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COMMENTARY

The Complexity of Teletherapy: Not Better or Worse, but Different

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The article by Lin and Anderson (in press) provides a timely and thorough systematic review and meta-analysis on the highly relevant and frequently debated topic of the efficacy of teletherapy and how this compares to in-person therapy. To complement their rigorous meta-analysis of randomized controlled trails, I would like to highlight some of the areas of complexity of teletherapy research and clinical practice. First, I will reflect on methodological limitations of research on teletherapy outcomes, and then I will zoom in (pun intended) on what we have learnt from our own research on teletherapy about the therapeutic process itself.

Teletherapy Defined

As highlighted by Lin and Anderson (in press), the definition of teletherapy is not clear-cut. In recent years, researchers and clinicians have used similar terms for different treatment formats as well as a variety of terms for similar treatment formats. For example, terms such as phone therapy, online therapy, remote therapy, e-mental health, telemental health, computer-based psychotherapy, that are often used interchangeably, might refer to very different treatment formats. Depending on the author, these terms might reflect asynchronously administered treatments, without real-time interaction between therapist and patient, or clinician-supported synchronous treatments, in which therapists and patients interact in real-time at regular intervals, albeit not being together in the same room. Other studies that use the terms "teletherapy," "online therapy," or "live video-delivered psychotherapy" might all refer to the same type of remote therapy format in which a therapist and a patient synchronously interact via a videoconferencing platform. Although most of the teletherapy literature appears to describe 1-1 psychotherapies with adult patients, the teletherapy format could also be applied to couples work, play therapy with children, or group psychotherapies.

The review by Lin and Anderson (in press) includes the most common types of synchronous teletherapy between one therapist and one patient, comparing therapy per telephone or per videoconference to in-person therapy. Although videoconferencing brings the benefits of allowing for nonverbal communication that resembles the in-person therapy set-up more closely, it also brings along more technical challenges, requiring Wi-Fi and the use of online platforms. It might thus not be surprising that teletherapy via videoconferencing was at greater risk of patient attrition than teletherapy via phone.

Teletherapy Outcomes Defined

The COVID-19 pandemic led to an increase in the uptake of teletherapy and studies on this matter. Teletherapy emerges not only as a popular and convenient choice but also one that is now upheld by meta-analytic evidence. The effect size differences reported by Lin and Anderson (in press) do slightly favor in-person therapy, suggesting that more studies examining the effects of teletherapy are needed. To determine the types of studies that would be helpful to the field, it is important to reflect on the limitations of the current empirical evidence. First, although many different narrative, systematic review and meta-analyses have been conducted recently on the topic of outcomes of teletherapy, they each appear to cover only one piece of the pie; only certain types of patients, disorders, therapists, treatments, control groups, or teletherapy formats, which makes it hard to gain clarity on the field at large. Second, none of the reviewed studies by Lin and Anderson (in press) reported within-patient change between in-person and teletherapy sessions, which means that unintended patient and therapist differences might explain part of the results. Many therapists, for example, think that patients with severe emotion-regulation difficulties, paranoid or psychotic symptoms, or suicidal ideation are not suitable for teletherapy. And many teletherapy trials enroll patients with less severe symptoms, who are more likely to respond to treatment. Third, the RCT findings might not generalize to clinical practice because outside the controlled context of an RCT, clinicians are likely to offer a hybrid treatment (i.e., some sessions in-person, some sessions via teletherapy), or have a hybrid caseload (i.e., some patients in-person, some patients via teletherapy). Thus, naturalistic studies on the type of blended teletherapy practices that are being provided now are warranted. It is possible that the flexibility of hybrid treatment formats further reduces treatment dropout and thus might result in better longer-term outcomes. Fourth, it is questionable how much the reviewed pre-pandemic RCTs actually generalize to our (post) pandemic world, as both patients and therapists have more positive opinions and at least more experience with this format of therapy now. However, the

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studies conducted since the start of the pandemic—a time in which in-person therapy options were not available-, are also limited because it is impossible to tease apart which effects are due to the pandemic context and which reflect effects of teletherapy more generally. In future, routine outcome monitoring might be one way of collecting within-patient session-by-session feedback on the patients' progress that can be applied via a link on a tablet (in-person) as well as online (teletherapy) in a hybrid treatment.

Even if the empirical studies would have been able to address these design limitations, other methodological concerns can be raised about the definition and measurement of teletherapy outcomes. An important question remains about how we operationalize treatment outcomes. Lin and Anderson (in press) consider symptom relief at post treatment and follow-up as well as dropout, which are very relevant metrics of treatment success. Notably, the follow-up measurements did not extend the 6-month timeline, so we do not yet know the longer-term differences in effects of the teletherapy vs. in-person treatments.

Others might argue that besides symptom change, a patient's level of satisfaction is also an important metric of treatment outcome. Given the potential for lower associated costs and easier access of teletherapy, it appears to be particularly promising. Even if teletherapy would not be "as effective as in-person therapy," a teletherapy that is "better than nothing" might suffice. In other words, maybe teletherapy does not have to be equally effective because it bridges a gap in service delivery for those who otherwise would not be able to receive any psychotherapy services at all, and it also requires less effort and time investment from the patient. It has lowered the barrier to entry for people who live in an area with a therapist shortage or for those with schedules that wouldn't allow for commuting to a therapist's office. For example, if teletherapy allows for the engagement of an otherwise disengaged parent in family therapy, or it allows for the active involvement of a partner who might not otherwise be able to attend in-person couples therapy, maybe teletherapy would be preferred, even if it weren't equally effective.

That said, given the choice between in-person and teletherapy, solely focusing on patients' satisfaction or preference might not always be beneficial per se. Recent research suggests that patients high on attachment avoidance might have more positive attitudes towards teletherapy (Békés et al., 2022), but that doesn't mean that the teletherapy work would necessarily be equally effective. Lin and Anderson (in press) reported that patients' age and gender did not moderate treatment outcomes in the RCTs but the potential importance of patients' attachment or personality orientation on teletherapy success remains to be examined.

Similarly, the therapists' preference and level of satisfaction with providing teletherapy is also important to consider. Some therapists experience extreme fatigue and feel unable to see as many patients a day, as they would in-person. Whereas for other therapists, it might mean that they can see their patients during regular 9-5pm hours because without the commute back and forth to the therapists' office, patients can fit the teletherapy session into their working day.

As Lin and Anderson pointed out, it is worth noting that, in spite of the documented successes of teletherapy many therapists continue to doubt its efficacy. Many still continue to report preference for, and greater competency in, in-person therapy (Aafjes-van Doorn, Békés, Luo, Prout, et al., 2021). This suggests that besides the "objective" measurements of efficacy and effectiveness of teletherapy outcomes, it might also be important to examine therapists' and patients' attitudes towards teletherapy technology. Because no such measure existed for the use of teletherapy, we developed "attitudes towards teletherapy" scales based on the Unified Theory of Acceptance and Use of Technology -model to assess patients' and therapists' attitudes, concerns, and future intention of using teletherapy (UTAUT-T; Békés et al., 2021; UTAUT-P; Békés et al., 2022).

Teletherapy Process

Although similarly effective/efficacious, teletherapy might be experienced as qualitatively different from in-person psychotherapy. Since the start of the pandemic, many clinicians have expressed their perspectives on the therapeutic challenges as well as the potential opportunities of the teletherapeutic process. For example, some argue that in teletherapy the focus and direction of the work might be easily lost, and patients as well as therapists might be distracted and less emotionally expressive or emotionally available than in in-person sessions. Because much of the communication is reduced to verbal exchanges, empathic mirroring might be obstructed, which means that patients may not experience their therapist's empathy and struggle to feel contained (Sayers, 2021). Ruptures in the therapeutic alliance, for example, might arise due to technical glitches, or the difficulty in maintaining eye contact, and these alliance ruptures might be difficult to notice via a screen (Dolev-Amit et al., 2021). Therapists have also reported increased levels of exhaustion and might not be able to see as many patients per day as they would otherwise. Without the rituals surrounding in-person therapy sessions, patients and therapists might also miss the transitional time and space between every-day life and the therapy sessions.

In contrast, others have highlighted aspects of teletherapy that might actually be facilitative of the therapeutic process. For example, the patient and therapist might feel freer to disclose their subjective experiences, feel safer, less self-conscious, and be able to connect in a more real and genuine way. The diminished asymmetry in the relationship could be liberating as it might result in a more informal atmosphere and might bolster patients' therapeutic agency and empowerment. An online therapeutic environment may facilitate transference reactions that are more reality based and meaningful. The teletherapy format might have an online disinhibition effect which leads some patients to become more emotionally forthcoming when treatments are moved onto screens or phones. For both therapist and patient, inviting the other into a space that can be associated with intimacy and safety may help facilitate similar feelings within the therapy relationship. Paradoxically, patients may thus perceive a greater sense of closeness as a result of the physical distance inherent in teletherapy.

Teletherapy practicalities might also become grist for the mill. For example, the patient's choice of setting from which to meet their therapist in teletherapy might provide cues to their transference experience of the therapist (Sayers, 2021). Therapists might also get an impression of the physical and interpersonal surroundings of the patient and might for example hear the suddenly hushed voice of someone not wanting their partner to get a drift of the conversation. It thus illuminates aspects therapists didn't see before. Thus, although stepping into a therapists' office might

have several therapeutic benefits and the physical distance and change in the teletherapeutic frame might create new enactments and disappointments, the teletherapy format might also facilitate unique therapeutic opportunities that may not be possible when therapy is conducted in person.

Indeed, recent empirical studies appear to confirm the multitude of teletherapy experiences; not better or worse per se, but different. Patient and therapist responses in international longitudinal surveys and in-depth interviews that we conducted (Aafjes-van Doorn, Békés, & Luo, 2021; Aafjes-van Doorn, Békés, Luo, Prout, et al., 2021; Békés et al., 2021, 2022) suggest that the teletherapy process reflects a complex amalgamation of potentially helpful and unhelpful therapeutic experiences. Many therapists and patients reported difficulties with emotional connection, distractions, and privacy when they transitioned to teletherapy. Many therapists disclosed more of themselves. Patients noted their therapists' increased self-disclosure, and also reported disclosing more themselves. Therapists and patients both reported that the working alliance and real relationship were equally good in teletherapy (vs in-person), and these aspects of the therapeutic relationship improved over time. It appears that in teletherapy the quality of the real relationship might be more pertinent than the working alliance and might be predictive of resilience over time. Not all therapists responded in the same way to the professional transition to teletherapy; therapists' age, experience, and use of adaptive defenses appeared to protect therapists against feeling professional self-doubt during the transition to teletherapy. Similarly, patient-reported working alliance and therapeutic agency in teletherapy appeared to be differentially important for patients with varying levels of attachment anxiety and avoidance, possible reflecting their individual preferences to hide or be seen. Patients with more teletherapy experience reported more therapeutic agency, just like therapists with more teletherapy experience were more acceptant of the technology. This suggests that gaining experience with teletherapy (even a forced transition during the pandemic) might have been helpful for patients and therapists alike to facilitate the therapeutic process and outcome in teletherapy.

The discussion around effectiveness and efficacy of teletherapy is not as clear cut as it seems. In this day and age, psychotherapy can be provided in a multitude of ways, and teletherapy via videoconference or phone might be a viable option for some patients, therapists, treatments, and moments in time. It's not always an either/or but how teletherapy versus in-person can be mixed in the most effective and efficient way. Sometimes, such as in pandemic times, or in remote settings, teletherapy does not necessarily need to be "as effective as in-person therapy" but "better than nothing" might suffice. While the data suggest that the outcomes of in-person versus teletherapy may be equal, the therapeutic experience itself is not the same. The therapeutic process in teletherapy is qualitatively different and offers a complex amalgamation of potentially helpful and unhelpful therapeutic experiences. It is hoped that future work will elaborate on the details of the therapeutic process, including specific implications for technique, and a nuanced discussion of the artistry critical to the work of this mode of psychotherapy.

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