>that they felt more connected with their clients and greater empathy toward them. “In some unexpected ways it has deepened the work with many of my clients,” (Mittal et al., 2023)</i></p> <ul style="list-style-type: none"> <li>• <i>“Although the majority of the mental health clinicians discussed the negative impact of COVID-19-related stressors on their clinical practice, there were a small group of participants who shared that they were not experiencing significant stressors and therefore, did not feel that their practice had changed significantly” (Mittal et al., 2023)</i></li> <li>• <i>“They attributed their experience of not feeling additional stress to having work–life balance or being in a different life and relationship stage” (Mittal et al., 2023)</i></li> <li>• <i>“However, with time, most of the MHWs came to support the use of virtual communications, stating how it was a ‘life-line’ for SUs during COVID-19 lockdowns. MHWs felt that this adaptation displayed how ‘flexible’ and ‘resourceful’ the mental health sector could be and noted the benefits of teletherapy for their productivity: where in-person therapy ‘would be an afternoon, gone, for one meeting’, teletherapy was typically ‘an hour and [MHWs] can get on with other stuff’ (Griffith et al., 2023)</i></li> <li>• <i>“found that teletherapies had also ‘opened up’ access for client groups who struggled with physical accessibility” (Griffith et al., 2023)</i></li> <li>• <i>“increased services’ flexibility which MHWs thought to improve comfort and access for SUs with impaired mobility” (Griffith et al., 2023)</i></li> </ul>
Choosing to persevere	“Adequate Substitution”	Can be an adequate substitution		<ul style="list-style-type: none"> <li>• <i>“Multiple practitioners reported that online treatment works sufficiently well and that clients are satisfied” (Fejit et al., 2020)</i></li> <li>• <i>“These learning experiences contributed to increased security and a more positive view of remote therapeutic work, which could help the therapists to give the patients a feeling of security when starting treatment: “Over time, I have built up trust in remote therapy, so I think I can now convey a kind of confidence in the format, early in the therapy process.” (Werbart et al., 2023)</i></li> <li>• <i>“It is striking that the therapists noticed different incongruous facets of the phenomenon without paying attention to the inherent paradox and without linking it explicitly with different patterns of the patient–therapist match. The best example of this paradox is that the therapists typically said both that the</i></li> </ul>

				<p><i>essence of therapy was preserved and that something essential was lost, thus keeping possibilities and difficulties with remote psychotherapy apart.” (Werbart et al., 2023)</i></p> <ul style="list-style-type: none"> <li>• <i>“described experiences of positive surprise and exceeded expectations regarding remote therapy.” (Werbart et al., 2023)</i></li> <li>• <i>“online therapy worked, or at the very least, worked better than expected, leading to favourably shifting attitudes and openness toward online therapy post-pandemic” (Kotera et al., 2021)</i></li> <li>• <i>“participants in this study who were already experienced online practitioners were more confident about the continuation of online treatment in the future compared to others” (Bierbooms et al., 2020)</i></li> <li>• <i>“On the one hand, the results suggest that because important barriers such as a lack of skills and experience have now been lowered, online treatment will be used more frequently” (Bierbooms et al., 2020)</i></li> <li>• <i>“professionals also expect that they, or their colleagues, will revert to regular face-to-face treatment as soon as possible, since a number of professionals and clients perceive regular face-to-face treatment as the only way to create a therapeutic alliance.” (Bierbooms et al., 2020)</i></li> <li>• <i>“mental health care professionals come to understand that much more is possible in online treatment than what they had initially expected” (Bierbooms et al., 2020)</i></li> <li>• <i>“Additionally, for some participants remote working was advantageous for specific conditions such as anxiety disorders, as it increased accessibility” (Brandon &amp; Fragkiadaki, 2023)</i></li> <li>• <i>“participants spoke positively and of an acceptance to the paradigm shift found in the delivery of online mental health services. Participants expected that clients will more frequently consider online treatment as an alternative now that they are aware of its potential value” (Brandon &amp; Fragkiadaki, 2023)</i></li> <li>• <i>“Participants found increased access to therapy significant for clients who preferred online sessions, or for those with specific needs could now be a possibility, offering them more independence and power of choice” (Brandon &amp; Fragkiadaki, 2023)</i></li> </ul>
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				<ul style="list-style-type: none"> <li>• <i>“Mental health care professionals also report that their clients tend to be more open when they are in their home environment and that genuine empathic contact is indeed possible in remote communication” (Bierbooms et al., 2020)</i></li> <li>• <i>“One respondent predicted that because clients are now experiencing the benefits of online treatment, there is a significant chance that they will continue to ask for it, which will to a large extent determine whether online treatment options will be integrated into the new normal.” (Bierbooms et al., 2020)</i></li> <li>• <i>“added value include the reduction in travel time, an increase in self-efficacy and activation in clients, more openness by clients when they are in their home environment, and increased accessibility to treatment due to flexibilities in time and place.” (Bierbooms et al., 2020)</i></li> <li>• <i>“Many participants perceived the good side of this paradigm and highlighted the greater flexibility and convenience it created in their work. Online service delivery was an efficient approach to mitigate barriers to in-person counselling services, such as travel constraints, which enhanced flexibility.” (Brandon &amp; Fragkiadaki, 2023)</i></li> <li>• <i>“absence of nonverbal communication and the lack of a designated safe space for therapy were identified as challenges participants faced with the changes to mental health provision. Yet, practitioners spoke of solutions to maintain a therapeutic space suitable for their sessions.” (Brandon &amp; Fragkiadaki, 2023)</i></li> <li>• <i>“participants learned something new by delivering therapy online alongside becoming more open minded and adaptable with the use of the medium. Remote work for them required resilience, flexibility, and a rapid adaptation to change to enable the development of robust therapeutic relationships” (Brandon &amp; Fragkiadaki, 2023)</i></li> <li>• <i>“online therapy has many benefits for the clients who now request it more often. Practitioners in this study agree that remote work will now be incorporated to mental health services creating a “new normal” (Brandon &amp; Fragkiadaki, 2023)</i></li> </ul>
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				<ul style="list-style-type: none"> <li>• <i>“participant interestingly reported teletherapy to be ‘85% as good as the real thing’. (Rielly et al., 2022)</i></li> <li>• <i>“The absence of physical presence and inability to perceive non-verbal cues such as eye contact can make participants feel more comfortable in ‘bringing the therapy to a deeper level’ (P8) over the telephone and can facilitate further exploration; as one participant said, ‘I often say to a client on the phone now, you know, “I’m just wondering about this, or I was wondering about that.” I wonder more on the phone with a client than I wonder face to face’ (P10).” (Rielly et al., 2022)</i></li> <li>• <i>“It is important to establish boundaries early in therapy and ‘get all of that right from the outset’ (P2), and, in an attempt to re-establish these boundaries in this new teletherapeutic space, participants laid out explicit guidelines to keep it similar to meeting in-person such as setting aside 50 minutes to do the session and making sure that they are in a confidential space where they would not be overheard and would not be disturbed, as this communicates to the client that, ‘I very much care about this, you’re important to me, your issues are important to me’ (P1). Re-establishing these therapeutic boundaries provided participants with the prerequisite foundation for nurturing a strong therapeutic relationship similar to how they would have in person, albeit through an unfamiliar, virtual medium.” (Rielly et al., 2022)</i></li> <li>• <i>“Although the majority of the mental health clinicians discussed the negative impact of COVID-19-related stressors on their clinical practice, there were a small group of participants who shared that they were not experiencing significant stressors and therefore, did not feel that their practice had changed significantly” (Mittal et al., 2023)</i></li> <li>• <i>“Moreover, MHWs believed virtual therapeutic spaces to have protective qualities for SUs with social anxiety or avoidance, as they have ‘more control” (Griffith et al., 2023)</i></li> <li>• <i>“increased services’ flexibility which MHWs thought to improve comfort and access for SUs with impaired mobility” (Griffith et al., 2023)</i></li> </ul>
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## Appendix F



**Preparing Manuscripts for Publication  
in Psychology Journals:  
A Guide for New Authors**

**American Psychological Association  
Washington, DC**

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## Manuscript Preparation Guide

### Introduction

This guide provides an overview of the process of preparing and submitting a scholarly manuscript for publication in a psychology journal. Drawing on the experiences of authors of scholarly writings, peer reviewers, and journal editors, we seek to demystify the publication process and to offer advice designed to improve a manuscript's prospects of publication. To exemplify the process, we describe specific publication procedures for journals of the American Psychological Association.

As anyone planning to submit a manuscript for publication is well aware, the process of conceptualizing testable research questions, reviewing the literature, conducting experiments, performing analyses, interpreting results, and, finally, writing a paper that effectively describes the study and communicates the findings involves large investments of time and energy. When one also considers the pressure to publish in academic settings; the high rejection rates of prestigious journals, APA journals being among these; and the waiting period for a publication decision, the stress that can accompany the process becomes readily understandable.

Yet, the rewards of discovery and contribution to the literature of psychological science are substantial. In the research and writing process, scholars are likely to meet exciting challenges in developing their intellectual and creative potential. Through publication, authors have a unique opportunity to build on previous discoveries and add to the lore of science.

We therefore encourage new authors to take heart, recognizing that, like any worthwhile endeavor, developing skills in conducting research and writing scholarly manuscripts is a learning process. Those embarking on this journey need not feel alone but rather are encouraged to seek mentors and colleagues to help guide them in the genre of psychological science. It is in this spirit that the current guide was written.

We cover three areas of journal publication. First, we present an overview of the process, focusing on manuscript submission and peer review, affording readers a behind-the-scenes view of the ways in which a new manuscript might be approached by an editor or a reviewer. This is followed by a more detailed discussion of some characteristics of a strong manuscript, which are drawn alongside shortcomings that may detract from a manuscript's publication potential. Finally, because a new scholar's initial manuscript submission is often developed from the dissertation, we offer some suggestions for converting a dissertation into a journal article.

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### The Journal Publication Process

In this section, we provide an overview of journal publication from an editorial perspective. We consider the front end of the process, beginning with submission of a manuscript for journal publication and proceeding to consideration of the peer review process.

#### Submitting a Manuscript for Publication

The selection of the journal to which one's manuscript will be submitted is an important one. A manuscript of more specific, local interest may be better suited to a more specialized journal, whereas one with broad interest across subdisciplines may reach a wider audience in a journal with a more generalist approach, such as *Psychological Bulletin* or the *American Psychologist*.

A key criterion in publication decisions is the manuscript's fit for the particular journal and the readership of that journal. Colleagues and mentors in one's field are likely to be well versed in the types of manuscripts published by various journals in the field and can serve as additional resources in making the selection.

One may also wish to consider the quality and reputation of the journal. Both the journal's impact factor (a measure of how frequently its articles are cited in other journals) and its rejection rate provide indices of its quality. For APA journals, impact factors are listed in the current Periodicals Catalog of the Journals Program of the American Psychological Association ([www.apa.org](http://www.apa.org)), and rejection rates are published annually in the archival (August) issue of the *American Psychologist*. As ethical guidelines prohibit submission of a manuscript elsewhere while it is under consideration for a particular journal, timeliness considerations may also guide one's choice.

Manuscripts for APA journals are to be submitted according to the "APA Journals Manuscript Instructions for All Authors" on the APA website as well as the specific Instructions to Authors for the journal of interest, which are published in the individual journals and also posted on the APA website. An online manuscript portal, the Journals Back Office ([www.jbo.com](http://www.jbo.com)), facilitates the process of submission, allowing authors to upload their manuscripts in a few steps through a common online entry point.

General guidelines for preparing the manuscript for submission are summarized in the *Publication Manual of the American Psychological Association* (6th ed.; APA, 2010, pp. 228–231). Authors may also find the document "Checklist for Manuscript Submission" on the APA website helpful for preparing manuscripts for APA journals.

On receipt, the journal editor may give the manuscript a preliminary read to ensure that it generally adheres to APA Style, that the content is within the purview of the journal, and that the type of article (e.g., empirical study, theoretical review) is appropriate for the journal. If a manuscript is clearly inappropriate, the editor informs the author. Otherwise, the author can expect the manuscript to undergo peer review. The review process can vary in length, but authors can anticipate a response regarding the publication decision within 2–3 months.

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### The Peer Review Process

Fundamental to progress in science is its nature as shared knowledge and understanding about the world. In the words of Hengl and Gould (2006), “the core goal of any scientific work is to make discoveries and explain them” (p. 3). Much of this communication occurs through the exchange of ideas and findings in scholarly publications. Essential to this constructive, communicative process is that scientists understand and work within the social conventions of their respective disciplines (Committee on Science, Engineering, and Public Policy; National Academy of Sciences; National Academy of Engineering; & Institute of Medicine, 1995).

A key convention in the publication of research is the peer review process, in which the quality and potential contribution of each manuscript is evaluated by one’s peers in the scientific community. Like other scientific journals, APA journals routinely utilize a peer review process to guide manuscript selection and publication decisions. Toward the goal of impartiality, the majority of APA journals follow an established masked review policy, in which authors’ and reviewers’ identities are concealed from each other.

APA journal reviewers are scholars selected by the action editor (typically, the journal editor or associate editor) to review a manuscript on the basis of their expertise in particular content areas of their field. To enhance objectivity, two to three peer reviewers typically are selected to evaluate a manuscript. In addition to technical expertise, criteria for selection of reviewers may include familiarity with a particular controversy or attention to a balance of perspectives (APA, 2010, p. 226). Whereas the journal editor holds final responsibility for a manuscript, the editor usually weights reviewers’ inputs heavily.

Authors can expect their manuscripts to be reviewed fairly, in a skilled, conscientious manner. Reviewers are held to demanding standards: They must (a) present a clear decision regarding publication, considering the quality of the manuscript, its scientific contribution, and its appropriateness for the particular journal; (b) support the recommendation with a detailed, comprehensive analysis of the quality and coherence of the study’s conceptual basis, methods, results, and interpretations; and (c) offer specific, constructive suggestions to authors.

### “Quick Read”

After reviews are in hand but before considering the reviews in detail, the decision editor (either the editor or associate editor) scans the paper to gain an independent view of the work. This “quick read” provides a foundation for the more thorough reading that follows—it by no means determines the final decision. On the other hand, it probably parallels how authors can expect many reviewers (and readers) to approach their papers.

First, the editor scans the paper from beginning to end for obvious flaws in the research substance and writing style. If problems show on the surface, a deeper reading is likely to uncover other matters needing attention. The quick-read process is relatively simple. In the initial examination of your manuscript, the editor or associate editor will follow these general guidelines:

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- *Read the abstract.* The editor thinks about the following questions: What is the sense of the research question, methodology, findings, and interpretations? Major problems in the abstract often reflect internal flaws. The major goal in reading the abstract is to understand the research question. Is it clearly defined, relevant, and supported by the methodology? APA publication policy emphasizes *conclusion-oriented* abstracts: What did the research find, and what do the findings mean?
- *Examine the full manuscript.* If it is more than 35 typed, double-spaced pages (including references, tables, and figures), this could pose a problem for some journals. How long are the introduction and the Discussion section relative to other sections of the paper?
- *Scan the paper's headings.* Are they well organized? Does a clear structure emerge? If not, the author has not achieved coherence.
- *Scan the references.* Are they in APA Style? If not, the author is not using APA publication format.
- *Scan the tables and figures.* Do they portray the information clearly? Can they stand alone without captions? Are they well constructed and in APA Style? A "no" to any of these questions suggests problems in the author's presentation of findings. If the text contains a large number of statistics, could they be more appropriately put into tables or figures?
- *Finish the quick read by reading a page or two from each section of the paper.* How often does the red pen jump into the mental fingers? Do problems result from sloppiness or something deeper? Are there long paragraphs (more than a page) and sentences (more than three lines)? Does the author communicate skillfully? Writing problems can signal more serious shortcomings.

The quick read leads to an initial impression of the care with which a manuscript has been prepared. Weaknesses do not necessarily speak to the quality of the research, but they do reflect barriers to understanding the work and give a sense of the paper's quality and suitability for publication. Authors preparing their own papers should ask themselves questions like those listed above.

### Actions Taken on a Manuscript

After completing a quick read, the decision editor scrutinizes the manuscript and the reviews. The following categories constitute the editorial actions that may be taken on a manuscript:

### Manuscript Preparation Guide

- *Rejection.* The flaws that lead to this decision generally center on substantive or methodological issues. A manuscript is usually rejected because (a) it is outside the area of coverage of the journal; (b) it contains serious flaws of design, methodology, analysis, or interpretation; or (c) it is judged to make only a limited novel contribution to the field. Below, we further discuss problems that may increase the probability of rejection.
- *Rejection with invitation to revise and resubmit.* In some cases, manuscripts may have publication potential but are not yet ready for final publication. The study as presented may not merit acceptance as is but may warrant consideration after substantive revision (e.g., reorganizing the conceptual structure, conducting additional experiments, or modifying analyses). The action editor will give the author an invitation to revise and resubmit for another round of reviews (usually with the same reviewers). An action editor cannot guarantee acceptance of a revised manuscript, but authors who respond flexibly and attend closely to suggested revisions enhance their chances for an acceptance. Authors are advised to include a detailed cover letter outlining their responses to the revisions.
- *Acceptance.* In very few cases, a manuscript may be accepted for publication on first reading, with only minor revisions required. More typically, acceptances follow the successful revision of a manuscript previously rejected with invitation to revise and resubmit. Once a manuscript is accepted, it enters the production phase of publication. At this point, no further changes can be made by the author other than those suggested by the copyeditor.

New scholars who wish to learn more about the editorial and peer review process as it operates with APA journals are referred to "The Publication Process" (Chapter 8 of the *Publication Manual*; APA, 2010; see also Eichorn & VandenBos, 1985).

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### Characteristics of a Strong Manuscript

Before describing the characteristics of a good manuscript, we turn briefly to problems associated with a poor one. Bartol (1983, cited in Eichorn & VandenBos, 1985) identified chief problems as the following:

- inadequate review of the literature,
- inappropriate citations,
- unclear introduction,
- ambiguous research questions,
- inadequately described sample,
- insufficient methodology,
- incompletely described measures,
- unclear statistical analysis,
- inappropriate statistical techniques,
- poor conceptualization of discussion,
- discussion that goes beyond the data,
- poor writing style, and
- excessive length.

Sternberg (1988) gave a list of misconceptions about research manuscripts, which may help new authors avoid common pitfalls.

Beyond the more serious shortcomings highlighted above, Kupfersmid and Wonderly (1994) have drawn attention to the problems of the lack of relevancy and scientific contribution of a number of articles that are, in fact, published in professional journals. Clearly, creating a strong empirical or review manuscript that contributes to scientific knowledge requires thought and planning at each stage of the research and writing process.

Below we highlight features of substance and style that pertain to the quality of the manuscript and have bearing on its evaluation in the editorial review process. Throughout we refer to relevant sections of the *Publication Manual* (APA, 2010). The manual picks up where this guide leaves off, providing authors with a rich source of information on both substantive concerns and APA Style, which is well established as the gold standard in editorial style for a wide range of disciplines in addition to psychology.

### Substantive Aspects

Central to the quality of an empirical research paper or literature review is its substantive core—that is, the research questions that are posed; the ways in which they are conceptualized; and the methodological soundness with which they are studied, assessed, and interpreted. From this perspective, we consider, in turn, various sections of the manuscript and refer the interested reader to more extensive description of the qualities of

## Manuscript Preparation Guide

a strong research paper in the *Publication Manual* (APA, 2010; see also Bem, 2004; Hengl & Gould, 2006; Kupfersmid & Wonderly, 1994; Sternberg, 1988).

**Title and abstract.** The title and the abstract are key elements that inform the reader of the contents of the manuscript and, as a rule, are the parts of the manuscript that gain the widest exposure. Haggan (2003) observed a trend toward increasing informativeness of titles and referred to them as “texts in miniature,” which in this fast-paced world of information overload “must add to the reader’s mental representation of the world” (p. 312). Given the title’s prominence, we encourage authors to exercise thought and creativity in selecting a title that will capture the reader’s attention and clearly inform the reader of the contents within.

Similarly, the abstract is read by far more readers than is the average article. The abstract serves important purposes in summarizing the hypotheses, design, and findings of the study and in representing the article in indexing databases. Readers frequently decide whether to delve further into an article on the basis of the abstract. Thus, a well-written abstract that conveys the research questions and findings succinctly can entice readers to learn more. It is not an understatement to say that “a well-prepared abstract can be the most important single paragraph in an article” (APA, 2010, p. 26).

Some journals use structured abstracts, in which participants, methods, results, and conclusions are set off in separate sections. Regardless of whether these elements are formally set off, authors should include these aspects of the study and seek to provide the information accurately and coherently and in a nonevaluative manner.

**Introduction.** A strong introduction engages the reader in the problem of interest and provides a context for the study at hand. In introducing the research concern, the writer should provide a clear rationale for why the problem deserves new research, placing the study in the context of current knowledge and prior theoretical and empirical work on the topic. Responsible scholarship stipulates that the writer properly credit the work of others. Whereas it is impractical to exhaustively describe all prior research, the most current and relevant studies should be cited. Swales and Feak (2004) identified four cornerstones of the introduction in a research paper, advising authors

- to establish current knowledge of the field;
- to summarize previous research, providing the wider context and background and the importance of the current study;
- to set the stage for the present research, indicating gaps in knowledge and presenting the research question; and
- to introduce present research, stating its purpose and outlining its design.

Within this framework, the writer states the hypotheses of the current study and their correspondence to the research design (APA, 2010, pp. 27–28).

**Method.** In both quantitative and qualitative research, the use of appropriate methods of participant sampling, study design, measures, and statistical analysis critically influences the study’s methodological soundness. Calfee and Valencia (2007) suggested that good methodology can be described by the two “Cs”—clean and clear.

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The soundness of the study hinges on *clean* methodology, that is, use of appropriate, valid, and unflawed methods of sampling and use of instruments, procedures, and analysis. In a clean study, Calfee and Valencia (2007) noted that the researcher ensures that

- sample variables are free of confounding influences (e.g., education is controlled for),
- recruitment and sampling techniques are appropriate,
- measures are reliable and valid for assessing the variables of interest, and
- the statistical procedures are appropriate and sufficiently sophisticated to examine the data and are carried out appropriately.

The ideal Method section is written in a *clear* manner, such that another researcher could duplicate the study. Toward this end, the writer should provide a thorough description of methods of recruitment, participant characteristics, measures and apparatus, and procedures. Recruitment methods and effects of attrition should be articulated. The writer should take care to thoroughly describe the sample with regard to demographic characteristics, including notation of any characteristics that may have bearing on the results (e.g., socioeconomic status). This information assists the reader in understanding the characterization of the current sample and the degree to which results may be generalizable. Measures should be appropriately referenced, including notation of their reliability and validity, and any adaptations to their customary use should be noted. In a clear study, the author explicates the research design and plan for analysis, noting whether conditions were manipulated or naturalistic, whether groups were randomly assigned, and whether the design explored variables within or between participants (APA, 2010).

**Results and discussion.** The Results section should include a summary of the collected data and analyses, which follows from the analytic plan. All results should be described, including unexpected findings. Authors should include both descriptive statistics and tests of significance. The *Publication Manual* provides information on tests of significance, including null hypothesis testing, effect sizes, confidence intervals, inferential statistics, and supplementary analyses.

In the Discussion section, the writer evaluates and interprets the findings. This section should begin with a statement of support or nonsupport for the original hypotheses in light of the findings. If the hypotheses were not supported, the author considers post hoc explanations. In interpreting the results, authors consider sources of bias and other threats to internal validity, imprecision of measures, overall number of tests or overlap among tests, effect sizes, and other weaknesses of the study (APA, 2010, p. 35).

Limitations and a discussion of the importance of the findings should conclude the discussion. Providing a link to future research, the author may offer recommendations for further study. More specific recommendations are more useful. As Skelton (1994) observed, researchers too often end their papers with a recommendation that is “too imprecise to be operationalized, or too grand to be implemented by a decision at much lower than a ministerial level” (p. 459).

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**Tables and figures.** Tables and figures are particularly valuable for conveying large amounts of information and for showing relationships among data. The expanding development of advanced tools for graphic display provides authors with greater flexibility and capability for illustrating their results. Such tools can convey information in visually engaging ways that facilitate the reader's understanding of comparisons and evaluations of change over time. Authors should avoid duplicate reporting of data but instead should decide on the most comprehensible ways of presenting the information, whether it is through text or through tabular or graphic form.

Good tables and figures should be structured according to APA Style and be clear and self-explanatory so that, with their captions, they can stand apart from the text. In addition to Chapter 5 of the *Publication Manual* on displaying results, the interested writer may wish to consult the APA publication, *Displaying Your Findings* (Nicol & Pexman, 2010), as well as the article on this topic published in the *American Psychologist* (Smith, Best, Stubbs, Archibald, & Roberson-Nay, 2002).

### Ethical Considerations

In planning for and conducting a study, researchers should consult the “Ethical Principles of Psychologists and Code of Conduct” (APA, 2002) as well as the ethical guidelines of the institution where the research was conducted. The APA Ethics Code requires that researchers ensure approval by relevant institutional review boards and obtain informed consent from all participants. Fulfillment of these requirements should be noted in the Method section. Researchers should take care to exercise proper conduct in administering measures and carrying out experiments with participants. When applicable, participants should be thoroughly debriefed, and such procedures should be indicated in the manuscript.

### Style

Style in scholarly manuscripts can refer to various aspects of the writing technique. Here, we highlight *editorial style* and *writing style*. Authors preparing a manuscript for submission will want to attend closely to APA editorial style, the mechanics of convention laid out in the *Publication Manual*—the decisive resource for capitalization, italics, abbreviations, heading structure, and so forth. The *Publication Manual* also includes guidance on avoiding bias in language, which is particularly important in demonstrating sensitivity to such concerns as participants' mental illness and cultural background.

A strong manuscript will demonstrate the author's command of writing style in the academic genre of a research article. Tardy and Swales (2008) characterized writing genres in the following way:

Written texts are known to have culturally preferred shapes that structure their overall organization and influence their internal patterning. These shaping forces,

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at both general and local levels, are neither incidental nor accidental; rather, they exist to provide orientations for both readers and writers. (p. 565)

Learning the language of the genre will contribute to the production of a technically sound, well-written manuscript. In the case of an empirical research article, perhaps the most apparent feature is its standard structure, which follows some variation on the format of Introduction–Method–Results–Discussion. Beyond this organizational frame, however, there are a number of major and more subtle features that characterize the empirical research article.

A good research article hinges on its coherence and organization. These aspects of the article are influenced by the ways in which the study evolves from the data. Whereas a typical psychology research article will follow a standard framework of ordered sections, as noted above, a coherent article is not usually written in the order of these sections but instead develops from the data analyses. As expressed by Bem (2004) in his chapter on the empirical research article,

There are two possible articles you can write: (a) the article you planned to write when you designed your study or (b) the article that makes the most sense now that you have seen the results. They are rarely the same, and the correct answer is (b). (p. 186)

Although the research paper should be guided outward from the hypotheses and resulting data, the paper should be guided by ideas and one's point of view. As stated by Sternberg (1988), "Facts are presented in service of ideas: to help elucidate, support, or refute these ideas. They provide a test against which the validity of ideas can be measured" (p. 4). Along these lines, an organizing principle of strong research papers is to convey central features first, followed by more peripheral or less important aspects (Bem, 2004).

Whereas selectivity in presentation is important, it is crucial to present facts objectively, both those that refute and those that support one's position. "Scientists demand that scientific reporting be scrupulously honest. Without such honesty, scientific communication would collapse" (Sternberg, 1988, p. 5).

Additional suggestions for writing accurate, clear, and concise research articles are provided in Chapter 3 of the *Publication Manual*, which discusses continuity and transitions, tone, precision, word choice, and grammatical principles. Another source of useful information is the APA Style website ([www.apastyle.org](http://www.apastyle.org)).

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### Converting One's Dissertation Into a Journal Article

Beginning scholars will often choose to develop a journal article from a doctoral dissertation (or master's thesis) as an initial submission for publication. In this section, we first provide some considerations regarding the status of the dissertation with regard to its potential for publication. We then offer suggestions for converting the dissertation into a publishable manuscript. Often this involves reducing a document of over 100 pages to perhaps one third its original length. In particular, we highlight the following features most likely to distinguish the two types of documents: brevity, extent of literature review, data analyses, writing style, and interpretation of results.

### Deciding to Submit the Manuscript

First, the writer will want to consider whether the study merits publication in a journal article—specifically whether the findings tell a compelling story or answer important questions and whether the research makes a novel contribution to the literature. If the study is deemed worthy of publication, consideration should be given to such issues as whether all of the original research questions should be included in the present study and whether the results warrant additional experiments that could assist in answering the research questions more fully.

The author may also want to consider such factors as whether the current sample size provides sufficient power to merit publication and whether additional analyses might clarify ambiguous findings. Consultation with colleagues can help the author evaluate the status of the manuscript and its potential for publication as well as the selection of an appropriate journal to which to submit one's manuscript.

### Adapting a Dissertation for Publication

Once a decision is made to convert a dissertation into an article, the author will want to focus attention on adapting the manuscript to an empirical article (or literature review) for publication. By attending to brevity and focus, relevant data analyses, appropriate interpretation of results, and writing style, authors can enhance the fit of a manuscript for journal publication. Editors and reviewers readily recognize an article that has been hastily converted from a dissertation. Whereas most reviewers are generous with their time and knowledge in guiding a new colleague through the publication maze, greater effort on the part of the author to make these adjustments at the front end is likely to increase the manuscript's potential for serious consideration.

**Brevity and focus.** Throughout a manuscript to be considered for journal publication, brevity is an important consideration, particularly in the Introduction and Discussion sections. In a dissertation, the writer's task is to demonstrate breadth of knowledge on a topic as well as the skills to fully explore the research problem under consideration. In contrast, an empirical article must maintain a clear focus. The abstract

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may need to be condensed to meet the length requirements of the journal. Whereas *Dissertation Abstracts International* accepts abstracts of up to 350 words, journal abstract requirements are likely to be more limited. For most APA journals, the maximum length is 250 words.

One of the major challenges in the dissertation's transformation is that of paring the more comprehensive literature review characteristic of a dissertation to a more succinct one suitable for the introduction of a journal article. The writer's task is one of selectivity, in which he or she takes care to preserve the relevant substance while omitting extraneous material. The writer will want to edit the text to material relating to the more immediate context of the research questions.

Selection of sources is similarly important. Given the rapidly expanding literature, it is generally impractical to exhaustively review prior research in a journal article. The author should nonetheless take care to reference the most relevant and current studies and avoid omitting key studies pertinent to the research problem. Citation of reviews and meta-analyses can guide the interested reader to the broader literature while providing an economical way of referencing prior studies. Depending on the timing of rewriting, the author should review the most recent literature to avoid overlooking relevant studies that may have been published since the writing of the dissertation.

**Evaluation of analyses.** The researcher should be selective in choosing analyses for inclusion in the journal article. An unbiased approach is important to avoid omitting study data. However, reporting every analysis that may have been run for the dissertation often is not feasible, appropriate, or useful in the limited space of a journal article. Instead, analyses that directly address the research questions should be retained and more supplemental analyses excluded. Prior to submitting the manuscript, the researcher may also wish to consider whether the existing data would be better explained by additional or more sophisticated analyses. Sternberg (1988) noted that the Results section should be organized so that the most important results are listed first, followed by results of secondary or post hoc analyses.

**Interpretation of results.** In writing the Discussion, researchers should focus on interpreting the results in light of the research questions. In particular, Calfee and Valencia (2007) advised new authors to be aware of tendencies to overinterpret their data. Taking into account sample size and composition, effect size, limitations of measurement, and other specific considerations of the study is important to avoid extrapolating beyond the data.

A strong Discussion section notes areas of consensus with and divergence from previous work. New authors should make particular efforts to attend to connections with existing literature. Such attunement strengthens the communicative function of the research article within the framework of the broader scientific literature.

**Writing style.** New scholars are advised to familiarize themselves with the details of APA Style. In addition to the general considerations on style noted above, two points are worth highlighting here. First, a manuscript that closely follows APA Style guidelines is likely to make a more seamless presentation, with fewer features to distract the reviewer from the content of the paper. *Second, in some cases, there are differences*

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between formatting requirements specific to one's university or dissertation publishing services and journal style requirements. Areas of difference can involve tables and figures, organization of sections, and reference lists. For example, theses and dissertations may include bibliographies, which list additional sources beyond those included in the reference list. In such cases, the reference list will need to be edited to include only those references cited in the submitted manuscript.

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### **Conclusion**

Although conducting research and writing publishable articles invokes challenges that involve considerable investments of time and energy, intellectual rigor, and fortitude, we encourage new scholars and researchers to take the progressive steps of developing their manuscripts for submission to psychology journals. Bringing to fruition the hard work of one's research and sharing one's findings with the scientific community can bring personal rewards. Beyond such rewards, it is through the continued communication of theoretical developments, carefully planned and executed research, and discovery that the field of psychological science and application can advance.

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