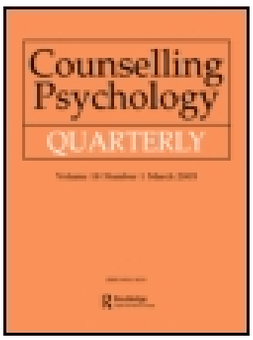

Counselling Psychology Quarterly

ISSN: (Print) (Online) Journal homepage: https://www.tandfonline.com/loi/ccpq20

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To cite this article: Katie Aafjes-van Doorn , Vera Békés & Tracy A. Prout (2020): Grappling with our therapeutic relationship and professional self-doubt during COVID-19: will we use video therapy again?, Counselling Psychology Quarterly, DOI: 10.1080/09515070.2020.1773404

To link to this article: https://doi.org/10.1080/09515070.2020.1773404

Published online: 03 Jun 2020.

COUNSELLING PSYCHOLOGY QUARTERLY
https://doi.org/10.1080/09515070.2020.1773404

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ARTICLE

Grappling with our therapeutic relationship and professional self-doubt during COVID-19: will we use video therapy again?

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ABSTRACT

The social restrictions during the COVID-19 crisis led to many therapists providing therapy remotely, despite some therapists' concerns regarding its efficacy, technical challenges and their ability to build a strong therapeutic relationship online. This survey study reports on the experiences of 141 therapists who transitioned to providing video therapy during the pandemic. Aspects of the therapeutic relationship (e.g. working alliance, real relationship), experienced anxiety and professional self-doubt, attitudes towards and intention of video therapy use in the future were assessed. Although therapists reported some anxiety and self-doubt, most felt that online sessions had a sufficient working alliance and a strong real relationship. Therapists with more online therapy experience, lower levels of self-doubt and anxiety, and those who experienced a strong online real relationship during the pandemic, or thought their patients viewed it positively, tended to be more accepting of video therapy. Therapists were largely undecided as to whether they planned to use video therapy in the future; however, those with prior video therapy experience were more likely to endorse future utilization. Training is needed, especially for therapists with less online therapy experience, in order to foster a better experience and to support effective use of online therapy in the future.

ARTICLE HISTORY
Received 20 April 2020
Accepted 20 May 2020

KEYWORDS
Video therapy; alliance; real relationship; professional self-doubt; UTAUT; COVID-19

In the world of telemental health interventions, video therapy (i.e. online therapy via a video conferencing) is one alternative to in-person therapy. Video therapy offers the benefits of telemental health (e.g., access in remote and rural areas, time and cost-savings; Simpson, 2009) while allowing for real-time synchronous interactions of speech and body movement. Most therapists have little training and experience in providing video therapy and many therapists believe that video therapies are less effective than sessions conducted in-person (e.g., Topooco et al., 2017). Commonly expressed concerns focus on the practicalities of conducting video therapy, such as the impact of technical glitches, insufficient internet literacy, or assuring confidentiality online (e.g., Topooco et al., 2017). Many therapists are also reluctant to use video therapy because of relational concerns, especially regarding difficulties with building a strong therapeutic relationship online (Connolly, Miller, Lindsay, & Bauer, 2020; Roesler, 2017; Sucala, Schnur, Brackman, Constantino, & Montgomery, 2013).

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These concerns about the therapeutic relationship in video therapy are not necessarily based on empirical findings. Studies on the working alliance, one of the most researched aspects of the therapeutic relationship, suggest that patients benefit from video therapy and experience it positively. Although therapists tend to perceive a lower working alliance in video compared to in-person therapy (Rees & Stone, 2005), the working alliance in video therapies has shown to be high (see review by Norwood, Moghaddam, Malins, & Sabin-Farrell, 2018), and comparable to in-person therapies (e.g., Bouchard et al., 2000), especially when rated by patients (e.g., Ruwaard et al., 2009). It is thus possible that negative expectations of video therapy, rather than its actual relational deficits affect therapists' perceptions of the working alliance in video therapies (Rees & Stone, 2005). Another important aspect of the therapeutic relationship, the real relationship (i.e. the genuine and realistic personal relationship; Gelso, 2011), distinctly contributes to in-person treatment outcomes (Bhatia & Gelso, 2018), but has not yet been studied in video therapy.

During the COVID-19 pandemic, social distancing guidelines were instituted by health authorities in an effort to slow down the spread of the virus. Patients and therapists alike were advised to stay home, which meant that millions of in-person therapies transitioned to video at once. Consequently, many therapists began providing video therapy without much time to access training or support. Whereas using platforms allowed therapists and patients to continue ongoing treatments, it is unclear how these treatments are experienced by therapists. For many therapists, the experiences gained during the pandemic may shape their views and attitudes about video therapy and impact their attitudes towards future online work (Békés, Aafjes-van Doorn, Prout, & Hoffman, in press).

In the present cross-sectional survey study, we aimed to explore therapists' experiences of video therapy after switching from in-person to video sessions during the pandemic. More specifically, we examined: 1) Therapist perceptions of the therapeutic relationship (working alliance and real relationship) in video sessions compared to previous in-person therapy; 2) Therapist confidence in professional competence (professional self-doubt) and experienced anxiety related to providing video therapy; 3) Therapist attitudes towards video therapy technology in general, as well as intentions to continue using video therapy in the future.

Methods

Recruitment

An online therapist survey was advertised via professional listservs and social media. Due to the forced-choice logic of the online survey, no data were missing. Participants were eligible to take part if they were therapists (either licensed or in training) and if they had conducted at least one video therapy session since the start of the pandemic. The participants were first provided with an online information sheet and were asked for their consent before being directed to the online survey. The survey took approximately 15 minutes to complete and included several individual items as well as standardized measures in a set order. The study was reviewed by the Western Institutional Review Board. The present study reports on responses from 141 therapists collected between March 25 and 30 March 2020.

Measures

The survey included demographic questions, including age, gender, location, profession, and licensure. Several individual items inquired about previous in-person and video therapy experience, previous training and their experienced challenges with the transition to online therapy. Therapists were also asked to identify all the ways in which they prepared for the transition on a list of possible options, such as "I talked to colleagues", and "I read journal articles". Moreover, one item asked the therapists to rate their perception of patients' online experiences ("During the pandemic, how do your (previously in-person) patients tend to experience having therapy online?") on a 5-point Likert scale (1 = Extremely positive, 2 = Somewhat positive, 3 = Neither positive or negative, 4 = Somewhat negative, 5 = Extremely negative).

Standardized scales assessed the aspects of the therapeutic relationship (working alliance and real relationship), therapists' professional experience (self-doubt and anxiety), and attitudes towards acceptance and usage of video therapy more generally. In order to reflect therapists' overall experience of the working alliance, real relationship, and professional self-doubt in their online therapy, the instructions of the scales were slightly adapted to "In general, in your online sessions during the pandemic."

The **Working-Alliance Inventory-Short Form** (WAI-SF; Hatcher & Gillaspy, 2006) was adapted from the earlier versions of the WAI (Horvath & Greenberg, 1989) using extensive factor analyses. The WAI-SR assesses the level of agreement on the goals of treatment, agreement on the steps toward meeting the patient's goals, and the relationship between the patient and therapist. The ten items are rated on a Likert scale ranging from 1 (never) to 7 (always). A global working alliance rating of 4 (sometimes), the middle point of the scale, is interpreted as a neutral working alliance, with higher scores indicating a stronger working alliance (Horvath & Greenberg, 1989). The WAI-SF has shown adequate reliability and validity (Hatcher & Gillaspy, 2006).

In normal circumstances (not during an abrupt transition due to the pandemic), the therapist-rated alliance on the WAI-SF in video therapy is generally high (e.g., M = 5.7, SD =.83; Stubbings, Rees, Roberts, & Kane, 2013; M = 5.4, 95% CI = 4.72–6.07; Morland et al., 2015), similar to face-to-face therapy.

In the present study, total scores on the WAI-SF demonstrated good reliability (Cronbach's α = .87). To examine the transition from in-person to video therapy specifically, the following item was administered: "Compared to in-person sessions, during my online sessions the therapeutic relationship felt … " to be responded on a three-point Likert scale (1 = more connected than in-person, 2 = the same, 3 = less connected than in-person).

The **Real Relationship Inventory–Therapist Form** (RRI; Gelso et al., 2005) assesses the real relationship in psychotherapy, defined as "the personal relationship existing between two or more persons as reflected in the degree to which each is genuine with the other and perceives the other in ways that befit the other" (Gelso, 2011, pp. 12). The RRI consists of 24 items on a Likert scale ranging from 1 (strongly disagree) to 5 (strongly agree), with higher overall scores reflecting a more genuine and authentic relationship. Reliability has shown to be high, with coefficient alphas ranging from .80 to .90 in various samples (e.g., Fuertes, Gelso, Owen, & Cheng, 2013; Fuertes, Moore, & Ganley, 2019; Marmarosh et al., 2009). Convergent and discriminant validity have been supported by the relation of the

RRI to ratings of working alliance, session quality, transference, patient insight, social desirability, and therapist and patient attachment (Fuertes et al., 2013, 2019; Marmarosh et al., 2009). Predictive validity has been supported by its relation with outcome (Fuertes et al., 2019; Marmarosh et al., 2009). As a point of reference, in studies on in-person treatments, the average real relationship has been reported as $M = 3.81$; $SD = 1.01$ (Bhatia & Gelso, 2018) and $M = 2.94$, $SD = .12$ (Gelso et al., 2012). The real relationship has not been previously assessed with regards to online therapies.

For the present sample, the internal consistency estimate was Cronbach's $\alpha = .86$. To assess the experienced change in the real relationship since the switch to video therapy, the following item was added: "Compared to in-person sessions, during my online sessions the therapeutic relationship felt … " to be responded on a three-point Likert scale (1 = more authentic than in-person, 2 = the same, 3 = less authentic than in-person).

The **Professional Self-Doubt** scale (PSD; Nissen-Lie et al., 2017) assesses the level of uncertainty a therapist has in their ability to help a patient. The PSD includes nine items about how confident and competent the therapist feels, including phrases like; "Unsure how best to deal effectively with a patient," and "Afraid that you are doing more harm than good in treating a patient." Items are rated on a six-point Likert scale from 0 (never) to 5 (very often) and summed for a total score, with higher scores indicating more self-doubt. This 9-item PSD scale is derived from the larger 21-item scale on difficulties in psychotherapy practice, as part of the comprehensive self-reported DPCCQ questionnaire (Orlinsky et al., 1999) on professional training and development. Professional self-doubt predicts patient outcomes and may be used to surpass the inaccuracy of self-appraisal (Nissen-Lie, Monsen, Ulleberg, & Rønnestad, 2013; Nissen-Lie et al., 2017). Among licensed therapists, PSD, especially when coupled with self-compassion, has shown to be positively related to patient progress in treatment (Nissen-Lie et al., 2013); however, in trainees a decrease in professional doubt over treatment appears to be related to patient improvement (Odyniec, Probst, Margraf, & Willutzki, 2019). Research has shown that psychotherapy trainees and licensed therapists experience considerable professional self-doubt (e.g., trainees: $M = 1.52$, $SD = .94$; Odyniec et al., 2019; or licensed therapists; $M = 1.24$, $SD = .70$; Nissen-Lie et al., 2013).

The Cronbach's α in the present study was .84. To assess change in therapists' experienced competence and confidence we added the following two items: "Compared to in-person sessions, online sessions make me feel … " to be responded on a 3-point Likert scale (1 = more competent than in-person, 2 = the same, 3 = less competent than in-person) and "Compared to in-person sessions, online sessions make me feel … " to be responded on a 3-point Likert scale (1 = more confident than in-person, 2 = the same, 3 = less confident than in-person).

The **Unified Theory of Acceptance and Use of Technology** model (UTAUT, Venkatesh, Morris, Davis, & Davis, 2003) was used to assess attitudes towards acceptance and usage of video therapy. The UTAUT framework offers a comprehensive model of acceptance and subsequent utilization of technological innovations and has been adapted to various contexts, including occupational and physical therapy (Liu et al., 2015) and also for reviewing attitudes about video therapy (Connolly et al., 2020). The 21 items of the UTAUT are scored on a Likert Scale of 1 (Strongly disagree) to 5 (Strongly agree), with higher scores indicating a more positive attitude towards technology. The UTAUT has been validated in health care settings. The Cronbach's α for the subscales

varies between .68 and .91. (Liu et al., 2015). The 13 items of the original UTAUT model have been used as determinant of technology-use (Venkatesh et al., 2003). Later researchers extended the UTAUT (e.g., Venkatesh, Thong, & Xu, 2012) including subscales on Anxiety (6 items) and Behavioral Intention (2 items). The UTAUT Anxiety scale refers to the feeling of apprehension or anxiety that one experiences when using technology (Compeau, Higgins, & Huff, 1999). The UTAUT Anxiety scale has been shown to have a direct negative effect on technology use and is thus seen as an important inhibitory variable (Cenfetelli & Schwarz, 2011). The UTAUT Behavioral intention subscale assesses explicitly declared intent and plan to use technology in the future (e.g., Wu, Tao, & Yang, 2007). In the present study the internal consistency of the UTAUT was α = .77, the UTAUT Anxiety subscale had an α = .83 and the UTAUT Behavioral Intention subscale an α = .94. In this study the wording of the UTAUT items was adapted to reflect the video therapy context. Similar to the previous standardized measures, we added an item to assess changes in attitudes, inquiring about the therapists' views about video therapy before and during the pandemic.

Results

Therapists characteristics

The majority of the 141 therapists were female (*N* = 105; 74.5%) and identified as Caucasian (*N* = 120; 85.7%). Therapists ranged in age between 23 and 79, with an average age of 46 years (*SD* = 14.83). Most therapists were based in the United States of America (*N* = 96; 69.1%), Canada (*N* = 9; 6.5%), or European countries (*N* = 34, 24.5%) such as Hungary, Italy, United Kingdom, Germany, Norway, Sweden, Switzerland, Latvia, Ireland, Denmark, and Austria, in descending order. Most therapists were licensed (*N* = 107; 77.5%), in either clinical psychology (*N* = 91; 64.5%) or counseling (*N* = 14; 9.9%), or were clinical psychology trainees (*N* = 15, 10.6%). Most therapists had more than nine years of clinical experience (*N* = 94; 66.6%) of which 57 therapists had 17 years or more of clinical experience. Therapists worked with adult patients (*N* = 137; 94.5%), adolescents (*N* = 51; 36.2%), older adults (*N* = 45; 31.9%) or children (*N* = 31; 22.0%). Most worked in private practice (*N* = 101; 71.6%), outpatient clinics (*N* = 30; 21.3%) or hospitals (*N* = 12; 8.5%) and had an integrative therapy approach (*N* = 57; 40.4%) and identified with psychodynamic (*N* = 71; 50.4%), CBT (*N* = 50; 35.5%), humanistic (*N* = 28; 19.9%), and psychoanalytic (*N* = 23; 16.3%) orientations. The majority of therapists reported a caseload of 10–20 (*N* = 45; 31.9%), or 20–30 (*N* = 44; 31.2%) in-person patients per week. About half of all participating therapists had at least some experience with video therapy before the pandemic (*N* = 70; 49.6%).

Transition to video therapy during the COVID-19 pandemic

In order to prepare for the transition to video therapy most therapists spoke to colleagues (*N* = 94; 66.7%), followed posts on listservs (*N* = 86; 61.0%), read governmental guidelines (*N* = 69; 48.9%)), and/or prepared consent forms (*N* = 53; 37.6%). In addition, one-third of therapists also attended webinars on how to conduct video therapy (*N* = 47; 33.3%), read journal articles (*N* = 42; 29.9%) or spoke to a supervisor, (*N* = 42; 29.8%). Also, many

therapists prepared their patients for the transition to video therapy by discussing it in person before (N = 83; 58.9%) and/or in the first session after the switch (N = 92; 65.2%). Many therapists provided their patients with technical support (N = 58; 41.1%), a consent form (N = 62; 44.0%) and/or an information sheet about the transition to video therapy (N = 42; 29.8%). Most therapists kept the same fees (N = 133; 94.3%) and the same cancellation policies (N = 120; 85.1%).

The most frequently reported challenges for the therapists during the transition to video therapy concerned technical difficulties with the online platform (N = 86; 61.0%). Other common challenges regarded patients' difficulty in finding a suitable space for therapy (N = 68; 48.2%) and the risk of the patient (N = 59; 41.8%) or the therapist (N = 46; 32.6%) getting distracted during session. Other reported concerns regarded the nature of the patient-therapist interaction, such as feeling less connected with the patient (N = 58; 41.1%), having difficulty reading the patients' emotions (N = 52; 36.9%) and difficulty feeling or expressing empathy (N = 29; 20.6%). Despite these challenges, very few therapists thought that their patients experienced video therapy negatively (N = 10; 7.1%), the vast majority perceived patient experience as either positive (N = 88; 63.8%) or neutral (N = 40; 28.4%).

Perceptions of the therapeutic relationship in video therapy

Even though therapists felt less connected to their patients during online sessions than in-person sessions (M = 2.43, SD = .54, range: 1.00–3.00), overall, they reported having a relatively good therapeutic relationship with their online patients, indicated by neutral ratings of the working alliance on the WAI-SF (M = 4.09, SD = .48, range: 2.70–5.00), albeit lower than therapist WAI-SF alliance ratings reported in the few available studies on video therapy treatment samples (Morland et al., 2015; Stubbings et al., 2013). For example, in comparing therapist working alliance ratings in the present study to those reported by therapists in the Morland et al. (2015) video therapy sample for women with posttraumatic stress-disorder, a one-sample t-test revealed a significant difference ($t(136) = 36.82$, $p < .0001$). Similarly, although therapists felt less authentic online than in-person (M = 2.27, SD = .50, range: 1.00–3.00), scores on the RRI indicated a good quality of the real relationship between patient and therapist during their online sessions (M = 3.80, SD = .46, range: 2.33–4.92), similar to the published in-person therapy samples (Bhatia & Gelso, 2018; Gelso et al., 2012).

Women reported higher working alliance in online sessions compared to men ($t(137) = 2.18$, $p < .05$), licensed practitioners reported higher alliance score than trainees ($t(136) = 2.33$, $p < .05$), and practitioners in North America (USA and Canada) compared to those in Europe ($t(137) = 2.08$, $p < .05$). Within the sample, higher online alliance was also reported by those who used a greater variety of methods (as opposed to fewer methods) to prepare patients for the transition ($r = .26$, $p < .01$), and those who perceived their patients' experience with video therapy more positively (as opposed to less positively) ($r = .32$, $p < .001$).

Similar to the working alliance, the perceived quality of the real relationship was related to using more methods to prepare the patients to the transition ($r = .18$, $p < .05$) and perceived positive patient experience ($r = .24$, $p < .01$). Age, years of clinical experience, number of patients seen weekly before the pandemic, previous video therapy

experience, and views of video therapy before the pandemic were not associated with the perceived quality of alliance or the real relationship in online sessions.

Professional self-doubt and anxiety

On average, therapists experienced professional self-doubt sometimes or frequently (M = 2.41, SD = .67, range: 1.11–4.78) in video therapy during the pandemic, which is higher than the level of self-doubt experienced by therapists in a prior naturalistic study of PSD (Nissen-Lie et al., 2013; $t(136) = 20.45$, $p < .0001$), but still on the lower end of the 5-point Likert scale. Therapists felt less competent (M = 2.28, SD = .52, range: 1.00–3.00) and less confident (M = 2.15, SD = .56, range: 1.00–3.00) about their professional skills during online compared to in-person sessions. Higher levels of reported professional self-doubt were related to several demographic variables, such as younger age ($r = -.34$, $p < .001$), less clinical experience ($r = -.33$, $p < .001$), and worse perceived patient experience ($r = -.36$, $p < .001$).

Therapists' anxiety about using video therapy was moderate (M = 2.87, $S.D.$ = .86, range: 1.00–4.83). Similar to professional self-doubt, higher anxiety was associated with female gender ($t(137) = 3.24$, $p < .05$), younger age ($r = -.30$, $p < .001$), less clinical experience ($r = -.36$, $p < .001$), smaller number of patients before the pandemic ($r = -.18$, $p < .05$), no previous experience with video therapy ($t(138) = 3.63$, $p < .001$), not being licensed yet ($t(136) = 3.28$, $p < .001$), perceiving patients as having a negative video therapy experience ($r = .27$, $p < .001$).

Attitudes towards using video therapy and intention to use it in the future

Overall in our sample, therapists reported somewhat positive attitudes towards video therapy (M = 3.42, SD = 0.50, range: 2.31–4.69). Although their views about video therapy had become more positive since the start of the pandemic ($t(140) = 2.06$, $p < .05$); they still thought that video therapy was somewhat less effective compared to in-person therapy (M = 2.19, SD = 0.65, range: 1.00–4.00).

Therapists who held more positive attitudes towards video therapy tended to have previous experience with video therapy ($t(142) = 3.53$, $p < .05$) and to have positive perceptions of their patients' online experience ($r = .30$, $p < .001$). Higher rated working alliance and real relationship were associated with more positive attitudes towards video therapy ($r = -.34$, $p < .001$ and $r = -.40$, $p < .001$, respectively) whereas professional self-doubt was associated with more negative attitudes ($r = -.34$, $p < .001$).

The sample of therapists as a whole was undecided as to whether they would like to continue using video therapy in the future (i.e. expressed a neutral response on the UTUAT Behavior Intention subscale), with large differences among therapists (M = 3.14, SD = 1.23, range: 1.00–5.00). Therapists who intended to use video therapy in the future were more likely to have prior experience with video therapy ($t(138) = 2.91$, $p < .01$), and tended to have positive perceptions of their patients' online experience ($r = .32$, $p < .001$).

See Table 1 for an overview of the correlations between the standardized measures. The relational, professional and technology-related scales were correlated in the expected direction. Specifically, scores on the real relationship and working alliance were positively correlated, and professional self-doubt and anxiety were positively related to each other

Table 1. Correlations among the measures of the therapeutic relationship, professional doubt and anxiety and attitudes towards video therapy technology.

	Measures	*M* (*SD*)	1	2	3	4	5	6
Therapeutic relationship	1. WAI	4.09 (.48)	-					
	2. RRI	3.80 (.46)	.52***	-				
Professional doubt	3. PSD	2.41 (.67)	.40***	−.42***	-			
& anxiety	4. UTAUT Anxiety	2.87 (.86)	−.19*	−.27**	.50***	-		
Attitude towards	5. UTAUT Acceptance	3.42 (.50)	.34***	.40***	−.34***	−.44***	-	
video technology	6. UTAUT Intention	3.14 (1.23)	.28***	.28**	−.28***	−.41***	.60***	-

WAI: Working Alliance Inventory. RRI = Real Relationship Inventory. PSD = Professional Self-Doubt. UTAUT = Unified Theory of Acceptance and Use of Technology Scale.
*p <.05; **p <.01, *** p <.001.

but negatively to the reported working alliance and real relationship, indicating that therapists with lower levels of professional self-doubt and anxiety reported a stronger working alliance and real relationship with their online patients during the pandemic. The attitudes towards and intention to use video therapy in the future were positively associated with ratings of the working alliance, and real relationship, and negatively related to professional self-doubt and anxiety (see Table 1).

Discussion

To our knowledge, this is the first study to explore certain aspects of the therapeutic relationship, including the real relationship, as well as professional self-doubt and anxiety in relation to attitudes towards the video therapy technology video therapy. The participants in this study indicated that they had made efforts to prepare themselves and their patients for the rapid transition from in-person to video therapy during the COVID-19 pandemic. Even though the therapists experienced challenges during the transition to video therapy, overall, they felt that their patients had a relatively good experience with the video therapy sessions.

In accordance with the literature on therapist concerns around video therapy (e.g., Topooco et al., 2017), therapists in this study reported technical and logistic concerns, but also about interpersonal and relational challenges of video therapy, such as difficulty communicating emotions and empathy online, and difficulty connecting with the patients. Despite these concerns, they reported a neutral working alliance online, albeit lower than those reported in previous studies on video therapy (Morland et al., 2015; Stubbings et al., 2013). Similarly, despite feeling that the patient-therapist relationship was less authentic than in-person therapy, results implicated a relatively strong real relationship online, similar to levels reported in studies of in-person therapy (Bhatia & Gelso, 2018; Gelso et al., 2012). This may indicate that this aspect of the therapeutic relationship remains intact on a video platform, or alternatively, that the current situation has a positive impact on the real relationship. It is possible that during the shared experience of the pandemic, therapists and patients feel more connected as human beings, possibly reflected in the relatively high real relationship scores.

Moreover, the surveyed therapists reported higher levels of professional self-doubt in their online sessions than previous levels reported in studies on in-person therapies (Nissen-Lie et al., 2013; Odyniec et al., 2019). Despite feeling less competent and less confident about their professional skills in video sessions, their scores only indicated

a moderate level of self-doubt. Overall, therapists reported moderate levels of anxiety about using video therapy; however, professional self-doubt and anxiety were higher in younger and less experienced therapists in our sample. This is supported by prior research indicating that experience level is predictive of therapist self-efficacy (Mesrie, Diener, & Clark, 2018).

Furthermore, even though therapists thought that video therapy was somewhat less effective than in-person therapy, they still had relatively positive attitudes towards it, with a wide range of individual differences in their intention to use video therapy in the future. Specifically, therapists with positive relational experiences in their video sessions, with previous video therapy experience, and perceived positive patient experience had more positive attitudes and were more likely to use video therapy in the future, whereas therapists with high levels of self-doubt and anxiety, and with perceived negative patient experiences held more negative views and did not plan to utilize it after the pandemic.

Limitations

Several limitations of this study can be identified. First, given the cross-sectional observational study design, no pre and post pandemic scores were collected and the use of questions about the change may be informative but less valid. The threshold for participation – having conducted at least one video therapy session since the start of the pandemic – was low, which may have resulted in a high degree of variability among therapists in terms of their use of remote therapy platforms. Moreover, the validity of the standardized scales of working alliance, and real relationship could be questioned, given that these measures were used to assess the therapists' experiences with their typical online patient, rather than one patient in particular. Also, it is possible that these responses did not only reflect the transition to online therapy but also the context of the global pandemic, possibly increasing therapists' and patients' stress levels and thus indirectly relating to more professional doubt. Finally, there is also a possibility that the nature of the survey questions might have prompted the therapists to overstate their experiences (e.g., reporting more professional self-doubt than they might have reported if they would have been asked about their professional experience more generally).

Implications

This sudden uptake of remote therapies during COVID-19 sheds a unique light on telemental health and its challenges. The study results indicate that experiences during the pandemic might shape therapists' attitudes towards acceptance and usage of video therapy and their likelihood to continue using video therapy in the future. Therapists' views on video therapy tend to get more positive after trying it out and with usage, and therapists with more (online) experience tend to report fewer technical and relational challenges (Connolly et al., 2020). Thus, it is possible that during the first few weeks of a transition, video therapy experiences might appear more negative compared to in-person therapy, whereas with more experience therapists might adapt and be able to see more benefits of video therapy.

The relatively higher levels of professional self-doubt and anxiety in less experienced therapists might be unsurprising given the novelty of the treatment delivery method, and the

lack of preparedness for this new situation. It would thus be important to provide more clinical training and support for (junior) therapists so that they can become more comfortable with providing video therapy. Besides traditional didactic training and supervision, telemental health platforms offer the opportunity to record, review and learn from therapy sessions.

Conclusion

Overall, our results show that, during the rapid transition to video therapy amidst the COVID-19 pandemic, therapists experienced some professional self-doubt and anxiety, and worried about technicalities and therapeutic relationship difficulties. However, despite this, they reported a relatively good working alliance and strong real relationship with their online patients, thought that their patients had a positive video therapy experience, and overall, they were moderately accepting of video therapy, but somewhat divided about intention to use it in the future. Moreover, factors that were related to more professional self-doubt and anxiety, such as lack of experience and worse in-session relational experience could be addressed in future professional trainings on how to best conduct video therapy. Since trying out video therapy is likely to lead to more positive attitudes towards it (Connolly et al., 2020), it is possible that once the initial stress subsides and therapists gain more experience and more training, they will feel more at ease using video therapy.

Disclosure statement

No potential conflict of interest was reported by the authors.

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