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SERVICE MODELS, FORMS OF DELIVERY AND CULTURAL ADAPTATIONS OF CBT

Better than expected: client and clinician experiences of videoconferencing therapy (VT) during the COVID-19 pandemic

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Abstract

Videoconferencing therapy (VT) has been an emerging medium of psychological therapy, and during the COVID-19 pandemic there has been substantial growth in its usage as a result of home working. However, there is a paucity of research into client and clinician perceptions of VT. This study sought to assess client and staff experiences of VT. This mixed methods study produced both quantitative and qualitative data. Seven clients who had previously received VT and 11 psychotherapists who had previously delivered VT were recruited from two NHS sites. Clients and psychotherapists took part in qualitative interviews which were analysed using thematic analysis. Quantitative surveys were developed based on themes generated from the interviews and were completed by 172 clients and 117 psychotherapists. These were analysed using simple percentages. VT often exceeded client and psychotherapist expectations and overall experiences of VT were generally positive, although there were mixed findings regarding the therapeutic alliance. Several barriers to VT were cited, such as IT issues, and challenges identified in conducting behavioural experiments, and potential exclusion of certain populations were also cited. The medium of VT was received well by both clients and clinicians, with advantages around convenience seemingly outweighing losses in quality of therapeutic relationship. Future research should focus on overcoming barriers to accessing VT in populations prone to digital exclusion. NHS services not currently employing VT may wish to reconsider their stance, expanding choice of therapy delivery and improving accessibility.

Key learning aims

(1) To gain insight into client and clinician experiences of VT during the COVID-19 pandemic.
(2) To assess the acceptability and feasibility of VT within two NHS short-term psychological support services.
(3) To identify barriers and facilitators to the implementation of VT within two NHS short-term psychological support services.

Keywords: cognitive behavioural therapy; Improving Access to Psychological Therapies; qualitative methods; thematic analysis; videoconferencing therapy

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Introduction

Following the outbreak of the coronavirus disease (COVID-19), the world has experienced severe economic and societal impacts (Nicola *et al.*, 2020). An emerging body of research has shown the COVID-19 pandemic to be associated with increased levels of common mental health difficulties (Chandola *et al.*, 2020; Daly *et al.*, 2020), high levels of loneliness (Groarke *et al.*, 2020), and stress levels exceeding population norms (Jia *et al.*, 2020). Consequently, there has been an increased demand on mental healthcare services. However, the nature of the disease itself, and the restrictions put in place to safeguard the population (e.g. national lockdowns) restrict the provision of psychological support. As such, there is a need to adopt alternative approaches to accommodate for the increased demands (Johnson *et al.*, 2021).

In response to NHS and UK Government Guidelines, a large proportion of Improving Access to Psychological Therapies (IAPT) services have moved to remote working (National Health Service, 2020). IAPT is the primary care mental health service of the NHS in England (Clark, 2011), and aims to provide wider access to empirically validated psychological interventions for mild to moderate depression and anxiety disorders in a stepped care approach (Bower and Gilbody, 2005). The prevailing modality of intervention within IAPT is cognitive behavioural therapy (CBT) consistent with recommended guidelines (National Institute for Clinical Excellence, 2009). While IAPT is no stranger to telephone therapy (see Hammond *et al.*, 2012; Turner *et al.*, 2018), services have seen an increase in usage of the more novel video-conferencing therapy (VT). For the purpose of this paper, we operationally define VT as psychotherapy delivered via online video using smart devices with built-in cameras.

The last decade has seen an expansion in the application and evaluation of VT with reviews such as Simpson (2009), Backhaus *et al.* (2012), Gros *et al.* (2013) and Poletti *et al.* (2020) showing VT to have comparable outcomes to in-person therapy. Within these reviews CBT is the most commonly employed form of therapy, with VT being applied to a range of disorders such as panic, post-traumatic stress, and major depressive disorder. Generally, results indicate little to no difference in clinical outcomes, attrition and satisfaction compared with traditional in-person therapy. Several noted benefits of VT include the potential to widen access, increase attendance, reduce stigma, and overcome logistical barriers such as cost and travel (Richardson *et al.*, 2009). In contrast, commonly cited concerns are a perceived loss of emotional safety and worries over conveying empathy and communicating effectively in order to establish a strong therapeutic alliance (TA) (Roesler, 2017). The TA is of chief concern as it is frequently recognised as a significant predictor of therapeutic outcomes (e.g. Norcross and Lambert, 2011), with agreement on the therapeutic goals of the treatment, agreement on therapeutic tasks, and the development of a personal bond made up of reciprocal positive feelings being identified as the core elements of this process (Ardito and Rabellino, 2011; Bordin, 1994).

Within VT's expanding evidence base, several cross-sectional studies have utilised self-report measures to evaluate clinician and client attitudes towards VT. Findings generally show mixed attitudes amongst clinicians, for example there is a general perception that VT is less effective than in-person therapy (Topooco *et al.*, 2017). However, recent reviews by Békés and Aafjes-van Doorn (2020) and Connolly *et al.* (2020) found that clinician attitudes towards VT have become more positive, particularly around perceived gains such as ease of use, increased accessibility and greater flexibility, although criticisms around technological difficulties, increased workload, and interference with the TA were still present. Regarding clients, the evidence suggests some initial scepticism about the effectiveness of VT. Kysely *et al.* (2020) highlight varying experiences of the TA, with concerns again raised on the clinician's ability to empathise online, as well as issues pertaining to technology and confidentiality. However, Stubbings *et al.*, 2013) investigated experiences of the TA amongst clients and clinicians using the Working Alliance Inventory Short Form (Tracey and Kokotovic, 1989), a self-report questionnaire evaluating Bordin (1994) components of the working alliance, as part of a wider

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evaluation of in-person CBT compared with CBT via VT. In addition to finding no significant differences between groups in reduction of stress, anxiety and depression scores, ratings of the TA were similar across both groups. Overall and despite initial reservations, following initial periods of discomfort and adaptation clients have reported levels of satisfaction for VT and the TA equal to that of in-person therapy, and note VT's ability to overcome the barrier of stigma (Thomas *et al.*, 2021).

Previous research has noted the importance of clinician and client attitudes in the acceptability and feasibility of treatment (Apolinário-Hagen *et al.*, 2017; Békés and Aafjes-van Doorn, 2020; Omylinska-Thurston *et al.*, Omylinska-Thurston *et al.*, 2019). To date there is a shortage of qualitative research exploring client and clinician experiences of VT. A qualitative approach may contribute to a deeper understanding of beliefs and attitudes towards VT, which can give a richer insight into its application. Stubbings *et al.* (2015) pave the way for this approach in their explorative thematic analysis of a single case study. Their approach provides an in-depth breakdown of various stages within the therapeutic process, with findings mirroring results of quantitative studies, e.g. digital media facilitating client disclosure. Furthermore, there is a unique opportunity to explore these attitudes in the context of a global pandemic, in which the social restrictions and lack of the in-person option may have changed attitudes.

Aims

Our primary aim was to assess the acceptability and feasibility of VT as a medium to deliver CBT-based interventions during a global pandemic within an IAPT setting, from clinicians' perspectives in delivering VT, and clients' experiences in receiving VT. From previous findings, a focus was taken on potential facilitators and barriers to the implementation and efficacy of VT including the TA, client access and accessibility, and technological issues. A qualitative investigation of these experiences may yield findings which could inform future practice. A linked study assessed the impact of remote working on (1) overall clinical recovery, (2) clinical recovery across different care steps, and (3) clinical recovery across different client groups, including ethnicity, age, gender and provisional diagnosis (Nguyen *et al.*, publication pending).

Method

Participants

Two groups of participants were included. They were: (1) clients who ended treatment with Lambeth Talking Therapies (LTT) or Croydon Talking Therapies (CTT) in the period April 2020 to October 2020, and (2) staff working at LTT or CTT. LTT and CTT services provide psychological therapy services for clients with common mental health problems who are registered with GPs based in their respective boroughs.

Clients

Interviews. Clients were invited to participate in interviews by emails from staff. These were sent to a convenience sample of clients who had ended treatment between April and October 2020. Invitees included clients who had either: (1) referred into the service and had chosen not to continue with therapy, (2) started with in-person therapy and then switched to VT due to the transition to homeworking caused by the COVID-19 pandemic, (3) received a course of VT only, or (4) had started VT sessions and dropped out. Clients for interview were selected on a first-come, first-served basis.

Survey. All clients who had completed low-intensity CBT or high-intensity CBT during the period April to October 2020 were invited to take part in the survey. Their treating clinician emailed a

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link to the online survey and requested that they take part. A follow-up email was sent to encourage participation.

Staff

Interviews. Staff were invited to take part in interviews by email. Due to study timing, only London[1] staff were invited. From staff expressing an interest in taking part, a sample representing the range of roles within the service were selected.

Survey. All staff employed by London[2] IAPT and London[1] IAPT were invited by email to take part in the staff survey. The email contained a link to the online survey.

Qualitative interviews

A series of one-to-one semi-structured interviews were undertaken with participants. All interviews took place virtually via Microsoft Teams. Interviews were conducted by six researchers (D.D., E.N., J.B., J.N., N.M. and S.K.) who worked as psychological wellbeing practitioners or assistant psychologists within London[1] and London[2] IAPT. Interviews were audio recorded and then transcribed by the interviewer. All interviews lasted approximately an hour each, and all clients who took part were given a £10 voucher for their time. All staff who took part were allowed to take part in the interview as part of their working day but were not given a £10 voucher. The interview schedule was informed by consultation within the research team, all of whom were clinicians within London[1] and London[2] IAPT and had delivered VT or had taken part in virtual client contact themselves. The draft interview schedule was reviewed and amended by two service users who were engaged through the South London and Maudsley NHS Trust Involvement Register. The service users were paid for the reviewing time. The interview was designed to gather client and staff attitudes towards VT which was provided instead of in-person therapy due to the transition to homeworking arising from the COVID19 pandemic. The schedule consisted of open-ended questions designed to generate discussion surrounding client and staff opinions on VT. The schedule also aimed to gain an understanding of possible practical and therapeutic barriers to VT, accessibility of VT, enjoyment of VT, and potential benefits of VT. If clients chose not to receive therapy due to the online format, the interview was centred on barriers to therapy and reasons for not opting to receive the therapy. All participants were informed of the research aims prior to consenting to the interviews. Interviews were held until data saturation was reached. Full interview schedules can be found in Appendix 1 of the Supplementary material.

Data analysis

Data were subject to a thematic analysis using NVivo software (version 12.6.0). We worked in accordance with Braun and Clarke's (2006) guidelines for thematic analysis. Themes were generated independently by two researchers and discrepancies were addressed by discussion. Staff interview themes (generated by N.C.M. and J.N.) and client interview themes (generated by N.C.M. and S.K.) were analysed separately. Following a discussion with the two researchers involved in generating themes, themes were then checked over by a third researcher (N.M.) and themes reviewed. Transcripts and a summary of themes generated were not returned to either clients or staff who participated for their comments.

Quantitative surveys

A series of anonymous quantitative surveys were created and distributed to participants and staff. Participants needed to have received VT or have delivered VT to meet inclusion criteria.

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Table 1. Qualitative demographics

Demographics	Staff (*n*, %)	Clients (*n*, %)
Gender		
Female/male ratio		7 (78%)/2 (22%)
Average age of participant in years and age range		Range: 20 to 71 years old Mean: 39.4 years
Ethnicity		
White British		4 (44%)
White European		2 (22%)
British Asian		1 (11%)
Mixed race		2 (22%)

Demographics were not obtained for staff as it was deemed that these could be seen as identifiable factors for participants wishing to keep their anonymity.

Quantitative surveys were designed based on themes generated from the qualitative surveys and were designed to generate responses from a larger number of participants.

An invitation to take part in the research, together with a link to the online survey, was sent to all clients discharged from individual therapy (guided self-help or 1:1 CBT) by their treating therapist. Two reminder emails were also sent. Staff were invited via email to the whole staff team in both London[2] and London[1] services.

The surveys were designed to gather client and staff opinions on VT which was provided instead of in-person therapy due to the transition to homeworking arising from the COVID19 pandemic. We asked various questions surrounding the themes of connection, accessibility, practical difficulties, the therapeutic relationship and difficulties in therapy.

The surveys consisted of approximately 40 questions. Participants had to rate the degree in which they either agreed or disagreed with various statements using a 5-point Likert scale. There were also some open questions where participants could give more detail about their experience with remote therapy. As with the qualitative interviews, participants were required to give demographic information. Full surveys can be found in Appendix 2 of the Supplementary material.

Data analysis

A simple analysis was carried out, calculating how many people agreed or disagreed with each statement in simple percentage terms. Only clients who received VT were included in the data analysis.

Results

A total of 18 participants completed the qualitative interviews (seven clients and 11 staff members). Participants covered differing ethnicities; the largest grouping was those with a White British background (44% of clients). A total of 289 participants completed the quantitative surveys (172 clients and 117 staff members). The majority of respondents from the client group were female (71%) and the majority of clients who responded were White British (72%). More detail can be found in Tables 1 and 2.

Staff interviews

The analysis of staff opinion on VT produced two main themes of 'better than expected' and 'client access'. Further subthemes emerged, detailed in Table 3. Table 4 provides an overview of illustrative quotes.

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Table 2. Quantitative demographics

Demographics	Staff (*n*, %)	Clients (*n*, %)
Gender		
Female/male ratio		123 (71%)/49 (29%)
Average age of participant in years and age range		
Ethnicity		
White		124 (72%)
Mixed or multiple ethnic groups		16 (9%)
Asian or British Asian		8 (5%)
Black, Africa, Caribbean or Black British		16 (9%)
Other		7 (4%)
Employment status		
Employed and working		113 (66%)
Employed and on furlough		12 (7%)
Unemployed		29 (17%)
Student		11 (6%)
Carer		2 (1%)
Retired		4 (2%)

Demographics were not obtained for staff as it was deemed that these could be seen as identifiable factors for participants wishing to keep their anonymity.

Table 3. Staff interview themes and subthemes

	Main theme	Subtheme
Delivering VCT	1. Better than expected	1A. Adaptation
		1B. Connection and attunement
		1C. Doing experiments
		1D. Structure and collaboration
		1E. Positive outcomes
	2. Client access	2A. Dangers of exclusion
		2B. Accessibility

Delivering VT

1. Better than expected

1A. Adaptation. When VT was introduced as the main treatment format at the beginning of homeworking, nine participants expressed some initial doubts and uncertainties regarding the therapeutic relationships built over VT as well as its effectiveness.

> *I thought it was going to be horrible, I thought I wasn't going to enjoy it . . . I love the connection with others, so I thought I was going to get depressed.* [Participant D]

> *I was not expecting it to be that great. I was thinking it was just going to be quite typical and quite hard to read people, I suppose my expectation was quite low.* [Participant C]

However, as clinicians gained more experience with VT, they became more positive and confident about the treatment format:

> *It* [VT] *is much better than I thought it was going to be.* [Participant D]

Repeated practice, creativity, and flexibility were major elements cited by participants to cultivate an increasing sense of perceived competence and confidence in VT.

> *Practice makes perfect . . . I feel like I've gotten the hang of being creative with what you've got, and getting clients to go out by themselves and staying on the phone, etc.* [Participant B]

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Table 4. Illustrative quotes for themes and subthemes of staff interviews

Main theme	Subtheme	Quotations
1. Better than expected	1a. Adaptation	I have found that they [virtual sessions] are almost the same as face to face to be honest. Sometimes they can be challenging because you have to think, how am I going to do this virtually but we are getting all the support as well. So yes I found this is not a problem and I find clients are enjoying it which is the most important. [Participant F]
		You need to study, reinvent yourselves and discuss a lot in supervision but I don't see any problem. [Participant D]
	1b. Connection and attunement	It doesn't matter because as long as you're paying attention and you still see you're responding in your body and your gestures and your facial expressions — (. . .) I'm sort of in tune with a client is I feel zoned in with them. (. . .) I don't think the rapport is compromised. [Participant J]
		I had very good, you know, relationships with people, just seeing them online, so I don't think it's been a barrier, no. [Participant K]
	1c. Doing experiments	Some things are less interactive. So for example with OCD, what I sometimes do with client is throw a ball and catch it . . . there are a few things like that that I would do with clients but I can't do. [Participant E]
	1c. Structure and collaboration	You can have the materials in front of you to support you, so you don't have to commit everything to memory. [Participant L]
	1d. Positive outcomes	[I am] really pleased with some of the outcomes, particularly the PTSD outcomes [Participant F]
2. Client access	2a. Danger of exclusion	There's been clients who (. . .) don't have a confidential space (. . .) and have to find that space where they can talk openly has been quite difficult for them. [Participant A]
		Their experiences of working with someone behind screen may have been an immigration interview, so it doesn't facilitate a trusting relationship. [Participant F]
		As a service, we're probably not screening clients for suitability for virtual clinic as much, like: Are they likely to engage? Will they be frustrated with online work? Are they like technically savvy? We don't really do that extra bit of assessment at triage. [Participant L]
	2b. Accessibility	If you are suffering from depression the level of motivation that may be required to attend an appointment in person might not impair them from attending an appointment online. (. . .) Maybe even early stages of clients with an experience of shame, social anxiety of BDD and OCD. (. . .) Intrusions that people have in OCD might feel little bit easier to talk about behind a screen. [Participant F]

Ease of sharing documents on screen-share was seen as a benefit, but also a source of therapist anxiety that they might inadvertently share confidential information, as Participant L noted: *I'm really scared I'll share something confidential.*

Clients could also be adaptive to the VT process, including knowing how to use Teams and reading materials online, with further guidance from their clinicians. This might demonstrate the versatility of VT to different groups of clients.

> *It took them* [older clients] *maybe a bit longer.* [. . .] *they needed more support, you had to show them how to do it, but actually, when they were on Teams and they had done it once or twice, they were fantastic as well, they were able to engage anyway. So just be more patient.* [Participant K]

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1B. Connection and attunement. Views differed over the sense of attunement and connection between therapist and client that was possible in VT, with some therapists reporting little difference:

> *I've not had any problems in terms of establishing rapport with people. I find after a while you actually forget that there are these virtual boundaries.* [Participant J]

Participants commented on communication being interrupted by freezing screens, which Participants C and G explained could '*make the flow very difficult*', as clinicians had to '*ask them* [clients] *to repeat*'. There was also an acknowledgement of some losses from the absence of physical presence, as Participant J explained: '*There is something about a sense of connection that's still slightly sort of more prevalent when you are in the same room with someone.* [. . .] *There is something a little bit more. It's slightly less impersonal when you have virtual sessions*'.

1C. Doing experiments. Clinicians' constant adaptation, reinvention and flexibility allowed for the transition of stooge experiments and sharing materials to virtual space.

> *They* [social anxiety experiments] *went really smoothly.* [. . .] *It went fine, and they got some really nice learning from it.* [Participant A]

In contrast, some participants suggested that it was difficult for them to conduct behavioural experiments over VT, as clinicians were unable to accompany clients outside or carry out impromptu activities. This appeared to be a major barrier in high intensity CBT, where behavioural experiments are an essential technique in working with specific anxiety disorders. Consequently, the impact of the therapy could be diminished, as Participant F explained: '*Work up a health anxiety hierarchy of going to places where they are worried they will get sick is harder, we can enlist the help of partners but they will not always give the same support of a trained therapist*'.

1D. Structure and collaboration. VT seemed to lend itself to more ordered therapy sessions, with mixed effects. Participant B described that VT helped her sessions become '*more structured*' and '*stick with the tasks*' as there was less casual conversation between her and her clients, which seemed to result from the virtual boundary. The counterpoint to the increased structure was a possible loss of collaboration. Participants commented on the loss of the physical whiteboard as a mechanism for spontaneous joint working. Participants L and E also felt that it was more difficult to help clients get involved in their treatments, which might lead to a lack of collaboration and self-practice.

> *In face to face, I could ask them to come up to the whiteboard with me or if they felt comfortable to write it down, like getting them to be a bit more independent in sessions* [. . .]. *Whereas with virtual clinic . . . a lot of it is driven by me, and I'm the one making the notes or direct (sic) them to materials.* [Participant L]

1E. Positive outcomes. Overall VT was not a barrier to the efficacy of CBT interventions. Participant D reported that '*my recovery rates haven't gone down at all*'. Furthermore, Participant J reported that '*I have definitely less dropouts, cancellations or DNAs*', indicating a possibility for improved engagement on VT.

2. Client access

2A. Dangers of exclusion. Although clients also demonstrated a capacity to adapt to VT, there were still some potential barriers for clients to overcome, such as the lack of equipment (e.g. laptop, weak Wi-Fi), confidential space, and therapeutic environment at home.

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Table 5. Client interview themes and subthemes

	Main theme	Subtheme
Receiving virtual therapies (VCT)	1. Convenience	
	2. Relationship building	
	3. Changing nature of experiential work	A. More interactive writing
		B. Less experiments
	4. Issues with the medium	

Participant B described that she sometimes had to '*spent a good chunk of the session*' to resolve practical issues. There were fears that these barriers were insurmountable for some clients, as Participant K explained: '*I do feel a bit concerned when it comes to all those clients. "I don't have access to a computer or a phone", you know, this is discrimination if you want*'. Clients needing interpreters and older clients were seen as particularly vulnerable to exclusion. Three participants suggested that further assessment with clients in the future should be conducted to explore the suitability of VT for them, to identify possible barriers, especially when their presentations might become barriers in treatment.

2B. Accessibility. VT was commended by participants for its increased accessibility for clients. Having therapy by video meant that clients did not need to arrange for childcare or travel to the therapy appointment, had therapy in the comfort of their own home, and were less likely to be prevented from attending therapy by physical health problems.

> *I think some clients with long term health conditions who have a major flare up and travelling to an appointment would incapacitate them so like this even if they are in pain, they are still able to attend an appointment.* [Participant F]

Client interviews

The analysis of client opinions on VT led to the emergence of four main themes: 'Convenience', 'Relationship building', 'Changing nature of experiential work' and 'Issues with the medium'. Further subthemes were found in the 'Changing nature of experiential work', detailed below in Table 5. Table 6 details further overview of quotes.

1. Convenience

VT was commended by clients for convenience and those that opted for VT reported that sessions were perceived as more accessible than in-person therapy. Sessions were said to be more relaxed and participants were more likely to attend due to the convenience.

> *. . . I think it saves a lot of time travelling, for example one hour to the centre, one hour to have a session, one hour to go back to your place. It could save a lot of time so for me it was effective.* [Participant P]

It was also noted that increased accessibility of therapy affected how active clients had to be in order to attend their appointments. This may suggest that although video therapy was praised for being more accessible, it did not have the additional benefit of increasing client activity, which is often an aim in CBT:

> *I was looking forward to being able to plan to go somewhere and it was the idea of if I'm like in a depressive state, at least I have to leave the house to go to a place to interact with people and then leave. It's like a planned thing there, because there were days where I wouldn't leave the*

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Table 6. Illustrative quotes for themes and subthemes of client interviews

Theme	Subtheme	Quotation
1. Convenience		I just think there were moments when I would be feeling quite emotional afterwards and I wouldn't want to be sitting on a tube or a bus going home … So I think personally I preferred it. [Participant U]
		I guess relaxed at home … I think I do have some social anxiety and I don't know if that's sort of a little bit worse when I'm actually physically in front of a person. [Participant T]
		… I think it saves a lot of time travelling, for example one hour to the centre, one hour to have a session, one hour to go back to your place. It could save a lot of time so for me it was effective. [Participant P]
		I think in some ways I actually felt slightly more relaxed, not having to kind of rush to the appointment at the Bethlem and worrying about traffic and all that kind of stuff. I think in in the end I actually got used to it and found it a little bit more convenient, I guess. [Participant Q]
2. Relationship building		By the end I felt really connected and close and completely comfortable opening up. [Participant R]
		Good, I felt like I was able to tell him things fairly easily. I found him a lot easier to talk to than the first lady that I had the telephone assessments with. [Participant M]
		Then from the virtual aspect of it, if I were in like an in person therapy session they like covertly shove some tissues in my direction. You can't really do that virtually so it was still like well done and I felt like we were able to move on and still address the emotions. [Participant N]
		I could have imagined that having not had those sessions with X to start with in person, it might have been more challenging to build up that trust and relationship in that way, to be able to get the benefit or the most out of this therapy to start with. [Participant M]
		I just find it difficult to maintain a relationship with someone if it is just video chat, I think if I had been able to talk to someone in person it would have made it feel more personal. I think everything being virtual feels very impersonal. [Participant N]
		I think there are moments in people's lives where they just need someone to just tap their hand or something and be like OK look I'm a human being I'm here for you. So I feel like that's something the physical, yeah. [Participant O]
		I would definitely. I think I feel like I did benefit from having met [the therapist] in person … I feel like slightly, I don't know, I just feel like the relationship is slightly different. Having actually met. [Participant Q]
3. Changing nature of experiential work	3a. More interactive writing	We were consolidating all the learning that I've done into a flow chart … I did that on my iPad and then I can send it over and edit it, I found that really helpful. [Participant N]
		Felt good in the sense that when I did the homework that he'd screen share and then point out things I'd written about and asked do you want to talk more about when this happened or how did you get on with this? It felt like I wasn't just filling out all of these tables every week for no reason. It felt like I was doing work and then we were going through in session and it was like a team in that sense. [Participant M]
	3b. Less experiments	I know I was supposed to do more in person activities and going out and stuff like that which I haven't been able to do so that is something that was missing. Like exposure stuff. So I think it would have helped if I could have done that, maybe it would have made things a bit quicker and easier to get started rather than I think it took a bit longer starting out online. [Participant T]
		I was looking forward to being able to plan to go somewhere and it was the idea of if I'm like in a depressive state, at least I have

(*Continued*)

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Table 6. (*Continued*)

Theme	Subtheme	Quotation
4. Issues with the medium		to leave the house to go to a place to interact with people and then leave. It's like a planned thing there, because there were days where I wouldn't leave the house in the videoconferencing therapy. I was like oh it's fine I can wake up 10 minutes before and still do it in my pyjamas. It doesn't make me feel as a functional person. [Participant N]
		It was more challenging to address some of the things, but we were able to try and do them in other ways, just not in the ways that we would have normally done them. [Participant M]
		It's not as good as seeing someone face to face with the kind of human element of it ... I think it would have been a very different experience altogether if we had never met face to face. [Participant V]
		I think if I had been able to talk to someone in person it would have made it feel more personal. I think everything being virtual feels very impersonal. It's not as good as seeing someone face to face with the kind of human element of it. [Participant N]
		Difficult to navigate [Participant Q]
		Sometimes there would be the connection is not so great and it's a bit frustrating and like usually sometimes things need to be wrote down and in the session and shown on a piece of paper and that kind of stuff you can't pass it between each other so and the sharing screen thing doesn't always work. [Participant T]
		I mean the same kind of technological glitches that you can get with any type of remote working and I think that type of thing can, if you're talking about something very sensitive, and the call drops or something, that can be more difficult to get back into it. [Participant M]
		I mean for me in the past, and still sometimes a little bit now and I have had some issues around like body image and feeling very self-conscious about the way that I look. So seeing myself on the screen was sometimes slightly distracting. [Participant Q]
		I won't be filmed, I can't be filmed. I just can't do it, I've been like that all my life I've been offered opportunities in telly and all sorts but I just can't be filmed. But I won't, I just don't like it. [Participant W]
		Working during a pandemic, there's two of us in the house, and so you know, there's not necessarily that private, or the same type of private space that you would have in a doctor's office to do that. [Participant M]
		It's absolutely pointless if I have to speak about my problems in front of my child and at home when we have very thin walls – I live in a block of flats we have very thin doors and everyone in the corridor can hear me so it's absolutely silly. [Participant U]

house in the virtual therapy. I was like oh it's fine I can wake up 10 minutes before and still do it in my pyjamas. It doesn't make me feel as a functional person. [Participant N]

2. Relationship building

VT did not appear to affect the development of a good TA. Participant P commented that '*we connected very well*' and Participant O stated that it was '*possible to have that connection even through the screen*'. Clients felt comfortable opening up to their therapist and expressed, despite absence of in-person cues, that clinicians were still attuned to their emotions as shown below:

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Then from the virtual aspect of it, if I were in like an in person therapy session they like covertly shove some tissues in my direction. You can't really do that virtually so it was still like well done and I felt like we were able to move on and still address the emotions. [Participant N]

It was acknowledged that although the TA was unaffected by the end, it could take longer to build or could be more difficult to maintain, as participants that experienced both in-person therapy and VT added that they missed the human element of therapy:

It's not as good as seeing someone face to face with the kind of human element of it … I think it would have been a very different experience altogether if we had never met face to face. [Participant V]

3. Changing nature of experiential work

It was found that experiential work changed in two different directions based on the type of work that was being done. The sessions appeared to be more interactive, which patients valued highly. However, it appeared that experiments were used less throughout the sessions despite the opportunity to conduct experiments, appearing higher with sessions occurring in clients' home environment. Thus two subthemes were established to account for the difference.

3a. More interactive writing

First, the software used for sessions enabled easy sharing of materials and enabled participants to easily share their work and collaborate with clinicians on work. Clients reported that this facility helped them to feel their homework was valued:

We were consolidating all the learning that I've done into a flow chart … I did that on my iPad and then I can send it over and edit it, I found that really helpful. [Participant N]

It felt like I was doing work and then we were going through in session and it was like a team in that sense. [Participant M]

3b. Less experiments

Conversely, CBT sessions often involve experiments or active components performed with a clinician that helped supplement self-help or homework tasks. This was not possible in some cases as it would have been completing the sessions in person:

I was supposed to do more in person activities and going out and stuff like that which I haven't been able to do so that is something that was missing. Like exposure stuff. So I think it would have helped if I could have done that, maybe it would have made things a bit quicker and easier to get started rather than I think it took a bit longer starting out online. [Participant T]

4. Issues with the medium

Clients interviewed noted issues with technology during their sessions were '*frustrating*' (Participant T) and '*difficult to navigate*' (Participant Q). Connection or Wi-Fi issues were highlighted in particular as an issue in sessions, as clients found it distracted them from their session or interrupted them. Three participants interviewed mentioned that being on camera prevented them from engaging in their sessions due to embarrassment or self-consciousness. In fact, Participant W outlined that this was a contributing factor to their decision to drop out of treatment.

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I won't be filmed, I can't be filmed. I just can't do it, I've been like that all my life, I've been offered opportunities in telly and all sorts but I just can't be filmed. But I won't, I just don't like it. [Participant W]

As many completed VT in their home, concerns over the confidentiality of VT and appropriate level privacy, or VT '*intruding on my home life*' (Participant N) were also raised. These concerns in fact were the primary reasons Participant U decided to decline treatment:

It's absolutely pointless if I have to speak about my problems in front of my child and at home when we have very thin walls – I live in a block of flats, we have very thin doors and everyone in the corridor can hear me so it's absolutely silly. [Participant U]

Survey results

1. Staff survey

Results of the staff survey shown in Table 7 showed VT to be an acceptable form of therapy. It appeared that staff found that the personal connection with their patients were as strong as in-person therapy and they could pick up on emotions expressed by patients. The majority of staff reporting that they felt they could collaborate well with patients using shared documents and they could meet their clients' expectations well and achieve their goals. Staff did not highlight any issues about accessibility and even stated that attendance was increased. However, staff did report that they had trouble conducting behavioural experiments and their general enjoyment of therapy was reduced.

2. Clients surveys

Results from the client survey are shown in Table 8 and clients reported that VT was better than they expected. They were able to develop a good TA, and their clinicians understood their difficulties and responded to emotions well.

Some patients missed the physical presence of in-person therapy, However, the majority of patients would not have wanted to wait longer for therapy in person. Patients reported that features of VT such as sharing documents were helpful and interruption caused by internet connections or issues with the medium did not disrupt sessions. Clients reported that they felt safe and comfortable in their sessions, and most were able to find confidential time and space.

We stratified survey answers based on ethnicity to see whether client ethnic group impacts client opinions and experiences of VT. Upon visual observation it does not appear that client opinions of VT differ based on client ethnicity. Over 75% of clients from all ethnic groups either agreed or strongly agreed that VT was better than expected. Furthermore, over 87.5% of clients form each ethnic group felt connected to their therapist. A breakdown of client responses based on ethnicity is found in Table 9.

Discussion

The primary aim of this study was to gather an initial understanding of clients' and clinicians' experiences of VT to assess the acceptability and feasibility of VT during a global pandemic within an IAPT setting. A second objective was to then identify barriers and facilitators of the modality. Some of the core themes centred in participants' experiences were of the therapy being 'better than expected', 'relationship building', and considerations for 'client access'.

Retrospectively, clinicians noted they held concerns and uncertainties regarding the medium of VT. However, many reflected that those expectations did not equate to reality, with some even reporting VT to be almost the same as face to face, thus leading to the theme of 'Better than expected'. Practice, flexibility, supervision and creativity were cited as key facilitating factors in

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Table 7. Clinician survey

Statement	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
	n (%)	*n* (%)	*n* (%)	*n* (%)	*n* (%)
1. Videoconferencing therapy works better than I expected	2 (3.57%)	0 (0%)	3 (5.36%)	27 (48.21%)	24 (42.86%)
2. I enjoy videoconferencing therapy as much as face to face therapy	0 (0%)	18 (32.14%)	13 (23.21%)	17 (30.36%)	8 (14.29%)
3. I find clients seeing my homeworking space in video sessions intrusive	13 (23.64%)	27 (49.09%)	12 (21.82%)	3 (5.45%)	0 (0%)
4. I feel competent and confident making and sharing documents virtually	0 (0%)	3 (5.45%)	4 (7.27%)	37 (67.27%)	11 (20%)
5. Internet connection problems regularly spoil my sessions	11 (20%)	22 (40%)	11 (20%)	9 (16.36%)	2 (3.64%)
6. Videoconferencing therapy is just as effective as face to face	0 (0%)	5 (9.09%)	18 (32.73%)	19 (34.55%)	13 (23.64%)
7. Videoconferencing therapy is less effective if we didn't have at least some face to facesessions	8 (14.55%)	22 (40%)	15 (27.27%)	10 (18.18%)	0 (0%)
8. Doing some face to face therapy is essential for my development as a therapist	2 (3.64%)	7 (12.73%)	11 (20%)	28 (50.91%)	7 (12.73%)
9. Videoconferencing therapy works but it takes more effort from me	5 (9.09%)	20 (36.36%)	7 (12.73%)	20 (36.36%)	3 (5.45%)
10. I can carry out all the behavioural experiments I need virtually	2 (3.64%)	28 (50.91%)	8 (14.55%)	14 (24.45%)	3 (5.45%)
11. The therapeutic connection isn't as strong in videoconferencing therapy	8 (14.55%)	25 (45.45%)	13 (23.64%)	9 (16.36%)	0 (0%)
12. I can pick up my clients' emotions when working virtually	1 (1.82%)	3 (5.45%)	5 (9.09%)	34 (61.82%)	12 (21.82%)
13. I am not able to contain my clients' emotions when working virtually	12 (21.82%)	32 (58.18%)	8 (14.55%)	3 (5.45%)	0 (0%)
14. It is easy to work collaboratively with my clients virtually	0 (0%)	3 (5.45%)	8 (14.55%)	30 (54.55%)	14 (24.45%)
15. My clients attend more reliably for videoconferencing therapy	0 (0%)	3 (5.45%)	6 (10.91%)	22 (50%)	24 (43.64%
16. My clients feel comfortable and safe in videoconferencing therapy	0 (0%)	1 (1.82%)	10 (18.18%)	36 (65.45%)	8 (14.55%)
17. I am just as able to meet my clients' goals through videoconferencing therapy	0 (0%)	2 (3.64%)	11 (20%)	30 (54.55%)	12 (21.82%)
18. Videoconferencing therapy is accessible for almost all of my clients	0 (0%)	4 (7.27%)	6 (10.91%)	35 (63.64%)	10 (18.18%)

Statements 1 and 2, *n*=56; statements 3–18, *n*=55; one participant did not complete full survey and could not be included.

cultivating competency and confidence in delivering VT. These experiences reflect previous findings that increased experience and familiarity with VT correlates with positive perceptions, reducing initial scepticism and ambivalence (Brooks *et al.*, 2012; Connolly *et al.*, 2020; Hernandez, 2011). Overall, findings from both clinician and client interviews are mirrored in the subsequent surveys and lean towards a general acceptance of VT within the two services.

Themes and subthemes were found amongst both clients and clinicians regarding the TA, with findings yielding mixed perceptions. Within 'Connection and attunement' some clinicians reported little to no difference in rapport, while others emphasised a missing element to the TA that seemed to centre on a lack of 'presence', a concept linked to the therapeutic bond (Simpson and Reid, 2014). These views were mirrored in clients' experiences through the theme of 'relationship building'. While there was a feeling that the TA was established, it took longer to build and could be more difficult to maintain, with clients again citing a missing 'human' element. Horowitz (2013) notes that this lack of presence may lead to less emotional

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Table 8. Client survey

Statement	Strongly disagree *n* (%)	Disagree *n* (%)	Neither agree nor disagree *n* (%)	Agree *n* (%)	Strongly agree *n* (%)
1. Videoconferencing therapy was better than I expected	3 (1.84%)	4 (2.45%)	12 (7.36%)	77 (47.24%)	67 (41.11%)
2. I had a good therapeutic relationship with my therapist	3 (1.84%)	1 (0.61%)	3 (1.23%)	52 (31.9%)	105 (64.42%)
3. The therapist got a good idea of me and my difficulties	2 (1.23%)	2 (1.23%)	2 (1.23%)	58 (35.58%)	99 (60.73)
4. I could not communicate as well as I would have been able to in person	33 (20.25%)	61 (37.42%)	36 (22.09%)	26 (15.95%)	7 (4.29%)
5. I felt safe and comfortable having the therapy from my own home	3 (1.84%)	8 (4.91%)	21 (12.88%)	65 (39.88%)	66 (40.49%)
6. The convenience of videoconferencing therapy was important to me	4 (2.45%)	8 (4.91%)	30 (18.41%)	63 (38.65%)	58 (35.58%)
7. The convenience of videoconferencing therapy made up for the loss of in-person contact	4 (2.45%)	15 (9.2%)	34 (20.86%)	56 (34.36%)	54 (33.13%)
8. I think that having some sessions in-person during my therapy was important (if all of your sessions were by phone or video, please tick 'not applicable')	4 (2.45%)	3 (1.84%)	10 (6.13%)	13 (7.98%)	14 (8.6%)
9. When I became distressed, the therapist noticed and responded helpfully	2 (1.23%)	3 (1.84%)	7 (4.29%)	68 (41.71%)	60 (36.8%)
10. I made better use of the therapy because of the COVID restrictions	6 (3.68%)	15 (9.2%)	65 (39.88%)	47 (28.83%)	30 (18.41%)
11. The therapy was less useful because of technical difficulties (e.g. wifi connection)	25 (15.34%)	71 (43.56%)	33 (20.25%)	18 (11.04%)	4 (2.45%)
12. We made less progress towards my goals because the therapy was virtual	47 (28.83%)	70 (42.94%)	27 (16.56%)	15 (9.2%)	4 (2.47%)
13. Problems with finding confidential time and space at home restricted my therapy	39 (23.93%)	68 (41.72%)	27 (16.56%)	20 (12.27%)	9 (5.52%)
14. I felt uncomfortable that the therapist could see my room	62 (38.04%)	76 (46.63%)	15 (9.19%)	5 (3.07%)	3 (1.84%)
15. Being able to look at shared documents over video was helpful	0 (0%)	2 (1.23%)	8 (4.91%)	80 (49.08%)	63 (38.65%)
16. Seeing myself on screen interfered with the therapy	28 (17.18%)	73 (44.79%)	26 (15.95%)	27 (16.56%)	6 (3.68%)
17. I think that I would have benefited more from seeing my therapist in person	15 (9.19%)	33 (20.25%)	55 (33.74%)	46 (28.22%)	14 (8.6%)
18. Overall I was satisfied with my therapy	2 (1.23%)	2 (1.23%)	3 (1.84%)	54 (33.13%)	102 (62.57%)
19. I would prefer to wait longer to have therapy in-person than have therapy by phone or video	48 (29.45%)	70 (42.95%)	21 (12.88%)	20 (12.27%)	4 (2.45%)

attention and commitment, thus weakening the emotional connection. However, Simpson and Reid (2014) reason that 'presence' can be formed and maintained within a VT format, with some individuals becoming oblivious to the virtual boundary. Furthermore, reports that VT did not hinder work towards agreed therapeutic goals, and experiences of positive relationship meet two of Bordin's (1994) requirements for the TA. Thus, despite several studies highlighting the concern that VT takes away from the TA, the collated findings of this study, in line with Connolly *et al.* (2020), indicate a positive relationship between client and clinician, and that while it may take longer to establish, and the quality for some may be inferior to in-person therapy, it is still possible to form a strong and efficient TA (Horowitz, 2013).

VT is recognised for both its ability to improve access to psychological support, as well as its potential to exclude certain populations. These views were echoed in the themes of 'Client access'

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Table 9. Client survey by ethnicity

Statement	White (*N*=117) *n* (%)	Black, African, Caribbean or Black British (*N*=16) *n* (%)	Asian or Asian British (*N*=8) *n* (%)	Mixed or multiple ethnic groups (*N*=16) *n* (%)	Other ethnic groups (*N*=6) *n* (%)
1. Videoconferencing therapy was better than I expected (Agree+Strongly agree)	106 (90.6%)	12 (75%)	8 (100%)	12 (75%)	6 (100%)
2. I had a good therapeutic relationship with my therapist (Agree+Strongly agree)	113 (96.58%)	15 (93.75%)	7 (87.5%)	16 (100%)	6 (100%)
3. The therapist got a good idea of me and my difficulties (Agree+Strongly agree)	113 (96.58%)	16 (100%)	7 (87.5%)	15 (93.75%)	6 (100%)
4. I could not communicate as well as I would have been able to in person (Agree+Strongly agree)	21 (17.95%)	6 (37.5%)	1 (12.5%)	3 (18.75%)	2 (33.33%)
5. I felt safe and comfortable having the therapy from my own home (Agree+Strongly agree)	95 (81.2%)	11 (68.75%)	6 (75%)	13 (81.25%)	6 (100%)
6. The convenience of videoconferencing therapy was important to me (Agree+Strongly agree)	88 (75.21%)	6 (75%)	6 (75%)	11 (68.75%)	5 (83.33%)
7. The convenience of videoconferencing therapy made up for the loss of in-person contact (Agree+Strongly agree)	82 (70.09%)	8 (50%)	6 (75%)	11 (68.75%)	4 (66.66%)
8. I think that having some sessions in-person during my therapy was important (if all of your sessions were by phone or video, please tick 'not applicable') (Agree+Strongly agree)	17 (14.53%)	4 (25%)	2 (25%)	2 (12.5%)	2 (33.33%)
9. When I became distressed, the therapist noticed and responded helpfully (Agree+Strongly agree)	92 (78.63%)	14 (87.5%)	4 (25%)	14 (87.5%)	4 (66.66%)
10. I made better use of the therapy because of the COVID restrictions (Agree+Strongly agree)	43 (36.75%)	9 (56.25%)	6 (75%)	5 (31.25%)	2 (33.33%)
11. The therapy was less useful because of technical difficulties (e.g. wifi connection) (Agree+Strongly agree)	19 (16.24%)	1 (6.25%)	0 (0%)	2 (12.5%)	0 (0%)
12. We made less progress towards my goals because the therapy was virtual (Agree+Strongly agree)	10 (8.55%)	5 (31.25%)	0 (0%)	4 (25%)	0 (0%)
13. Problems with finding confidential time and space at home restricted my therapy (Agree+Strongly agree)	26 (22.22%)	2 (12.5%)	1 (12.5%)	0 (0%)	0 (0%)
14. I felt uncomfortable that the therapist could see my room (Agree+Strongly agree)	4 (3.42%)	2 (12.5%)	0 (0%)	2 (12.5%)	0 (0%)
15. Being able to look at shared documents over video was helpful (Agree+Strongly agree)	101 (86.32%)	15 (93.75%)	8 (100%)	14 (87.5%)	5 (83.33%)
16. Seeing myself on screen interfered with the therapy (Agree+Strongly agree)	26 (22.22%)	2 (12.5%)	0 (0%)	2 (12.5%)	3 (50%)
17. I think that I would have benefited more from seeing my therapist in person (Agree+Strongly agree)	43 (36.75%)	6 (37.5%)	2 (25%)	6 (37.5%)	3 (50%)

(*Continued*)

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Table 9. (*Continued*)

Statement	White (*N*=117) *n* (%)	Black, African, Caribbean or Black British (*N*=16) *n* (%)	Asian or Asian British (*N*=8) *n* (%)	Mixed or multiple ethnic groups (*N*=16) *n* (%)	Other ethnic groups (*N*=6) *n* (%)
18. Overall I was satisfied with my therapy (Agree+Strongly agree)	113 (96.58%)	15 (93.75%)	7 (87.5%)	15 (93.75%)	6 (100%)
19. Given the choice I would choose:					
20. I would prefer to wait longer to have therapy in-person than have therapy by phone or video (Agree+Strongly agree)	18 (15.39%)	1 (6.25%)	2 (25%)	2 (12.5%)	1 (16.67%)

and 'Convenience', with flexibility being noted as a facilitating factor in promoting engagement, with high attendance rates reported by clinicians. The flexibility of VT is particularly important to consider in the context of those with long-term physical health conditions such as chronic pain or arthritis, etc., as it may enable them to attend appointments that their conditions may have previously impeded them from going to. However, within 'Client access' concerns were raised over exclusion for those unable to access or use technology. In particular, fears were raised regarding older adults. These fears are reflected in Patel *et al.*'s (2021) findings of a lower uptake of remote consultations, and more significant reduction in the number of consultations amongst older adults compared with working age adults during the pandemic. Several papers have highlighted wider concerns of digital exclusion due to an inability to afford the necessary equipment, and lack of motivation or digital literacy to engage with the technology (Greer *et al.*, 2019; Seifert *et al.*, 2021). Reports that clients were able to adapt to VT with assistance from clinicians might suggest a role for 'digital enablement' to improve IT skills and overcome this barrier to VT. In line with this finding, Greer *et al.* (2019) emphasise a personalised and tailored learning format as a facilitator to overcome potential exclusion. However, it should be noted that training alone is not sufficient to overcome barriers such as lack of access to necessary equipment and confidential space, and further work must be done to bridge these gaps. There are likely to remain a group of clients for whom VT will remain either inaccessible or unsatisfactory, evidenced by the group of clients in the survey who indicated that they would be prepared to wait longer to receive in-person therapy, but it may be a smaller group than previously thought.

In addition to the potential exclusion of older adults it is possible that VT might exclude clients who are anxious about being filmed or seen on camera. Clients with social anxiety, for example, may find it uncomfortable to see themselves on screen in the videoconferencing session (Warnock-Parkes *et al.*, 2020). Seeing oneself on a screen may thus have been a potential exclusion factor preventing certain clients from attending IAPT during the pandemic when VT was the sole medium offered. Most clients self-refer to the two services in the study through service websites, and these contained updates that all treatment was by VT and telephone at this time, which could have prevented certain clients from reaching out to the service in the first place. Further thought needs to be put into this client group and the potential was to combat anxiety surrounding seeing oneself on screen as a barrier to receiving videoconferencing therapy.

It is worth noting the identification of creativity as novel factor in facilitating positive attitudes towards VT. Creativity has a longstanding association with problem-solving (e.g. Maier, 1930), and consequently would be an important element in addressing the barriers of VT. In addition, creativity can be considered an essential part of the therapeutic process (Frey, 1975),

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and despite its manualised protocols creativity is central to CBT itself, with Mooney and Padesky (2000) claiming it as a pre-requisite to change, and Friedberg and Wilt (2010) demonstrating its role in storytelling and metaphors within CBT. As such, creativity may contribute to both VT's acceptability and feasibility.

From a clinical perspective it appears a more pressing concern that VT relates to the content of therapy rather than the relationship, specifically in conducting behavioural experiments. Interestingly, previous findings have shown VT to be effective in the treatment of anxiety disorders such as panic and PTSD, which often involve behavioural experiments and exposure work (Poletti *et al.*, 2020). It is therefore plausible that environmental restrictions, i.e. a national lockdown, may have acted as a mediating barrier to behavioural experiments. At present it is not possible to disentangle COVID-19 restrictions from VT barriers, but is an issue warranting further investigation.

Implications and future research

The findings from this paper suggest that VT, despite its limitations, is generally received well. Future research could focus on gathering staff and client opinions of VT across multiple NHS trusts and services. To avoid bias in subjective responses it is advised to employ a standardised measure to evaluate certain components e.g. Stubbings *et al.*, 2013) use of the the Working Alliance Inventory to assess the TA. It would also be beneficial to further investigate potential differences between different disorder groups and levels of intervention. Future research could also be directed towards establishing the effectiveness of videoconferencing CBT using recovery rates and reliable improvement rates on various psychometric measures. As VT has become more routine over the course of the pandemic, it would be interesting to audit the number of services actively employing this medium. The widespread uptake of VT would not only expand patient choice but may also have an implication of saving NHS cost, although future research is needed.

Limitations

Several limitations of the present study are worth noting. Firstly, it is worth noting that we only collected data from two IAPT centres across one NHS trust. To increase generalisability of the quantitative and qualitative analysis, a wider sample could be collected. Secondly, we used a non-random self-selecting approach to recruit participants to take part in the qualitative interviews. Despite interviews being carried out until saturation, our sample may have been biased towards participants who perhaps had more favourable opinions towards VT, and therefore qualitative interviews may not have supported results derived from the quantitative surveys and results may not be generalisable. For example, only two of the participants interviewed declined to engage in VT, and thus the experiences of those that could not engage with VT may not be fully represented. In addition, recruitment was conducted via email, potentially favouring those who are digitally literate, to the exclusion of those who are not. To overcome this barrier, future researchers should use a random approach through multiple media when recruiting participants. Thirdly, our small interview sample consisted of predominantly White British females. It is important to consider that these views may not be representative of all clients. Future research would benefit from exploring the experience of a diverse range of clients to examine common as well as differing themes.

It is also worth noting that this study focused on the application of CBT via VT, and investigations of other modalities may yield different experiences, barriers and facilitators.

Fourthly, it is also worth bringing to attention the time scale of when we distributed quantitative surveys and carried out interviews. Interviews were carried out in October, shortly after transitioning to lockdown and homeworking. Quantitative surveys were not

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distributed until January the following year. The difference in time scale of when the surveys and interviews were carried out may have led to differing opinions of VT as clinicians and clients adjusted to homeworking and may have become more familiar and comfortable with using Microsoft technology. Finally, client and therapist views are clearly influenced by their context, which for this research was a worldwide pandemic which dramatically restricted social interaction. This may have normalised changes in behaviour, such as working from home and video calls replacing meetings, which will become less acceptable if and when COVID-19 has a less dramatic impact on day-to-day life.

Conclusion

In conclusion, this study suggests that CBT via VT is generally received well by clients and clinicians alike. These findings may have future clinical implications in considering VT as a standard optional medium of care within NHS settings, although more research is needed. An assessment of current levels of remote working in NHS services across the UK may give better insight into this potential. For IAPT services, there is also a need to evaluate the effectiveness of CBT via VT compared with face-to-face in IAPT service, and an investigation of this is underway (Nguyen *et al.*, publication pending).

Key practice points

(1) VT exceeded client's and clinician's initial expectations.
(2) A strong TA can still be formed through VT.
(3) VT has the potential to increase access to psychological support, although may exclude other populations, i.e. older adults without access to, or knowledge of, necessary equipment.

Supplementary material. To view supplementary material for this article, please visit: https://doi.org/10.1017/S1754470X22000125

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Ethical statement. The authors have abided by the by the Ethical Principles of Psychologists and Code of Conduct as set out by the BABCP and BPS. This study was approved by Clinical Governance and Audit Committee of the Psychological Medicine and Older Adults Directorate of South London and the Maudsley NHS Foundation Trust.

Data availability statement. The data that support the findings of this study are available on request from the corresponding author, N. McNulty. The data are not publicly available due to their containing information that could compromise the privacy of research participants.

Further reading

Connolly, S. L., Miller, C. J., Lindsay, J. A., & Bauer, M. S. (2020). A systematic review of providers' attitudes toward telemental health via videoconferencing. *Clinical Psychology: Science and Practice*, *27*, e12311.

Gros, D. F., Morland, L. A., Greene, C. J., Acierno, R., Strachan, M., Egede, L. E., Tuerk, P. W., Myrick, H., & Frueh, B. C. (2013). Delivery of evidence-based psychotherapy via video telehealth. *Journal of Psychopathology and Behavioral Assessment*, *35*, 506–521.

Johnson, S., Dalton-Locke, C., San Juan, N. V., Foye, U., Oram, S., Papamichail, A., … & Simpson, A. (2021). Impact on mental health care and on mental health service users of the COVID-19 pandemic: a mixed methods survey of UK mental health care staff. *Social Psychiatry and Psychiatric Epidemiology*, *56*, 25–37.

Poletti, B., Tagini, S., Brugnera, A., Parolin, L., Pievani, L., Ferrucci, R., Compare, A., & Silani, V. (2020). Telepsychotherapy: a leaflet for psychotherapists in the age of COVID-19. A review of the evidence. *Counselling Psychology Quarterly*, 1–16.

References

Apolinário-Hagen, J., Kemper, J., & Stürmer, C. (2017). Public acceptability of E-mental health treatment services for psychological problems: A scoping review. *JMIR Mental Health*, *4*. doi: 10.2196/mental.6186

Ardito, R., & Rabellino, D. (2011). Therapeutic alliance and outcome of psychotherapy: historical excursus, measurements, and prospects for research. *Frontiers in Psychology*, *2*. doi: 10.3389/fpsyg.2011.00270

Backhaus, A., Agha, Z., Maglione, M., Repp, A., Ross, B., & Zuest, D. *et al.* (2012). Videoconferencing psychotherapy: a systematic review. *Psychological Services*, *9*, 111–131. doi: 10.1037/a0027924

Békés, V., & Aafjes-van Doorn, K. (2020). Psychotherapists' attitudes toward online therapy during the COVID-19 pandemic. *Journal of Psychotherapy Integration*, *30*, 238–247. doi: 10.1037/int0000214

Bordin, E. S. (1994). Theory and research on the therapeutic working alliance: New directions. In A. O. Horvath & L. S. Greenberg (eds), *The Working Alliance: Theory, Research, and Practice (pp. 13–37)*. John Wiley & Sons.

Bower, P., & Gilbody, S. (2005). Stepped care in psychological therapies: access, effectiveness and efficiency. *British Journal of Psychiatry*, *186*, 11–17. doi: 10.1192/bjp.186.1.11

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*, 77–101. doi: 10.1191/1478088706qp063oa

Brooks, E., Manson, S., Bair, B., Dailey, N., & Shore, J. (2012). The diffusion of telehealth in rural American Indian communities: a retrospective survey of key stakeholders. *Telemedicine and E-Health*, *18*, 60–66. doi: 10.1089/tmj.2011.0076

Chandola, T., Kumari, M., Booker, C., & Benzeval, M. (2020). The mental health impact of COVID-19 and lockdown-related stressors among adults in the UK. *Psychological Medicine*, 1–10. doi: 10.1017/s0033291720005048

Clark, D. M. (2011). Implementing NICE guidelines for the psychological treatment of depression and anxiety disorders: the IAPT experience. *International Review of Psychiatry*, *23*, 318–327. doi: 10.3109/09540261.2011.606803

Connolly, S., Miller, C., Lindsay, J., & Bauer, M. (2020). A systematic review of providers' attitudes toward telemental health via videoconferencing. *Clinical Psychology: Science and Practice*, *27*. doi: 10.1111/cpsp.12311

Daly, M., Sutin, A., & Robinson, E. (2020). Longitudinal changes in mental health and the COVID-19 pandemic: evidence from the UK Household Longitudinal Study. *Psychological Medicine*, 1–10. doi: 10.1017/s0033291720004432

Frey, D. (1975). The anatomy of an idea: creativity in counseling. *The Personnel and Guidance Journal*, *54*, 22–27. doi: 10.1002/j.2164-4918.1975.tb04166.x

Friedberg, R., & Wilt, L. (2010). Metaphors and stories in cognitive behavioral therapy with children. *Journal of Rational-Emotive & Cognitive-Behavior Therapy*, *28*, 100–113. doi: 10.1007/s10942-009-0103-3

Greer, B., Robotham, D., Simblett, S., Curtis, H., Griffiths, H., & Wykes, T. (2019). Digital exclusion among mental health service users: qualitative investigation. *Journal of Medical Internet Research*, *21*, e11696. doi: 10.2196/11696

Groarke, J., Berry, E., Graham-Wisener, L., McKenna-Plumley, P., McGlinchey, E., & Armour, C. (2020). Loneliness in the UK during the COVID-19 pandemic: cross-sectional results from the COVID-19 Psychological Wellbeing Study. *PLOS One*, *15*, e0239698. doi: 10.1371/journal.pone.0239698

Gros, D., Morland, L., Greene, C., Acierno, R., Strachan, M., & Egede, L. *et al.* (2013). Delivery of evidence-based psychotherapy via video telehealth. *Journal of Psychopathology and Behavioral Assessment*, *35*, 506–521. doi: 10.1007/s10862-013-9363-4

Hammond, G., Croudace, T., Radhakrishnan, M., Lafortune, L., Watson, A., McMillan-Shields, F., & Jones, P. (2012). Comparative effectiveness of cognitive therapies delivered face-to-face or over the telephone: an observational study using propensity methods. *PLOS One*, *7*, e42916. doi: 10.1371/journal.pone.0042916

Hernandez, E. (2011). Older adults and online social networking: relating issues of attitudes, expertise, and use. HIM 1990–2015. 1199. https://stars.library.ucf.edu/honorstheses1990-2015/1199

Horowitz, M. S. A. (2013). *An exploratory study of therapist perceptions of the differences in therapeutic alliance between videoconference therapy and face-to-face therapy*. Doctoral dissertation, Fielding Graduate University.

Jia, R., Ayling, K., Chalder, T., Massey, A., Broadbent, E., Coupland, C., & Vedhara, K. (2020). Mental health in the UK during the COVID-19 pandemic: early observations. *MedRxiv*. doi.org/10.1101/2020.05.14.20102012

Johnson, S., Dalton-Locke, C., San Juan, N. V., Foye, U., Oram, S., Papamichail, A., … & Simpson, A. (2021). Impact on mental health care and on mental health service users of the COVID-19 pandemic: a mixed methods survey of UK mental health care staff. *Social Psychiatry and Psychiatric Epidemiology*, *56*, 25–37. doi: 10.1007/s00127-020-01927-4

Kysely, A., Bishop, B., Kane, R., Cheng, M., De Palma, M., & Rooney, R. (2020). Expectations and experiences of couples receiving therapy through videoconferencing: a qualitative study. *Frontiers in Psychology*, *10*. doi: 10.3389/fpsyg.2019.02992

Maier, N. (1930). Reasoning in humans. I. On direction. *Journal of Comparative Psychology*, *10*, 115–143. doi: 10.1037/h0073232

Mooney, K., & Padesky, C. (2000). Applying client creativity to recurrent problems: constructing possibilities and tolerating doubt. *Journal of Cognitive Psychotherapy*, *14*, 149–161. doi: 10.1891/0889-8391.14.2.149

National Health Service (2020). IAPT guide for delivering treatment remotely during the coronavirus pandemic. NHS publication reference. 001559. Retrieved from: https://www.england.nhs.uk/coronavirus/publication/iapt-guide-for-delivering-treatment-remotely-during-the-coronavirus-pandemic/

National Institute for Clinical Excellence (2009). Depression in adults: the treatment and management of depression in adults. NICE guideline, 90. Retrieved from: https://www.nice.org.uk/guidance/cg90

Nicola, M., Alsafi, Z., Sohrabi, C., Kerwan, A., Al-Jabir, A., & Iosifidis, C. *et al.* (2020). The socio-economic implications of the coronavirus pandemic (COVID-19): a review. *International Journal of Surgery*, *78*, 185–193. doi: 10.1016/j.ijsu.2020.04.018

Norcross, J. C., & Lambert, M. J. (2011). Psychotherapy relationships that work II. *Psychotherapy*, *48*, 4–8. doi: 10.1037/a0022180

Omylinska-Thurston, J., McMeekin, A., Walton, P., & Proctor, G. (2019). Clients' perceptions of unhelpful factors in CBT in IAPT serving a deprived area of the UK. *Counselling and Psychotherapy Research*, *19*, 455–464. doi: 10.1002/capr.12249

Patel, R., Irving, J., Brinn, A., Broadbent, M., Shetty, H., & Pritchard, M. *et al.* (2021). Impact of the COVID-19 pandemic on remote mental healthcare and prescribing in psychiatry: an electronic health record study. *BMJ Open*, *11*, e046365. doi: 10.1136/bmjopen-2020-046365

Poletti, B., Tagini, S., Brugnera, A., Parolin, L., Pievani, L., & Ferrucci, R. *et al.* (2020). Telepsychotherapy: a leaflet for psychotherapists in the age of COVID-19. A review of the evidence. *Counselling Psychology Quarterly*, *34*, 352–367. doi: 10.1080/09515070.2020.1769557

Richardson, L., Frueh, B., Grubaugh, A., Egede, L., & Elhai, J. (2009). Current directions in videoconferencing tele-mental health research. *Clinical Psychology: Science and Practice*, *16*, 323–338. doi: 10.1111/j.1468-2850.2009.01170.x

Roesler, C. (2017). Tele-analysis: the use of media technology in psychotherapy and its impact on the therapeutic relationship. *Journal of Analytical Psychology*, *62*, 372–394. doi: 10.1111/1468-5922.12317

Seifert, A., Cotten, S., & Xie, B. (2021). A double burden of exclusion? Digital and social exclusion of older adults in times of COVID-19. *Journals of Gerontology: Series B*, *76*, e99–103. doi: 10.1093/geronb/gbaa098

Simpson, S. (2009). Psychotherapy via videoconferencing: a review. *British Journal of Guidance & Counselling*, *37*, 271–286. doi: 10.1080/03069880902957007

Simpson, S., & Reid, C. (2014). Therapeutic alliance in videoconferencing psychotherapy: a review. *Australian Journal of Rural Health*, *22*, 280–299. doi: 10.1111/ajr.12149

Stubbings, D. R., Rees, C. S., & Roberts, L. D. (2015). New avenues to facilitate engagement in psychotherapy: the use of videoconferencing and text-chat in a severe case of obsessive-compulsive disorder. *Australian Psychologist*, *50*, 265–270. doi: 10.1111/ap.12111

Stubbings, D. R., Rees, C. S., Roberts, L. D., & Kane, R. T. (2013). Comparing in-person to videoconference-based cognitive behavioral therapy for mood and anxiety disorders: randomized controlled trial. *Journal of Medical Internet Research*, *15*, e258. doi: 10.2196/jmir.2564

Thomas, N., McDonald, C., Boer, K., Brand, R., Nedeljkovic, M., & Seabrook, L. (2021). Review of the current empirical literature on using videoconferencing to deliver individual psychotherapies to adults with mental health problems. *Psychology and Psychotherapy: Theory, Research And Practice*, *94*, 854–883. doi: 10.1111/papt.12332

Topooco, N., Riper, H., Araya, R., Berking, M., Brunn, M., & Chevreul, K. *et al.* (2017). Attitudes towards digital treatment for depression: a European stakeholder survey. *Internet Interventions*, *8*, 1–9. doi: 10.1016/j.invent.2017.01.001

Tracey, T., & Kokotovic, A. (1989). Factor structure of the Working Alliance Inventory. *Psychological Assessment: A Journal of Consulting And Clinical Psychology*, *1*, 207–210. doi: 10.1037/1040-3590.1.3.207

Turner, J., Brown, J., & Carpenter, D. (2018). Telephone-based CBT and the therapeutic relationship: the views and experiences of IAPT practitioners in a low-intensity service. *Journal of Psychiatric and Mental Health Nursing*, *25*, 285–296. doi: 10.1111/jpm.12440

Warnock-Parkes, E., Wild, J., Thew, G. R., Kerr, A., Grey, N., Stott, R., Ehlers, A., & Clarke, D. M. (2020). Treating social anxiety disorder remotely with cognitive therapy. *Cognitive Behavioural Therapy*, *13*, e30. doi: 10.1017/s1754470x2000032x

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