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To cite this article: Vera Békés & Katie Aafjes-Van Doorn (2022): Patients' attachment avoidance and their perceived quality of the real relationship predict patients' attitudes towards telepsychotherapy, *Counselling Psychology Quarterly*, DOI: [10.1080/09515070.2022.2075324](https://doi.org/10.1080/09515070.2022.2075324)

To link to this article: <https://doi.org/10.1080/09515070.2022.2075324>



Published online: 03 Jul 2022.



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Patients' attachment avoidance and their perceived quality of the real relationship predict patients' attitudes towards telepsychotherapy

Vera Békés  and Katie Aafjes-Van Doorn

Ferkauf Graduate School of Psychology, Yeshiva University, New York, USA

ABSTRACT

During the early months of the COVID-19 pandemic, patients in individual psychotherapy needed to suddenly transition to telepsychotherapy (TPT), and for many patients it was their first experience of remote treatment. Since TPT appears to be here to stay after the pandemic ends, it is crucial to understand which factors determine whether TPT is a good fit for patients. We aimed to examine patients' relational predictors, both trait- (attachment avoidance and attachment anxiety) and state-like (working alliance, real relationship) of patients' attitudes towards TPT, and the potential mediating role of state-like relational variables between trait-like variables and attitudes. We used a longitudinal design, where patients ($N = 719$) who were in individual TPT participated in an online survey at the beginning of the pandemic and at follow-up three months later. Patients completed measures of symptom severity, Covid-related distress, attachment anxiety and avoidance, perceived quality of the therapeutic relationship (working alliance and real relationship), and attitude towards TPT. Results suggested that higher levels of attachment avoidance predicted more negative attitudes towards TPT, and that patient-reported quality of the real relationship in their TPT sessions mediated this negative relationship between attachment avoidance and attitudes towards TPT. Patient's attachment avoidance and the real relationship are important predictors of patients' attitudes towards TPT, and could indicate suitability of the TPT format, as well as inform clinicians' efforts in building a real and genuine connection with their patients online.

ARTICLE HISTORY

Received 30 December 2021

Accepted 5 May 2022

KEYWORDS

Telepsychotherapy;
attitudes; working alliance;
real relationship; attachment

The pandemic, and the subsequent global social distancing measures have had ripple effects on the daily lives of many. It is therefore not surprising that the pandemic has shown to adversely affect our well-being, and increase psychological distress (e.g. Prout et al., 2020). Individuals with pre-existing mental health problems have been hit especially hard, reporting increased psychosocial distress and worsening of their symptomatology (e.g. Favreau et al., 2021), thus increasing their need for psychological support. In addition, many patients who were in in-person

CONTACT Vera Békés  vera.bekes@yu.edu

*Shared first authorship.

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psychotherapy before the pandemic had to transition to telepsychotherapy via video conferencing (TPT) at once, without much preparation or support (Lewis, Elran-Barak, Grundman-Shem Tov, & Zubery, 2021).

Patients' attitudes towards TPT

Although research suggests that the treatment efficacy of TPT might be comparable to in-person psychotherapy (e.g. Bouchard et al., 2020; Watts et al., 2020), and we know that psychotherapists have been relatively acceptant of TPT since the pandemic (Aafjes-van Doorn, Békés, & Prout, 2020; Békés, Grondin, & Bouchard, 2020), less is known about patients' attitudes towards the use and usefulness of TPT. Arguably, patients' attitudes towards the use of TPT is the most relevant, not just in this time of global distress (Brooks et al., 2020; Fiorillo & Gorwood, 2020), but also because TPT treatments are designed for, and paid for by patients. Patients are the individuals who seek help, and their treatment outcomes might ultimately be affected.

Two reviews, conducted before the start of the pandemic reported that most patients preferred in-person treatment over TPT (March, Spence, Donovan, & Kenardy, 2018; Meurk, Leung, Hall, Head, & Whiteford, 2016), mainly because they expected more benefit from in-person treatment. Patients reported more favourable views on TPT compared to therapists (Waller & Gilbody, 2009), and patients who had already gained experience with TPT were more likely to choose it again (Connolly, Miller, Lindsay, & Bauer, 2020; March et al., 2018). Pre-pandemic, patients' positive attitudes towards TPT were related to a strong working alliance in TPT (Reese et al., 2009). Since the start of the pandemic, many patients reported a good quality working alliance (Cataldo, Chang, Mendoza, & Buchanan, 2021; ter Heide et al., 2021) and experienced TPT as beneficial. However, when given the choice, patients preferred a return to in-person treatment or opted for blended treatments that include TPT and in-person sessions (de Beurs et al., 2021).

The therapeutic relationship in TPT

Despite therapists' concerns about the ability to develop a strong working alliance in online settings (Jerome & Zaylor, 2000; Rees & Stone, 2005) research suggests that the working alliance in TPT is usually strong (Norwood, Moghaddam, Malins, & Sabin-Farrell, 2018) and comparable to in-person therapies (Bouchard et al., 2020; Ruwaard et al., 2009; Watts et al., 2020). This is important because working alliance, the therapeutic relationship between therapist and patient, in which both parties strive to work together and achieve positive changes for the patient, is perhaps the most crucial factor when it comes to making progress in therapy (Flückiger et al., 2012). Although there is a lack of research regarding the impact of the working alliance on TPT outcomes, the working alliance, especially when reported by the patient, has been suggested to be crucial for good outcomes in TPT (Cataldo et al., 2021).

With regards to other aspects of the therapeutic relationship that are known to be important for treatment outcome in in-person therapy, such as the real relationship, very little is known within the TPT context. The real relationship (RR) is conceptualized in Gelso's tripartite model as an ongoing quality of the relationship distinguished from transference and the working alliance (Gelso, 2014). Put simply, the real relationship is

the personal relationship between patient and therapist marked by the extent to which they are genuine and perceive the other in ways that are realistic. The RR has been found to be positively related to treatment outcome, and although the RR is highly related to the working alliance, it also predicts unique variance in outcome (Gelso, 2014). A recent meta-analysis found that the association between RR and therapy outcome was moderate (Gelso, Kivlighan, & Markin, 2018) but none of the included studies were conducted in TPT. Based on therapist studies conducted by our own research group (Aafjes-van Doorn et al., 2020; Békés et al., 2020; 2021), it appears that therapists report relatively higher quality RR than WAI in the TPT context, which means that this aspect of the therapeutic relationship might be especially relevant in TPT. Therapists have, for example, reported difficulties with communicating empathy, missing nonverbal signs, and maintaining rapport, however, they also experienced a newfound authenticity and realness in the relationship, and a useful insight into the patients' (interpersonal) world (Békés, Aafjes-van Doorn, & Roberts, 2021).

Similarly, a recent qualitative study among 32 patients at the start of the pandemic, suggests that seeing their therapist's home environment via the screen made them see the therapist more as a "real" person, a fellow human, as opposed to an expert with superior knowledge and abilities (Békés, Aafjes-van Doorn, Shtrakhman, & Roberts, 2022). Although these studies give some indication of the potential challenges and benefits of TPT according to the patients, it remains unclear if/how patients might differ in their ability to make use of the therapeutic relationship in TPT, and their attitudes towards TPT since the start of the pandemic.

Patients' attachment

The ability to make use of the therapeutic relationship in TPT might partly be explained by the patients' attachment security. Bowlby developed his theory of attachment partly to explain his patients' defensiveness against intimacy and experiencing emotions (Duschinsky, 2020). Bowlby posited that individual differences in attachment security in early relationships with one's primary caregivers are carried forward and shape relationships with others, including the one with the therapist (Bowlby, 1988). Attachment representations in adulthood tend to be stable over time (Fralely, Heffernan, Vicary, & Brumbaugh, 2011), representing a patient-trait that have been suggested to be best categorized as

regions in a two-dimensional space, where the dimensions are attachment anxiety and avoidance (Brennan, Clark, & Shaver, 1998; Mikulincer, Shaver, & Pereg, 2003). Attachment anxiety involves a fear of rejection or abandonment and excessive need for approval from others, whereas attachment avoidance involves fear of intimacy and dependence and reluctance to self-disclose to others.

Individuals who endorse high levels of either attachment anxiety or attachment avoidance or both, are deemed to have an insecure attachment. Those with both low attachment anxiety and low attachment avoidance, described as securely attached, tend to rely effectively on others and enjoy reciprocal and collaborative relationships (Wei, Russell, Mallinckrodt, & Vogel, 2007). All individuals are somewhere on the continuum of attachment anxiety and avoidance, endorsing these insecure attachment representations to some extent in their interpersonal relationships (Levy, Kivity, Johnson, & Gooch, 2018).

Indeed, patients with an insecure attachment tend to be relatively more prevalent in clinical samples than non-clinical samples (Békés, Aafjes-van Doorn, & Böthe, 2021; Dagan, Facompré, & Bernard, 2018) and tend to experience higher levels of symptoms (Borelli, David, Crowley, & Mayes, 2010; Fonagy et al., 1996; Ivarsson, Granqvist, Gillberg, & Broberg, 2010), including posttraumatic stress (Woodhouse, Ayers, & Field, 2015).

The role of attachment security has been studied as a moderator of treatment outcome in (in-person) psychotherapy. Generally, patients who are relatively insecure in their attachment do worse in psychotherapy, that is, they improve less (Levy et al., 2018). A recent meta-analysis suggests that securely attached patients have the best psychotherapy outcomes, better than those with high attachment avoidance, and/or high attachment anxiety (Levy et al., 2018). Furthermore, individuals with high attachment avoidance might do slightly better than those who are more anxiously attached but are also more likely to drop out of treatment prematurely (Fonagy et al., 1996; Tasca et al., 2006).

Patients with high attachment anxiety have an intense and imminent need to depend on interpersonal relationships, especially during times of distress. It might thus be unsurprising that patients' attachment anxiety may put a high demand on the therapeutic relationship and on the therapist, sometimes leading to poorer outcomes (Levy et al., 2018). Indeed, a recent empirical study indicated that patients' level of distress (as indicated by the Outcome Questionnaire-45, i.e. symptom level, interpersonal, and social functioning; Lambert, Gregersen, & Burlingame, 2004) during in-person psychotherapy treatment was related to their level of attachment anxiety but not their level of attachment avoidance (An, Hillman, Kivlighan, & Hill, 2021). Moreover, patients with more secure attachment tend to report a stronger working alliance with their therapist, whereas more insecurely attached patients report a lower working alliance (for a meta-analysis, see Diener et al., 2011). More specifically, both attachment avoidance and attachment anxiety have shown to be negatively correlated with reports of the working alliance in-session (for a meta-analysis, see Bernecker, Levy, & Ellison, 2014).

Despite the accumulating evidence regarding the role of attachment in the in-person psychotherapy process, with the exception of our research group, the role of attachment in TPT has not yet received research attention. This is especially salient as the physical distance in TPT apparently impacted patients' sense of connection to their therapists; in some patients, the lack of physical proximity brought feelings of emotional disconnection, whereas other patients reported feeling more emotionally safe in TPT, and more able to open up about sensitive topics (Békés et al., 2022). Thus, we posit that the patients' experience with TPT might, to some extent, depend on patients' relational trait of attachment security.

Besides the state-like (working alliance) and trait-like (attachment) relational variables describe above, patients' symptom severity might also play a role in their attitudes towards TPT, however, studies reported mixed findings. When comparing a large sample of patients with mild to moderate depression ($n = 1004$), Schröder et al. (2017) found that whereas severity of symptoms was not related to attitudes towards TPT, however, patients recruited in a clinical setting reported more negative attitudes towards TPT than those recruited from the general community. In another study, primary care patients with moderate levels of depression showed a stronger preference for TPT as a treatment format compared to patients with mild depression (Dorow, Löbner, Pabst, Stein, & Riedel-Heller, 2018). The authors suggested that patients with higher levels of

symptoms who may have difficulty managing the demands of attending in-person sessions, might appreciate the opportunity to do TPT (Dorow et al., 2018). Regardless of patient preferences, there did not appear to be a difference in utilization of TPT among patients with serious mental illness and other patients with less severe mental health problems (Miu, Vo, Palka, Glowacki, & Robinson, 2021). A recent study, conducted during the COVID-19 pandemic with patients receiving treatment for trauma, found that TPT satisfaction neutral or somewhat positive ($M = 6.06$, $SD = 2.55$ on a scale of 0 – *not satisfied at all* to 10 – *as satisfied as can be*), and that satisfaction was higher among patients with lower levels of stress and general psychopathology (ter Heide et al., 2021). Studies during previous pandemics showed an increase in psychological symptoms in the general population (e.g. Liu et al., 2012) as well as clinical populations (e.g. Brown et al., 2020). Accordingly, it is possible that for patients with initially already severe symptoms, a further increase in mental health struggles during the pandemic makes engaging in TPT more challenging than simply continuing meeting a therapist in-person (Miu et al., 2021). In any case, more research is needed to see what factors impact attitudes towards TPT, and TPT preference over in-person setting both during and outside of pandemic times.

Aims

The overall aim of the present study was to explore patients' experiences with TPT and to examine how patients' trait- and state-like relational characteristics impact their attitudes towards TPT. Specifically, we aimed to explore patients' attachment anxiety and avoidance, and their perception of their online therapeutic relationship at the beginning of the pandemic, as potential predictors of patients' attitudes towards TPT.

RQ1: What are patients' attitudes toward TPT during the pandemic? Based on previous pre-pandemic (Dorow et al., 2018; Miu et al., 2021) and pandemic research (ter Heide et al., 2021), we hypothesized that patients would report somewhat positive attitudes toward TPT.

RQ2: How do patients perceive the therapeutic relationship in TPT? Based on previous research (Cataldo et al., 2021), we hypothesized that patients would perceive the online working alliance as relatively strong. Given the strong association between the quality of the working alliance and real relationship in in-person treatments (Kivlighan, Kline, Gelso, & Hill, 2017; Lo Coco, Gullo, Prestano, & Gelso, 2011), as well as levels of patient-rated real relationship reported in previous studies (ranging from $M = 2.72$; Fuertes, Gelso, Owen, & Cheng, 2013, to $M = 4.27$; Gelso et al., 2012), we expected the real relationship in TPT to be perceived as relatively strong, that is, higher than neutral (higher than 3 on the Likert scale).

RQ3: What relational factors predict patients' attitudes towards TPT? We hypothesized that relational characteristics, both trait- (attachment avoidance and attachment anxiety) and state-like (working alliance, real relationship) will predict attitudes towards TPT, in that more securely attached patients (lower attachment avoidance, lower attachment

anxiety), and those who reported higher ratings of working alliance and real relationship in their TPT sessions would have more positive attitudes towards TPT, while controlling for symptom levels (overall symptoms severity and Covid-related distress).

RQ4: Do the therapeutic relationship variables (state-like) mediate the relationship between patients' attachment pattern (trait-like) and their attitudes towards TPT? We hypothesized that the working alliance and real relationship would mediate the negative relationship between attachment avoidance and attitudes towards TPT, as well as the negative relationship between attachment anxiety and attitudes towards TPT.

Methods

Sample

Psychotherapy patients were recruited between April and July 2020 for baseline assessment mostly via mental health and psychotherapy related social media, where a call for participants was posted by the researchers and their team of students. These included English-language international social media platforms (e.g. Facebook, Twitter, Reddit) in the United States, Canada, and Europe, as well as translated surveys in Chinese and Hungarian social media groups. In addition, patients were also recruited via a variety of more general American neighborhood forums that were local to the researchers and their students (e.g. Craigslist, NextDoor).

Patients were eligible to participate in the survey if they had been in therapy before the onset of the pandemic and continued the treatment via TPT during the pandemic. Participants were not compensated or otherwise incentivised for completing the survey. Patients who completed the initial survey and consented to participate in a follow-up survey were asked to provide their email address. This subsample of 635 patients were contacted three months later (July-September 2020). In the present study, we included participants who completed at least one relevant measure at baseline ($n = 725$), and at follow-up ($n = 146$). All measures were assessed once, apart from the measure of Covid-related distress, which was assessed at baseline and at follow-up. The study was approved by the Institutional Review Board of Yeshiva University.

Measures

Overall symptom severity

Patients' overall symptom levels were measured at baseline with the 10-item Symptom Checklist (SCL-10; Nguyen, Attkisson, & Stegner, 1983). The self-report SCL-10 is a short, 10-item version of the SCL-90. Items are scored on a 5-point scale ranging from 1 (not at all) to 4 (extremely). The first four items assess anxiety, and the six remaining items assess depression. We calculated mean scores of the 10 items in the present study. A cut-off point of 1.85 as mean item score is recommended as a predictor of mental disorder (Strand, Dalgard, Tambs, & Rognerud, 2003). Multiple studies support the validity and reliability of the SCL-10 (Rosen et al., 2000; Strand et al., 2003). In our study the Cronbach's alpha was .87.

Covid-related traumatic distress

We used the Impact of Event Scale – Revised (IES-R; Weiss & Marmar, 1997), a 6-item self-report measure at baseline to assess subjective distress related to traumatic events. Respondents are asked to identify a specific stressful life event and then indicate how much they were distressed or bothered during the past seven days by each “difficulty” listed. Items are rated on a 5-point scale ranging from 0 (not at all) to 4 (extremely) and include, for example: “I felt as if it hadn’t happened or wasn’t real.”, “I was jumpy and easily startled.”, “I tried not to think about it.” Following protocols used in multiple studies during pandemics (e.g. Prout et al., 2020), the instruction’s wording was modified to include the COVID-19 pandemic as the stressor. For example: “For the past week, how much have you been distressed or bothered by the following difficulties related to the COVID-19 pandemic?” The Cronbach alpha in this study was .81.

Attachment avoidance and anxiety

Experiences in Close Relationship Questionnaire-Revised Short-form (ECR-RS; Fraley et al., 2011) was used to assess attachment avoidance (e.g. “I don’t feel comfortable opening up to others”) and attachment anxiety (e.g. “I’m afraid that other people may abandon me”) in close relationships in general as part of the follow-up assessment. The nice-items are scored on a 7-point Likert scale (1 = Strongly disagree to 7 = Strongly agree). The ECR-RS is a 9-item version of the 36-item ECR-R. The ECR-RS, as a short version of the 36-item ECR-R, has been found to be valid and reliable over time (Fraley et al., 2011). The expected average attachment anxiety in the general population is 2.53 (SD = 1.19), and an average attachment avoidance of 3.18 (SD = 0.96). In outpatient populations these expected average levels are likely to be higher for attachment anxiety (M = 3.79; SD = 1.13) and also for attachment avoidance (M = 3.29; SD = 1.22) (Katz & Hilsenroth, 2017). In our study the internal consistency of the attachment avoidance and attachment anxiety scales were 0.94 and 0.90, respectively.

The working alliance

The Working Alliance Inventory-Short Form Revised (WAI-SR; Hatcher & Gillaspay, 2006; Munder, Wilmers, Leonhart, Linster, & Barth, 2010) was used at baseline, it is a 12-item patient self-report scale that measures three domains of the therapeutic alliance: agreement between patient and therapist on the goals of the treatment (Goal; e.g. “The therapist and I are working towards mutually agreed upon goals”); agreement between patient and therapist about the tasks to achieve these goals (Task; e.g. “I believe the way we are working with my problem is correct”); and the quality of the bond between the patient and therapist (Bond; e.g. “I believe my therapist likes me”). Each item is rated on a 5-point Likert scale anchored at each end with “rarely or never” (1) and “always” (5). Higher scores indicate a better working alliance. Following recent recommendations (Falkenström, Hatcher, & Holmqvist, 2015), the overall mean WAI-SR score, rather than subscale scores, was used in this study. The WAI-SR has high internal consistency (Cronbach’s alpha of the total score is 0.9; Hatcher & Gillaspay, 2006; Munder et al., 2010) and good construct validity (e.g. Falkenström et al., 2015), as indicated by associations with other alliance measures and by prediction of therapy outcome (Munder et al., 2010; Zilcha-Mano, 2017). In our study we phrased the instruction in line with the unique context: “Since the pandemic, during your online sessions” The Cronbach’s α of the total score in our sample was .93.

Real relationship

The Real Relationship Inventory Client Form (RRI-C; Kelley, Gelso, Fuertes, Marmarosh, & Lanier, 2010) was used at baseline. The RRI-C assesses the genuine human relationship between patient and therapist from the patient's perspective; the RRI-C was included at the baseline assessment. In Gelso's tripartite model (Gelso, 2014), the RR is conceptualized as an ongoing quality of the relationship distinguished from transference and the working alliance. The RRI-C has 24 items that use a 5-point Likert scale from *Strongly Disagree* (1) to *Strongly Agree* (5). A recent meta-analysis of 16 studies revealed moderate correlations between the client-reported real relationship and psychotherapy outcome (Gelso et al., 2018). In our study, Cronbach's α was .86.

Attitudes towards TPT

The Unified Theory of Acceptance and Use of Technology Patient version (UTAUT-P; Békés et al.,) was used to assess attitudes towards TPT. The UTAUT-P is a novel measure based on the UTAUT framework (Venkatesh, Morris, Davis, & Davis, 2003), a comprehensive model of acceptance and subsequent utilization of technological innovations that has been adapted for a wide variety of contexts (Connolly et al., 2020; Liu et al., 2015; for a review see Venkatesh, Thong, & Xu, 2012). The UTAUT-T includes 24 items that assess various aspects of TPT. For example, "I think that online therapy works well," and "I feel apprehensive about using online therapy" (reverse item). Items of the UTAUT-P are scored on a Likert scale ranging from 1 (strongly disagree) to 5 (strongly agree), with higher scores indicating more acceptance of online therapy. The UTAUT-P was assessed at follow-up, and Cronbach's α was .91.

Statistical Analyses

Descriptive data were used to characterize the sample and study the frequency distribution of the variables of interest. Preliminary tests were conducted to assess normality of the data and associations with demographic variables. All statistical tests were two-tailed, with alpha set at .05.

In order to examine the predictors of patients' attitudes regarding TPT, we first used zero-order correlations to identify variables that are significantly related to UTAUT-P, as well as potential covariates. We included these significantly correlated variables as predictors, and UTAUT-P as outcome variables in a linear regression. To examine the relative significance of each predictor variable, we then conducted a stepwise regression with the same variables to see which variables explain additional variance in UTAUT-P once other variables are taken account for. To answer the fourth research question, we tested a mediational model including the variables that remained significant in the previous stepwise regression model. Using the PROCESS macro, version 3.5 (Hayes, 2019), the 5,000 bootstrap samples for a 95% CI were applied. All the data were analyzed using IBM SPSS Statistics 27.

Results

The 719 patients were on average 31.07 years old ($SD = 10.76$, range: 18–78). The majority of patients were White ($n = 586$, 80.8%), female ($n = 507$; 70.5%), single ($n = 374$, 51.6%), and from the United States ($n = 560$, 77.2%). In line with the inclusion criteria of the survey,

all patients reported that they had attended therapy sessions before the pandemic ($n = 682$; 94.9% in in-person therapy; $n = 37$; 5.1% remotely). The majority ($n = 648$, 89.5%) reported having at least one mental health diagnosis before the start of the pandemic. Female patients ($t(717) = 2.57, p = .011$), patients with lower distress on the SCL-10 ($t(640) = 3.05, p = .002$), and with higher real relationship ratings on the RR-C ($t(7525) = -2.76, p = .006$) more often completed the survey at follow-up than those who were male, more distressed and reported a lower real relationship with their therapists. There was no significant difference in age, presence of a mental health diagnosis, and working alliance on the WAI-C between the patients who completed the survey at follow-up versus those who only completed the survey at baseline. For a more detailed demographic description of the sample, see [Table 1](#).

Patients' attitudes towards telepsychotherapy and reported quality of the therapeutic relationship

Patients in our study reported relatively positive attitudes towards TPT in that on average, they were Neutral or Agreed with positive statements about TPT (on a 5-point Likert scale from Strongly Disagree to Strongly Agree). Patients' perceived quality of the working alliance in remote sessions was also relatively high (reflected in "Fairly often" and "Very often" endorsements of positive experiences with the working alliance with their therapists on a 5-point Likert scale from "Rarely" to "Always"). Similarly, patients perceived the real relationship relatively positively (Neutral or Somewhat agreed responses on average).

Factors predicting patients' attitudes towards TPT

[Table 2](#) shows means, standard deviations, and correlations between the variables. Analyses of the potential covariates indicated that patients' age was unrelated to attitudes towards TPT ($r = -.17, p = .085$). Patients' attitudes towards TPT also did not differ among patients who reported a mental health diagnosis (yes/no), $t(105) = .710, p = .479$, previous TPT experience (yes/no), $t(99) = 1.16, p = .250$. Similarly, reported levels of mental health symptoms and Covid-related traumatic distress were also unrelated to attitudes towards TPT. Due to the uneven distribution of gender at follow-up (female: 85, male: 9, non-binary: 7), we did not compare these groups.

The therapeutic relationship variables: Patients' attachment insecurity (high avoidance or high anxiety) was negatively related to working alliance and real relationship as well as to attitudes towards TPT, whereas the working alliance and real relationship was positively related to attitudes towards TPT.

In the next step, we entered the four relational variables as potential predictors, and UTAUT-P as outcome variable in a linear regression model. Collinearity diagnostics suggested that there was no cause for concern about multicollinearity between the predictors, as variance inflation factors (all ≤ 2.88) were well below the commonly used threshold of 10 and tolerance values (all $\geq .35$) were well above commonly used thresholds of .10 (Cohen et al., 2003). Attachment avoidance, attachment anxiety, working alliance, and the real relationship collectively significantly predicted UTAUT at follow-up

Table 1. Participant characteristics.

Variable	N (%)	
	Baseline (N = 725)	Follow-up (N = 146)
Gender		
Female	507 (70.5)	118 (84.3)
Male	180 (25.0)	12 (8.6)
Nonbinary	32 (4.5)	10 (7.1)
Ethnicity		
White	586 (80.8)	124 (84.9)
Asian/Asian Indian/Pacific Islander	69 (9.5)	13 (8.9)
Hispanic/Latinx/Spanish	41 (5.7)	6 (4.1)
Black/African American	19 (2.6)	2 (1.4)
American Indian/Alaskan Native	18 (2.5)	2 (1.4)
Middle Eastern	9 (1.2)	2 (1.4)
Other	24 (3.3)	6 (4.1)
Location		
USA	560 (77.2)	109 (74.7)
Europe	36 (6.3)	10 (6.9)
United Kingdom	30 (4.1)	8 (5.5)
India	26 (3.6)	2 (1.4)
Canada	19 (2.6)	4 (2.7)
Australia	15 (2.1)	4 (0.2)
Other	22 (3.0)	3 (0.2)
Employment		
Employed full time	371 (51.2)	60 (41.1)
Student	180 (24.8)	42 (28.8)
Employed part time	121 (16.7)	29 (19.9)
Unemployed/looking for work	65 (9.0)	13 (8.9)
Disabled	42 (5.8)	8 (5.5)
Retired	7 (1.0)	2 (1.4)
Other	24 (3.3)	5 (3.4)
Education		
Some college	270 (37.4)	57 (39.0)
College	182 (25.1)	35 (24.0)
Professional degree (e.g. trade school)	145 (20.0)	25 (17.1)
Master's degree	46 (6.3)	4 (2.7)
High school	45 (6.2)	10 (6.8)
Doctorate	31 (4.3)	9 (6.2)
Relationship status		
Single/never married	374 (51.6)	91 (62.3)
Married/cohabiting	310 (42.8)	46 (31.5)
Widowed/divorced/separated	32 (4.4)	3 (2.1)
Mental health diagnosis*		
Anxiety	453 (62.5)	100 (68.5)
Depression	429 (59.2)	140 (95.9)
Posttraumatic Stress Disorder	179 (24.7)	39 (26.7)
Attention Deficit Hyperactivity Disorder	128 (17.7)	25 (17.1)
Eating Disorder	110 (15.2)	25 (17.1)
Personality Disorder	68 (9.4)	11 (7.5)
Obsessive-Compulsive Disorder	68 (9.4)	14 (9.6)
Bipolar	62 (8.6)	11 (7.5)
Autism Spectrum Disorder	39 (5.4)	8 (5.5)
Substance-Use Disorder	34 (4.7)	6 (4.1)
Other	63 (8.7)	14 (9.6)
No diagnosis	76 (10.5)	18 (12.3)
Setting of therapy before the pandemic*		
Private practice	518 (71.4)	114 (78.1)
Outpatient clinic	113 (15.6)	16 (11.0)
Hospital	103 (14.2)	3 (2.1)
Inpatient clinic	50 (6.9)	-
Online/by phone	41 (5.7)	7 (4.8)
Other	38 (5.2)	11 (7.5)

(Continued)

Table 1. (Continued).

Variable	N (%)	
Number of sessions with current therapist before the pandemic		
Less than 5	144 (19.9)	8 (5.5)
5–10	114 (15.7)	16 (11.0)
10–19	101 (13.9)	18 (12.3)
20 or more	331 (45.7)	92 (63.0)
None, just started	28 (3.9)	6 (4.1)
Type of therapy*		
CBT	254 (35.3)	54 (36.0)
Humanistic	100 (13.9)	14 (9.3)
Psychodynamic	115 (16.0)	23 (15.3)
Psychoanalytic	78 (10.8)	18 (12.0)
Integrative	80 (11.1)	12 (8.0)
Systemic	15 (2.1)	2 (1.3)
Other	71 (9.9)	23 (15.3)
Not sure	216 (30.0)	39 (26.0)

* Multiple options could be selected for these survey responses

Table 2. Means (standard deviations) and Pearson correlations between study variables.

Variables	N	Mean (SD)	1	2	3	4	5	6	7
1. ECR-RS Avoidance	144	2.69 (1.58)	–						
2. ECR-RS Anxiety	144	2.50 (1.84)	.32aaa	–					
3. WAI-SR-P	119	3.84 (.86)	–.43***	–.06	–				
4. RRI-C	116	3.99 (.66)	–.41***	–.10	.79***	–			
5. IES-R	140	1.81 (.87)	.00	–.01	.10	–.13	–		
6. SCL-10	140	1.61 (.83)	.17	.16	–.08	–.22	.51***	–	
7. UTAUT-P	101	3.49 (.58)	–.36***	–.26**	.33***	.43***	–.14	–.11	–

ECR-RS = Experiences in Close Relationship Questionnaire-Revised Short-form; WAI-SR = Working Alliance Inventory Short-form Revised Patient version; RRI-C = Real Relationship Inventory Client version, IES-R = Impact of Event Scale – Revised; SCL-10 = Symptom Checklist 10. UTAUT-P = Acceptance of TPT-Patient version.

* $p < .05$, ** $p < .01$, *** $p < .001$.

($F(1, 85) = 6.43, p < .001, R^2 = .23$). The predictors were then entered into stepwise regression, where only attachment avoidance and the real relationship significantly predicted UTAUT-P ($F(1, 87) = 11.94, p = .044, R^2 = .20$), see Table 3.

Finally, we tested whether the in-session real relationship with the therapist mediated the relationship between attachment avoidance and attitudes towards TPT at follow-up, and found that the perceived quality of the real relationship partly mediated the relationship between attachment avoidance and attitudes towards TPT, see Table 4 and Figure 1, suggesting that the quality of the real relationship was partly responsible for the negative impact of patients' level of attachment avoidance on attitudes towards TPT.

Table 3. Stepwise regression model for attachment avoidance, attachment anxiety, real relationship, and working alliance predicting TPT acceptance (N = 90).

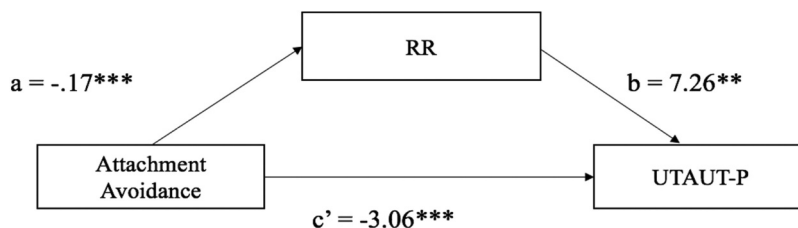
Predictor variables	Coeff	SE	95% CI	F	df	p	adjR ²
UTAUT-P							
RR-C	.30	.46	[.11, .50]			.003	
ECR-RS-Avoidance	–.08	.10	[–.15, –.01]			.044	
				11.94	(1, 87)	.044	.20

RR-C = Real Relationship, Client version. ECR-RS = Experiences in Close Relationship Questionnaire-Revised Short-form; UTAUT-P = Telepsychotherapy acceptance Patient version.

Table 4. Mediation model of the relationship of attachment avoidance to attitudes towards TPT via the real relationship (N = 90).

Direct effects		Coeff	SE	t	95% CI	p
UTAUT-P						
ECR-RS Avoidance (path <i>a</i>)		-.17	.04	-4.53	[-.24, -.09]	.000
ECR-RS Avoidance (path <i>c'</i>)		-.1.84	.90	-2.04	[-3.63, -.05]	.044
RR-C (path <i>b</i>)		7.26	2.33	3.11	[2.62, 11.90]	.002
Indirect effects through RR-C	Coeff	Boot SE	95% CI (boot)			
RR-C (path <i>ab</i>)	4-1.22	.47	[-2.22, -.37]			

RR-C = Real Relationship, Client version. ECR-RS = Experiences in Close Relationship Questionnaire-Revised Short-form; UTAUT-P = Telepsychotherapy acceptance Patient version.

**Figure 1.** Attitudes towards telepsychotherapy predicted by attachment avoidance and mediated through the real relationship (N = 90).

Note. In the mediation diagram, *a*, *b*, and *c'* are path coefficients representing unstandardized regression weights.

Discussion

In contrast to the therapists' attitudes towards telepsychotherapy (TPT), which has been examined extensively (e.g. Aafjes-van Doorn et al., 2020; Békés et al., 2020), patients' attitudes towards TPT have remained relatively unexplored. The present study examined patients' attitudes towards TPT during the beginning of the pandemic, as well as potential relational factors that might predict these attitudes, including trait-like attachment (avoidance and anxiety) and state-like therapeutic relationship variables (working alliance and real relationship), while controlling for the level of symptoms.

Our results suggest that, in response to our first research question, patients' attitudes towards TPT were relatively positive. Using TPT has many potential advantages over traditional in-person interventions, such as easier access to mental health services in remote areas and for patients with mobility issues, reduced costs and necessary time commitment, and reduced potential stigmatization (Békés et al., 2020). Our study also shows that attitudes towards TPT were unrelated to patients' demographic variables, symptom severity, and Covid-related distress at baseline, which provides hope that despite providers' concerns (Connolly et al., 2020), this format may be appropriate or at least preferable for patients with a range of symptom levels and distress. Moreover, previous research regarding attitudes towards TPT among therapists showed a change towards more positive views once they gained some experience using this treatment format during the pandemic (Aafjes-van Doorn, Békés, & Luo, 2021), which might provide some optimism regarding patient's relatively positive views in our study and are also encouraging in terms of future utilization of TPT.

Similarly, patients perceived the therapeutic relationship, and both its working alliance and real relationship aspects, as relatively strong. Pre-pandemic and pandemic studies showed that patients are generally satisfied with the working alliance in teletherapy (for a review of the literature, see Cataldo et al., 2021). Our findings are thus in line with previous research but are also remarkable given the abrupt transition to teletherapy which might have posed various challenges outside and within the therapy sessions. Pre-pandemic studies on the patient-rated real relationship reported mean scores ranging from $M = 2.72$ (Fuertes et al., 2013) to $M = 4.27$ (Gelso et al., 2012) among patients in university counselling or mental health centers, including means scores of $M = 3.71$ (Lo Coco et al., 2011) and $M = 4.19$ (Markin, Kivlighan, Gelso, Hummel, & Spiegel, 2014).¹ Patients' relatively high ratings of the real relationship in our study are thus similarly encouraging and might be related to the fact that in teletherapy, patients are often able to observe therapists in their personal environment, and thus potentially see therapists more as fellow humans rather than simply professionals. A recent qualitative study also supported the notion that patients perceived their therapists more as a "real" person, who is also experiencing a global crisis, which changed the relational dynamics in their TPT sessions compared to before the pandemic (Békés et al., 2021). Similarly, therapists and patients both reported that therapists self-disclosed more about their personal circumstances, and that patients also self-disclosed more (Luo, Aafjes –van Doorn, Békés, Prout, & Hoffman,), which could enforce a sense of genuineness in the therapeutic relationship.

Moreover, in response to our third research question, our findings indicated that when considering the trait- and state-like relational predictor variables, patients' attitudes towards TPT were predicted by their attachment avoidance, and their perception of the real relationship in TPT, whereas their attachment anxiety and reported working alliance did not contribute significantly. The importance of the real relationship, and not the working alliance, in attitudes towards online therapy, appears to be unique to patients, as the therapist literature suggests that it is the working alliance that contributes to predicting attitudes towards TPT (Békés et al., 2021). That said, the subsample of patients who completed the follow-up measurement appeared to report a stronger real relationship with their therapist at baseline, than the average patient in the overall baseline sample. Whether there are certain third variable patient characteristics that might make patients more likely to complete a survey (e.g. conscientiousness, altruism), that also make them more likely to establish a good quality real relationship with their therapist remains to be seen.

More specifically, patients who reported more positive attitudes towards TPT tended to have relatively lower attachment avoidance, possibly because these low-avoidant patients were able to make use of a high-quality real relationship with their remote therapists in their TPT sessions. Notably, a substantial amount of variance was *not* explained by patients' attachment avoidance and their reported real relationship. Other patient characteristics, such as level of reflective functioning and relational aspects, for example their perceived level of their therapist's attunement might also contribute to the patients' attitudes of TPT.

Previous literature on in-person psychotherapy indicated that attachment insecurity is related to more distress and symptomatology and worse treatment outcome compared to secure attachment (Levy et al., 2018). Moreover, according to a meta-analysis on the relationship between attachment and posttraumatic stress symptoms found that

individuals with avoidant attachment tend to experience less distress after being exposed to traumatic stress. Specifically, patients with high levels of attachment anxiety have shown to report more posttraumatic stress symptoms after trauma, whereas levels of avoidant attachment is unrelated to posttraumatic stress symptoms (Woodhouse et al., 2015). Arguably, during times of traumatic stress, avoidance of trauma-triggers, combined with avoidance of attachment-related worries, may be helpful in controlling trauma-related distress. For those with high attachment anxiety concerns about emotional dependency may intensify the distress (Woodhouse et al., 2015). In our study, this suggests that avoidantly attached patients might be less affected by the emotional stresses and strains of the pandemic and simply perceive the transition to TPT as a technical or practical difference. In contrast, for the patients with high levels of attachment anxiety, the transition to TPT might have felt as a double hit, not being able to rely on the same social-emotional support as pre-pandemic, and also having to relate to the therapist in this (physically) distant, new manner. Future research might examine if TPT would allow avoidantly attached patients to stay in treatment longer, exactly because it is less emotionally involved and allows for more patient agency and independence.

On the other hand, the literature has also emphasized the positive impact and utilization of the therapeutic relationship's more genuineness and realness that have arisen from seeing the therapist in their home environment, as well as the shared experience in the high-stress pandemic environment (Békés et al., 2021). The real relationship has been central in previous studies aiming to understand factors related to the utilization and perception of TPT in both patients and therapists. It is possible that for patients with insecure attachment, it is more difficult to navigate the changing psychological distance and closeness and the transformation of the therapeutic relationship into something more human and authentic from a purely professional setting when adjusting to the TPT format. This might especially be the case for patients with more avoidant attachment. According to Ainsworth, Blehar, Waters, and Wall (1978) original attachment classification, children with attachment avoidance, in contrast with securely attached individuals, do not expect the attachment figure to be available when they are distressed and inhibit their instinctual search for physical proximity with them. Arguably, one relational benefit of TPT is that the physical distance created by the remote format can be overridden by the development of a more real relationship with the therapist; due to avoidance of these closer relationships, patients with attachment avoidance might not be able to engage in the real relationship and thus to have an overall less positive experience of TPT, reflected in their more negative attitudes in our study.

Limitations and future research

This study has several strengths, including its timeliness, the availability of therapist comparison data, the use of a newly developed patient-reported measure of attitudes towards TPT, and the assessment of patients' relational trait- (attachment avoidance and anxiety) and state-like characteristics (working alliance and real relationship). However, our study design also has several limitations. First, given that this study only included patient ratings collected during the pandemic, it is possible that the reported findings partly reflect the intensity of the pandemic context, or the forced and sudden nature of the transition to telepsychotherapy and might not generalize to PTP more generally. That

said, general psychological symptoms and Covid-related distress levels did not appear to influence the patients' attitudes towards TPT. Results will need to be replicated outside of the pandemic, as it is possible that the societal unrest and lack of in-person options influenced patients' openness to new technologies.

Second, our recruitment efforts reflect convenience sampling, without equal subsamples of patient disorders, therapy orientation, treatment length, and those with or without previous experience in TPT. Despite the fact that our patient sample reflects a relatively large group of individuals from different geographical areas, with different mental health disorders, ages and psychotherapy treatment lengths (Gelinas et al., 2017), most patients were White, relatively highly educated and had access to technology to be able to complete the online survey. Future research on subgroups of patients of different characteristics (e.g. age, socioeconomic status) might be important to consider, as well as the potential moderating effect of different mental health problems, therapy orientation, treatment length, and session frequency.

Also, future research would benefit from longer-term follow-up measurements, to examine change over time in these patients' attitudes towards TPT and their experience of the therapeutic relationship. Specifically, given that using TPT appears to lead to more positive attitudes toward it, it is possible that that attitudes would become more positive over time, and patients may also be able to use the online therapeutic relationship in better ways; alternatively, they might become more dissatisfied with this format of psychotherapy during this stressful pandemic time (Messina & Loffler-Stastka, 2021).

Third, the attachment variables used in this study (attachment anxiety and avoidance) are seen as a continuum on which all individuals can be placed, endorsing more or less of these insecure attachment representations in their interpersonal relationships. Although these dimensional models of attachment are argued to be better suited for conceptualizing and measuring individual differences in attachment representations than simple categories of secure/insecure or avoidant/anxious, these dimensional scores make the interpretation of the combination of scores more complicated. For example, a patient could be low on attachment avoidance and at the same time high on attachment anxiety, which would suggest both a secure and insecure attachment pattern. Future studies using larger sample sizes, could differentiate between various attachment patterns and their relationship to TPT attitudes.

Forth, several other relational trait and state variables could be usefully examined in the future. In this study we choose to limit the burden on participants to around 15 min per survey, but additional measures of patients' interpersonal level of functioning, adverse childhood experiences, and mental health history could have been informative. Also, other dimensions of the therapeutic relationship, such as the (counter)transference and therapists' attunement to the patient (Békés et al., 2022) would expand this exploration of relational factions in TPT sessions.

Lastly, this study did not examine TPT effectiveness, so it is possible that patients with high attachment avoidance reported a more negative attitude towards TPT but might nevertheless have benefitted from this format of treatment, maybe even more than in the in-person treatment format. It is also possible that avoidantly attached patients are more critical of the therapeutic relationship and psychological treatment more generally, regardless of the treatment format.

Clinical implications

Overall, given that a strong therapeutic relationship and more positive attitudes toward a treatment process tend to relate to better treatment outcomes, this bodes well for patients' wellbeing in TPT. Second, by identifying predictors of patients' intention to use TPT and possible actual use in the future, therapists have an opportunity to support their patients in addressing different aspects of the therapeutic relationship in TPT. It is important to note that the use of in-person therapy or TPT does not have to be a binary clinical decision. Therapists and patients might consider integrating TPT sessions within an in-person treatment or do the full treatment via TPT (Van Daele et al., 2020). Patients may receive a combination of in-person and remote sessions based on changing needs over the course of therapy (Yellowlees & Nafiz, 2010). This sense of flexibility in how to integrate the potential use of TPT in their treatment might be particularly important, after the pandemic period of restrictions and societal rules.

Even though TPT might be perceived as challenging by therapists (Aafjes-van Doorn et al., 2020; Békés et al., 2021), patients might be more positively inclined and might be able to make particular use of the real relationship with the therapist in these online sessions. Patients' respective attitudes towards TPT might be important to address in the professional training and supervision of therapists, and possibly in the therapy sessions with the patients themselves.

Conclusion

This is the first study to consider psychotherapy patients' perspective on the use and usefulness of TPT, considering patient attachment traits as well as the in-session online therapeutic experiences in-session. Both person-specific (attachment avoidance) and situational (real relationship) relational variables might be important predictors of a patient's attitudes towards TPT. Further research is warranted to examine if certain treatments or therapists are better able to provide a high level of real relationship in online sessions, and if the importance of patients' attachment avoidance and the in-session therapeutic relationship are also important to consider in TPT, as provided outside the pandemic context.

Notes

1. We calculated the means based on the reported sum scores by dividing the sums by 24 (number of items in the RR-C).

Acknowledgments

The authors thank their lab students, and Dr. Tracy Prout and her students for their help in the patient recruitment.

Disclosure statement

No potential conflict of interest was reported by the author(s).

Notes on contributors

Dr. Vera Békés is an Assistant Professor of Clinical Psychology and Co-Director of the Psychodynamic Program at Ferkauf Graduate School of Psychology, Yeshiva University, New York. Her research focuses on the psychotherapy process in various settings, including online interventions, and on trauma.

Dr. Katie Aafjes-van Doorn is an Assistant Professor of Clinical Psychology at the Clinical Psychology Program of the Ferkauf Graduate School of Psychology, Yeshiva University, New York. Her research focuses on psychotherapy process in different modalities, therapist training and therapists' use of technology. She is currently associate editor of the journal *Clinical Psychology: Science & Practice*.

ORCID

Vera Békés  <http://orcid.org/0000-0003-3043-5155>

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