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Videotherapy and therapeutic alliance in the age of COVID-19

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Abstract

The arrival of the coronavirus (COVID-19) pandemic has confronted us with a global and unprecedented challenge of community-wide psychological distress alongside reduced access to therapeutic services in the traditional face-to-face format, due to the need to self-isolate. This previously unimagineable set of circumstances provides a unique opportunity, and indeed an imperative, for videotherapy to fulfil its potential in addressing mental health and well-being needs from a distance. Historically, the uptake of videotherapy has been hindered by psychotherapist expectations of inferior therapeutic alliance and outcomes, in spite of considerable research evidence to the contrary. Research suggests that videotherapy provides a powerful pathway for clients to experience enhanced opportunities for self-expression, connection and intimacy. This more neutral therapeutic 'space' provides clients with multifarious opportunities for self-awareness, creative experience and collaboration, with potentially a greater sense of agency over their own experience. This paper explores ways in which videotherapy can lead to a revitalisation of the concept of the therapeutic relationship, in order to meet the challenges associated with COVID-19. A number of specific considerations for videotherapy adaptations and etiquette in the midst of COVID-19 are described.

KEYWORDS

COVID-19, telemental health, telepsychology, therapeutic alliance, videotherapy

1 | INTRODUCTION

COVID-19 has forced us to reimagine the way we work and the way we live. It has also highlighted the impact of physical ill-health and social disruption on mental health and well-being (AMS, 2020; Holmes et al., 2020; Pfefferbaum & North, 2020), whilst at the same time removing our usual first line response to mental health challenges: in-person face-to-face therapy (Wind, Rijkeboer, Andersson, & Riper, 2020). By the end of May 2020, almost every country was experiencing restrictions to movement and closure of nonessential businesses, especially those that require face-to-face contact (Hale et al., 2020). Perhaps unsurprisingly, in this void, we are confronting levels of distress and anxiety in our local and global communities on an unprecedented scale (Frissa & Dessalegn, 2020; Holmes et al., 2020). This distress is not restricted to pre-existing mental health clients or even to groups at high risk of mental health challenges (MORI Ipsos, 2020). It is not restricting itself to the old or to the young, to women or to men (World Health Organisation [WHO], 2020a). Whilst we have known that mental health challenges have been a silent epidemic for decades (Whiteford, Ferrari, &

Degenhardt, 2016), early evidence suggests that the current trajectory of symptomatic presentations is likely to exceed the pandemic trajectory of the COVID-19 virus itself, as it affects not just the lives of those with the virus but also frontline healthworkers (Greenberg, Docherty, Gnanapragasam, & Wessely, 2020), and the lives of the many people living in fear of the virus or dealing with the personal, social and economic consequences of the virus (AMS, 2020; Silva, Resurrección, Antunes, Frasquilho, & Cardoso, 2020). It is often said that necessity is the mother of invention. In the case of 'videotherapy', the provision of synchronous psychotherapy via videoconferencing, it seems that necessity may be the mother of reinvention (Knopf, 2020; Torous, Myrick, Rauseo-Ricupero, & Firth, 2020). This evidence-based technological option for therapeutic contact may finally have an opportunity to live up to its potential as communities around the world move rapidly online and where videoconferencing communication is the new normal (Berwick, 2020). Further, synchronous videoconferencing sits amongst, and can be used alongside, a suite of digital mental health modalities or 'psycho-technologies', including text-chat, audio calls, virtual reality, mental health apps and online forums (e.g., Stubbings, Rees, & Roberts, 2015).

Even prior to COVID-19, more than 80% of those in developing countries were unable to access traditional treatment for mental health problems (United Nations, 2020). In developed countries, there is still a significant treatment gap, with evidence suggesting between 44% and 70% of those needing mental health care are unable to access evidence-based treatments (WHO, 2019). The current acute imperative for psychotherapists to incorporate videoconferencing and other forms of remote technology builds upon this pre-existing unmet need. Community wide isolation (Hale et al., 2020; Pietrabissa & Simpson, 2020) is occurring at the same time as exposure to trauma and the significant psychological impact of more than 30 million cases of COVID-19 illness worldwide, grieving for more than 943,000 deaths (WHO, 2020b), and adapting to rapidly changing social and economic conditions (United Nations, 2020).

Early studies described videotherapy as a solution to the provision of mental health services for those living in remote and rural areas (Thomas, Ellis, Konrad, Holzer, & Morrissey, 2009), as well as those unable to attend in-person sessions due to factors such as ill-health, reduced mobility, incarceration and/or working off-shore (e.g., Langarizadeh et al., 2017; Simpson, 2009). Our unprecedented current global circumstances bring this need into the 'mainstream'. Fortunately, the extraordinary development of information and communication technologies and expansion of the internet has ensured ubiquitous infiltration of e-technology into all spheres of our lives, thereby promoting greater tolerance of and engagement with technology, including, increasingly, in the sphere of mental health and psychotherapy (Weitz, 2018). Recent figures indicate that approximately 56% of the world's population utilises the internet (Roser, Ritchie, & Ortiz-Ospina, 2020). For some time now, surveys in the United States have suggested that 80% of North Americans access information about mental health via the internet and increasingly rely on it to meet their psychological needs (Elkin, 2008). Over recent months, COVID-19 has triggered unprecedented digital transformation in the marketplace, impacting human behaviour across almost all aspects of daily life (Kim, 2020; Yan, 2020) further creating a digital 'skills-ready' and 'receptive' marketplace for videotherapy (Hong, Lawrence, Williams, & Mainous, 2020). Further, the risk–benefit ratio has tipped in favour of telehealth, at least partly due to the fact that clinicians are as at risk as their patients. This has resulted in a rapid shift in attitude of clinicians in favour of using technology, and overhaul of the red-tape that has restricted the growth of this field (Webster, 2020).

Key Practitioner Message

- COVID-19 has presented significant challenges for the delivery of traditional in-person psychotherapy.
- Considerable research supports the clinical effectiveness of videotherapy, with strong therapeutic alliance ratings by both clients and therapists.
- Videotherapy provides a powerful pathway for clients to experience enhanced opportunities for self-expression, connection and intimacy, with potentially a greater sense of agency over their therapeutic journey.
- Psychotherapists are advised to consider specific considerations for videotherapy adaptations and etiquette in the midst of COVID-19.

2 | VIDEOTHERAPY: FACTORS AFFECTING UPTAKE

Historically, despite the documented need, promising outcome studies (Backhaus et al., 2012; Nelson & Patton, 2016; Richardson, Frueh, Grubaugh, Egede, & Elhai, 2009) and client acceptance (Simpson & Reid, 2014a) uptake has been slow (Austen & McGrath, 2006; Perle et al., 2013; Perle, Langsam, & Nierenberg, 2011; Pierce, Perrin, & McDonald, 2020; Richardson, 2012; Roine, 2008; Simpson, Guerrini, & Rochford, 2015; Wagnild, Leenknecht, & Zauher, 2006). Most notably, it has been therapists rather than their clients who have been slow adopters of technology (Simpson & Reid, 2014a). Typical challenges raised by clinicians regarding the use of videotherapy include concerns around obtaining informed consent and capacity to guarantee client confidentiality. Additionally, the logistics of managing crises can be more complicated due to reliance on internet-based communication (Rochlen, Zack, & Speyer, 2004). Further concerns arise in relation to reduced opportunity to verify clients' identities and location when meeting with them remotely (Rochlen, Zack, & Speyer, 2004). Following the onset of the pandemic, we have seen a rapid uptake of telemental health technology amongst more than 3000 therapists surveyed in the United States (Sammons, VandenBos, & Martin, 2020). Indeed, there was an increase in uptake from 30% to more than 80% becoming frequent users over a period of just weeks. Nevertheless, therapist concerns remain about the use of videotherapy (Sammons et al., 2020) and must be addressed to support the sustainability of

videotherapy practice throughout and beyond the life of COVID-19. Historically, therapists and service providers have identified three main concerns: (i) access, (ii) cost and (iii) therapeutic viability.

2.1 | Access

Access issues have included concerns for a digitally illiterate client base with lack of access to suitable technology (Lazarus & Mora, 2000). As described above, COVID-19 (and indeed the years leading up to COVID-19) has mitigated this concern through a world-wide digital transformation. With the ubiquitous availability of mobile phones, telehealth is becoming increasingly accessible to even the most disadvantaged. Over recent months, digital technologies are being used across developed and developing countries alike to reach those most in need. In India, virtual health care is more accessible through the public health care system than through private hospitals. Both Chinese and Indian governments have released a range of online applications that allow videoconferencing and instant messaging options to increase access to health care and information, including WeChat and WhatsApp (Webster, 2020). Alongside other digital technologies, videotherapy may improve equity of access to psychological services, to facilitate inclusion of those who are constrained by factors such as geographical remoteness, medical and psychiatric illnesses, mobility issues, incarceration and financial hardship (Joint Task Force for the Development of Telepsychology Guidelines for Psychologists, 2013).

The other side of this equation is access for therapists—there have been very few post graduate clinical and counselling programs that include training on online and videoconference-based therapies, with the exception of a notable few (e.g., Dunstan & Tooth, 2012; McCord, Saenz, Armstrong, & Elliott, 2015; Pierce, Perrin, & McDonald, 2020; Richardson, 2012; Simpson, Guerrini, & Rochford, 2015; Simpson, Rochford, Livingstone, English, & Austin, 2014), nor professional development opportunities, which contributes to concerns and negative expectations (Springer, Bischoff, Kohel, Taylor, & Farero, 2020). The practice of videotherapy requires specialist skills and knowledge to address unique practical, ethical and legal challenges (Pierce, Perrin, & McDonald, 2020). Again, COVID-19 has generated an urgent call and rapidly growing availability of telehealth training opportunities (Smith et al., 2020; Wosik et al., 2020). Online training courses that offer certification in the use of specific digital technologies for psychotherapy are becoming increasingly available (e.g., www.telehealth.org; http://onlinetherapyinstitute.com).

National and international professional organisations have also developed videotherapy guidelines in recent years and provide comprehensive practical and ethical recommendations (e.g., American Psychiatric Association, 2016; Joint Task Force for the Development of Telepsychology Guidelines for Psychologists, 2013; New Zealand Psychologists Board, 2012; Shore et al., 2018; Turvey et al., 2013; Yellowlees, Shore, & Roberts, 2010). Importantly, in the current context, these provide guidance on requirements for safe practice at a distance.

2.2 | Cost

Cost barriers to videotherapy have also been significantly overcome during COVID-19. In countries such as Australia and the United States, recent months have seen the introduction of a Medicare rebate for working with clients using videotherapy, which overcomes previously restrictive criteria and addresses issues of social equity in access (Smith et al., 2020). Public mental health services that have also historically been slow to embrace the advantages associated with utilising technology in the delivery of therapeutic services (despite potentially large cost-savings and more seamless multidisciplinary treatment delivery) (Hilty et al., 2013) have been rapidly pivoting towards telehealth delivery and revitalising telehealth infrastructure (Whaibeh, Mahmoud, & Naal, 2020).

2.3 | Therapeutic viability

Therapeutic viability is the final barrier to successful adoption of videotherapy—this is the primary concern for clinicians and the focus of this paper. Specifically, viability concerns centre on a perceived interruption to the therapeutic alliance—a disruption to the core mechanism for change and the most reliable predictor for both outcome and attrition (Horvath, Del Re, Flückiger, & Symonds, 2011; Wampold & Imel, 2015). One seminal study demonstrated that psychologists tend to rate therapeutic alliance lower for a session that was conducted via videoconferencing compared with in-person, even when the session was identical across both settings (Rees & Stone, 2005).

Our paper addresses the concern about therapeutic viability by exploring what we know about how technology can shape therapeutic alliance in the context of videotherapy. We go beyond proposing videotherapy as a 'good enough' therapy 'in the current circumstances' to challenge our basic assumptions about the factors that lead to effective therapy, including the widely held belief that conventional in-person treatment methods are the gold standard for all (Simpson & Reid, 2014b). This is neither wishful thinking borne of necessity nor an ambit claim. There is already some indication that this treatment modality may in fact enhance outcomes for some client groups, most notably, those with mood disorders and/or interpersonal avoidance, who may find in-person sessions overwhelming (Nelson, Barnard, & Cain, 2003, 2006; Richardson, Frueh, Grubaugh, Egede, & Elhai, 2009; Simpson, Bell, Knox, & Mitchell, 2005; Simpson & Slowey, 2011). Indeed, a randomised controlled study by Nelson, Barnard, and Cain (2003) compared in-person therapy and videotherapy for depression and found a significantly more rapid reduction in depressive symptomatology in the technology-based modality.

Reynolds, Stiles, Bailer, and Hughes (2013) refer to the 'online calming hypothesis', claiming that many therapists and clients experience the online environment as more comfortable and less threatening than the in-person setting, as shown by evidence that therapists and clients experience low arousal levels in online therapy. The additional safety experienced in this context may make online or videoconferencing-based therapy a less threatening option, especially

for anxiety-based disorders, such as social phobia, agoraphobia, obsessive compulsive disorder and other groups who find close contact overwhelming, such as autistic spectrum disorders (Reynolds, Stiles, Bailer, & Hughes, 2013; Stubbings, Rees, & Roberts, 2015).

We know that many clinicians inexperienced with video-technology report deeply held concerns that the technology will inhibit the development of therapeutic alliance due to the perception of the 'screen' as a barrier between participants (Morland et al., 2010; Rees & Stone, 2005; Suler, 2004). COVID-19 has brought many clinicians to videotherapy who have little previous experience or training. In this context, it seems likely that concerns about alliance may be further heightened by the fact that pivoting to videotherapy is occurring rapidly and during a time in which isolation and therapeutic separation is not by choice and may be prolonged (Sammons et al., 2020). We hope that this paper will provide some reassurance and guidance to therapists coming to videotherapy for the first time.

3 | THERAPEUTIC ALLIANCE IN PSYCHOTHERAPY VIA VIDEOCONFERENCING

Twenty-four studies that had examined therapeutic alliance in the context of videotherapy over the past 23 years were evaluated in a narrative review by Simpson and Reid (2014a). Although the wide range of technologies (Skype, ISDN- and IP-based videoconferencing, FaceTime etc.) and clinical groups being studied made comparisons difficult, some themes did emerge. There was a clear trend across studies that indicated high ratings of therapeutic alliance, with clients rating bond and presence that were commensurable with ratings of in-person settings across a range of clinical populations. Across the majority of studies, both therapists and clients rated high levels of therapeutic alliance, although in general clients ratings were comparatively higher from the earliest phase of treatment. Rapid adaptations to the pace and pattern of communication were observed both in therapists and clients early in videotherapy. Indeed, videotherapy appeared to be associated with an increased investment in the therapy process and greater tolerance in the case of disruptions and interruptions to planned sessions—perhaps due to an understanding of the potential glitches that take place when relying on technology and connecting at a distance (Bischoff, Hollist, Smith, & Flack, 2004; Manchanda & McLaren, 1998). There was some evidence that therapists find it easier to communicate with children and teenagers by videoconferencing (e.g., Himle et al., 2006, 2012) due to their familiarity with technology for gaming and communication. Indeed, client ratings indicated a consistent preference for videoconferencing over in-person therapy. Only two studies reported higher alliance ratings in the in-person condition: one investigated group anger management for veterans with posttraumatic stress disorder, (Greene et al., 2010; Morland et al., 2010) and the other was with teenagers diagnosed with seizure disorders and their parents (Glueckauf et al., 2002). Similarly, a recent study found no significant differences in the quality of empathy and therapeutic alliance across three modalities: in-person, telephone and videoconferencing (Reese et al., 2016). However, client-rated videotherapy alliance has been shown to be further enhanced for those matched with therapists who are confident working with psycho-technologies (Frueh et al., 2007).

It has been found that online therapeutic modalities can lead to greater disinhibition and openness, as a result of a heightened sense of safety and a more neutral power balance (e.g., Fletcher-Tomenious & Vossler, 2009; Roy & Gillett, 2008). Indeed, numerous studies have reported that clients find videotherapy less confronting than in-person contact, thus facilitating disclosure of difficult experiences and expression of difficult feelings (Simpson, 2005; Simpson, Doze, Urness, Hailey, & Jacobs, 2001). This may be due to a combination of factors, such as feeling 'at a safe distance' due to the additional privacy afforded by this therapy modality, especially for those in remote locations who are typically faced with few if any 'anonymous' local treatment options (Simpson et al., 2003; Simpson, Deans, & Brebner, 2001). Indeed, it is difficult for rural residents to attend face-to-face mental health clinics within their local town without this being witnessed by other residents. Videotherapy facilitates attendance of therapy sessions from the convenience of the person's own home without concern about being observed or stigmatised. Those clients who prefer videotherapy over other modalities often cite feeling 'less scrutinised', 'less self-conscious' and a greater sense of personal control (Simpson, Bell, Knox, & Mitchell, 2005; Simpson, Richardson, & Reid, 2016), which may be particularly important when dealing with shame-related issues (e.g., sexual abuse and body-image disorders) (Simpson et al., 2003; Simpson, Bell, Knox, & Mitchell, 2005; Simpson & Morrow, 2010). It may also be that certain client groups who find intimacy threatening, such as those with an avoidant personality traits, may be more suited to videotherapy (Simpson, 2009). Similarly, online and videoconferencing-based therapies may be more accessible to young males, a particularly at-risk group for suicide, who may avoid attending traditional mental health services due to fears of stigmatisation and discomfort around the open expression of emotions (Dunn, 2018). These client groups may be particularly at risk during periods of lockdown due to COVID-19 due to loss of daily structure, work, income and usual mental health supports.

4 | ADAPTING VIDEOTHERAPY TO THE AGE OF COVID-19

In light of the strong evidence base for videotherapy summarised above, psychotherapists do not need to be apologetic in transitioning their clients from in-person to videotherapy sessions but rather view this as an opportunity to provide a seamless mental health care that enables clients to stay safe at home, whilst mitigating potential anxiety and isolation triggered by COVID-19.

Videotherapy services are being offered in several countries to support those in need of mental health support (e.g., Liu et al., 2020; Ministry of Education of the People's Republic of China, 2020a, 2020b; Zhou, Liu, Xue, Yang, & Tang, 2020). Medical staff working on the 'front-line' in COVID-19 hospital wards may be especially at risk

of mental health issues such as traumatisation and burnout associated with higher exposure to the virus and working extended hours (Chen et al., 2020; Greenberg, Docherty, Gnanapragasam, & Wessely, 2020). Therapeutic support for frontline workers may be an issue of timing—the wave of posttraumatic responses may be yet to come.

4.1 | Therapeutic opportunities

As many clients will be accessing their videotherapy sessions at home, this will provide a unique opportunity to witness some of the living circumstances that they have described in sessions. Providing sessions in the clients' home may enable them to be more comfortable to experiment with some of the tasks that have been more difficult in the context of the psychotherapy office, such as exposure-based tasks, relaxation or meditation. Some of those with posttraumatic stress disorder can feel threatened by the prospect of sitting in the middle of an office space but may benefit more from trauma processing in the safety of their own home. Family pets can also provide an additional element of comfort and familiarity that would not generally be available in the therapist's office. A client who has been restricting themselves to one room of the house due to difficulties such as agoraphobia, or obsessive compulsive disorder, could show their video therapist the set-up of the room and the house in general, to explore ways in which their psychotherapy sessions can enable them to expand their horizons. Those with eating disorders can show the therapist the room where their binges take place, facilitating a collaborative exploration of ways they can increase a sense of self-awareness and control within this environment. The unique contextual circumstances of COVID-19 will continue to challenge us to collaboratively innovate to maintain core therapeutic conditions.

4.2 | Changing the nature of boundaries and 'safe' therapeutic spaces

As videotherapy becomes increasingly common in the COVID era, the client is more likely to be attending their videotherapy sessions from within the context of their 'real lives', taking place within their own homes, thereby creating a more organic or personal feel to the connection and potentially providing more access to immediate triggers and transference reactions. It has been suggested that a more neutral online therapeutic environment may facilitate transference reactions that are more reality based and meaningful (Dunn, 2012; Mitchell, 2020; Quackenbush & Krasner, 2012).

Across all therapeutic models, the therapeutic relationship is based on trust and the discipline-specific codes of ethical conduct (Badawi, 2016; Bridges, 1999; Brown & Stobart, 2018; Zur, 2007). In practice, maintaining boundaries is a dynamic process that requires therapists to draw on their own professional judgements and ethics (Hermansson, 1997). When therapy takes place in cyberspace, boundaries need to be flexible enough to embrace the benefits that psycho-technologies offer whilst providing a stable base for containment, affective attachment, attunement and safety (Sabin & Harland, 2017). In fact, it has been suggested that a 'fluid' construction of boundaries can facilitate the development of a deeper therapeutic relationship and sharing of power if the therapist is able to explore their meaning and purpose as they are constructed and to highlight and explore differences in perspective as they arise (Bridges, 1999; Totton, 2006a, 2006b). For example, in videotherapy, this may involve an exploration of the therapeutic connection via the screen and an exploration of feelings of safety and intimacy associated with location and size of self-other images on the screen, level of eye-contact, and experimenting with sitting closer to or further from the camera.

Nevertheless, these changes in setting challenge conventional notions of where and how therapeutic boundaries are set up and the way in which the work of therapy takes place. Whilst the flexibility of psycho-technologies can function to enhance therapeutic rapport, this can also provide fertile ground for boundary transgressions and violations. In particular, there is a danger that an increase in flexibility of therapeutic services may lead to a corresponding increase in the frequency of contacts, whilst the nature of exchanges has the potential to gradually become less formal and more casual. In addition, it is easy to mistakenly assume that the lack of physical proximity equates to protection from boundary crossings and taken to the extreme can lead to potentially deleterious effects on the professionalism of the therapeutic relationship and ultimately therapeutic outcomes. See Table 1 for further suggestions on upholding professional boundaries. These issues may be minimised through following best practice guidelines and regular access to professional training and clinical supervision (Anthony & Goss, 2009; Anthony & Nagel, 2010; Drum & Littleton, 2014; Luxton, Nelson, & Maheu, 2016; Maheu, Pulier, McMenamin, & Posen, 2012; Simpson, Richardson, & Reid, 2016).

4.3 | Establishing a collaborative model

From a pluralistic framework, clinical practice should ideally incorporate therapeutic ideas from the wider culture in which they operate, rather than limiting itself to precepts and methodology from the field of psychotherapy. Given the scale of the COVID impact on psychological health and well-being and given restrictions on access to traditional services, we need to find new ways of operating. Therapeutic outcomes can be enhanced if the therapist is willing to work with their clients to delineate an approach that fits within their modus operandi and can provide a functional contribution to resolve problems (McLeod, 2013). Co-creating a workable videotherapy model with our clients is part of this emerging challenge. We are finding our way together through unchartered territory. At the same time that we are offering access to new videotherapy services, many of our clients will be transitioning from their workplaces to working from home and utilising technology to attend work meetings as well as to conduct many work-related services. Familiarity and comfort with tele-technology is rapidly changing. For recommendations on facilitating separation of work-related technology space from the therapeutic space, see Table 1.

The pluralistic approach highlights the importance of actively seeking out and recognising the client's knowledge and experience of using technology in order to create new therapeutic possibilities. It

TABLE 1 Key skills for developing a strong therapeutic alliance in videotherapy

Key skills for developing a strong therapeutic alliance in videotherapy	Key reference
Providing a rationale for videotherapy: When explaining the transition to virtual sessions, psychotherapists can introduce videotherapy as part of their overarching commitment to provide the highest quality individualised, secure psychotherapy care. This can either be discussed in-person, or via email or telephone.	
Technical induction to videotherapy: Some clients will need to be 'walked through' the technology first, as a means of building confidence with the videoconferencing platforms being used. Contingency plans should also be put in place, so that a secondary videoconferencing platform and/or telephone can be utilised when any difficulties arise. Therapists can also briefly describe the security and confidentiality standards associated with the platform, and provide an opportunity for clients to express any concerns or ask questions. Time should also be provided within sessions for questions regarding the use of videoconferencing. Provision of a short information sheet with simple details on getting the most out of videotherapy, can provide reassurance and allay anxieties.	
Therapeutic induction to videotherapy: Where possible, offer an in-person session prior to starting videotherapy in order to allay concerns and initiate rapport—It should be noted that in reality this option is generally only taken up by a minority of clients. Information sheets (and Consent forms) can be provided in advance to explain the process and provide back-up forms of contact in case of technology or internet failure.	(Bischoff, Hollist, Smith, & Flack, 2004; Manchanda & McLaren, 1998).
Risk management: A collaborative risk-management plan should be developed and put in writing to ensure that steps are in place for ensuring patient safety. This may include changes associated with steps needed to organise hospitalisation in the case of suicidality or medical instability (e.g., in severe eating disorders and substance misuse). It may also include making sure that the client is in a safe space during the videotherapy session (e.g., not in a situation of acute domestic violence risk that may be triggered by the session)	
Communication enhancement (human): Expression of empathy and warmth can be conveyed more 'actively' through more regular checking-in to facilitate attunement to clients' emotional responses; 'leaning in' to the screen, intentionally using body posture, facial expressions, voice tone and body gestures. The dialogue can be slowed down through increased paraphrasing, summarising, and turn-taking. Therapists may also enquire more regularly to elucidate meanings associated with facial expressions and body movements/position.	(Bischoff, Hollist, Smith, & Flack, 2004; Himle et al., 2006; Lozano et al., 2015; Richardson, 2012; Simpson, 2009; Simpson, Richardson, & Reid, 2016; Tuerk, Yoder, Ruggiero, Gros, & Acierno, 2010).
Communication enhancement (technology): Exploration of feelings of safety and intimacy associated with location and size of self-other images on the screen, level of eye-contact, and experimenting with sitting closer to or further from the camera. For example, by placing the picture of the client in the top half of their screen near to the camera, it may be easier to create an experience of 'virtual eye contact', thus creating a greater sense of connection. Clients who find connection and intimacy confronting can be encouraged to 'play' with the technology, to experiment with size and location of images and sound, and to zoom the therapist in and out, in order to develop a sense of internal comfort and connection	(Simpson & Francesco, 2020)
Therapists can monitor and adjust their verbal and nonverbal responses through self-monitoring via the 'P in P' function (i.e., the self-image that appears on the screen). Clients can also utilise this function to attain valuable information regarding their own communication, or it can be switch off if preferred.	(Bouchard et al., 2004)
Sharing control: Clients have been reported to be more active in videoconference sessions, which may be linked to the democratising effect of being situated in their own 'territory' with responsibility for their own remote control and screen	(Day & Schneider, 2002; Simpson et al., 2003).
Maintaining boundaries: Maintain therapeutic boundaries through (1) establishing a therapeutic contract, clarifying time and financial and confidentiality commitments; (2) not accepting social media invitations from clients and maintaining a professional tone and manner in both video- and text based (e.g., emails and SMS) engagements; (3) where possible, maintaining consistency and predictability by keeping sessions to a regular time and ensuring that they begin on-time;	(Simpson, Richardson, & Reid, 2016)

(Continues)

TABLE 1 (Continued)

Key skills for developing a strong therapeutic alliance in videotherapy	Key reference
(4) dressing professionally, as in an in-person setting; (5) ensuring sessions take place in a private space, with minimal background noise.	
Session preparation: Therapists tend to spend more time in preparation for videoconferencing sessions, which may play a role in enhancing quality and effectiveness.	(e.g., Richardson, 2012; Simpson, Deans, & Brebner, 2001)
Advanced skills: Once psychotherapists develop a preliminary level of competence with the technology, videotherapy can offer multifarious opportunities for working and connecting in creative ways, such as through uploading drawings or using the 'whiteboard' facility to develop collaborative formulations and can even be adapted for experiential techniques such as chairwork and imagery rescripting. Further, incorporating avatar technology into videotherapy can provide a blank canvas or 'virtual world', which provides a setting through which client and therapist can co-create and connect. This provides further opportunity for therapist and client to deepen their understanding of the client's inner world	(e.g., Simpson & Francesco, 2020)
COVID-specific etiquette: There is a COVID-specific etiquette emerging, or at least an etiquette necessary in these unusual conditions to support privacy for client and therapist. Most of our clients are in self-isolation at home, with other family or household members sharing a confined space throughout the day making physical privacy during sessions unrealistic.	
Creating a therapeutic space: Clients working from home may need to develop a sense of separation from their 'workspace' whilst engaging in their therapy session. If a laptop or telephone is being used, suggest moving from the home office to another location, to create a more personal therapeutic space. Conversely, therapists working from home may need to ensure a sense of being in a 'workspace' at home that is separate from their personal or family space. Clients undertaking sessions from work, for examples, frontline healthworkers who may undertake videotherapy from a hospital setting, should be encouraged to ensure that access to the telehealth technology is in a private, bookable space to ensure that work does not impinge on the session, and that they are free to undertake the session without the wearing of a face mask. It may also be helpful to ensure that the session occurs at the end of a shift rather than during a shift-break given the potential for a session to be distressing.	
Privacy: The mute function can assist in maintaining privacy by blocking out background conversations or noise. Both therapists and clients can be encouraged to use headphones or earplugs to ensure that other family members cannot overhear or impinge on the therapeutic conversation. App-based artificial backdrops provide protection against seeing each other's homes, particularly when the only feasible space for a session is in a bedroom or other private space. This can operate functionally to screen out the home environment but may also be a form of self-expression through the images chosen.	(Lustgarten, Garrison, Sinnard, & Flynn, 2020).
Social scheduling: Where possible, sessions can be timed to take place during periods of reduced demands around childcare (e.g., evening clinics).	(Lustgarten, Garrison, Sinnard, & Flynn, 2020).
Security: Psychotherapists turning to videotherapy for the first time, or using it for the first time from home, should familiarise themselves with the security settings within their videoconferencing platform, to ensure that calls are secure, confidential and password protected.	(Lustgarten, Garrison, Sinnard, & Flynn, 2020).
Therapist self-care: Supervision via videotherapy is a critical part of providing a therapeutic service at this time. Unusually, both therapist and client are experiencing the COVID pandemic which affords potentially greater opportunities for empathy but also potentially for boundary violations. "Zoom fatigue" has recently entered into our lexicon. Already we are recognising that there is an additional cognitive load of interacting through virtual means for extended periods. It is important that therapists build in breaks to their videotherapy sessions to minimise burnout	(Sander & Bauman, 2020)

involves stepping outside our usual assumptions about what the client needs and how they need to receive it, by asking about their goals and requirements from videotherapy, and considering how this can be practically achieved. This approach proposes that instead of the therapist functioning as the primary 'keeper' of knowledge, a truly collaborative therapeutic relationship involves actively focusing on what knowledge our clients bring to therapy, including the way they conceptualise relationships and dialogue and their expectations and preferences of the therapeutic process (McLeod, 2013; Totton, 2006b). Implementing democracy in the therapeutic arena does not require the therapist to abandon their role in upholding the boundaries and professional responsibilities but requires that client experience remains central in the therapeutic process.

The challenge in working with psycho-technologies will be to find a balance between managing the fundamental imparity of the therapeutic relationship whilst facilitating reciprocity and alliance, within a neutral setting that promotes disinhibition and openness. The therapist must negotiate equilibrium between establishing therapeutic boundaries within the videotherapy environment whilst mindfully laying the foundations for the client's therapeutic experience. This may in part require maintaining an active awareness of the 'therapeutic presence' and the way in which the therapist–client connection is maintained. Further suggestions for enhancing therapeutic connection via videotherapy are listed in Table 1.

4.4 | Who benefits most?

There are many for whom technology offers an opportunity to access psychotherapeutic treatments that would otherwise be unobtainable for them. Historically, this has primarily included those living in geographically rural and remote areas, the elderly, those impaired by mobility or health issues and the incarcerated. Psycho-technologies may now offer a unique solution not just to these populations but also to the entire communities in self-isolation due to COVID 19, improving access and equitability in mental health care at a time of great, and growing, need. Videotherapy provides a mechanism that potentially offers equitable access even to specialist psychotherapy services (such as for addictions, eating disorders, pain-management, relationship issues, posttraumatic stress disorder)—as well as those who are shielding family members, juggling work and childcare from home and those who are contagious and in acute stages of COVID-19.

4.5 | Equity and access

Psychotherapists should remain aware of social equity issues around the transition to videotherapy. We must work to ensure that all of the population, particularly those most in the most socio-economically disadvantaged populations can access psychological therapy, regardless of their access to technological equipment and a reliable internet connection. Indeed, there has been a call for the development of an evidence-based digital inclusion strategy within the National Health Service in the UK to facilitate access to internet-enabled psycho-technologies for digitally excluded populations (Robotham, Satkunanathan, Doughty, & Wykes, 2016). Videotherapy may not be for everyone, and other remote communication alternatives may need to be considered for those who cannot access or are uncomfortable with video-based technology. Other forms of synchronous/asynchronous forms of psycho-technology such as email, Facebook Messenger and online chat forums may use less mobile data and be more accessible for some. The emerging research on suicide prevention apps is one such example of the way in which psycho-technologies can bridge the gap in access to psychological support and advice (de la Torre, Castillo, Arambarri, López-Coronado, & Franco, 2017).

There is an urgent need for improved digital access for those in at-risk groups with severe mental illness and medical complications (e.g., acute psychosis and severe anorexia nervosa). This is especially the case for those who fall foul of the 'digital divide' due to social inequity (Lazarus & Mora, 2000). In particular, older people with psychosis appear to be at high risk of exclusion, citing lack of knowledge as a barrier (Robotham, Satkunanathan, Doughty, & Wykes, 2016). Facilitating greater inclusion may require efforts to provide suitable devices (e.g., mobile phones) whilst facilitating development of skills and confidence with technology in underserved populations. Further, psychotherapy services could be more proactive in providing a range of options, such as through provision of loan devices or arranging for clients to access videotherapy from within their General Practice clinic or other local health providers, and even workplaces—although these options may be somewhat limited during COVID-19. Psychotherapists should also consider videoconferencing platforms which are designed to work with lower bandwidths, especially for connecting with clients in areas with lower internet access.

Further detailed guidance is also required for practitioners working with specific clinical problems as well as particular populations, such as military personnel, those working in maritime and/or other off-shore industries, and those in secure mental health settings. For example, whereas provision of access to psycho-technologies may improve services within forensic treatment units and prisons, it may also present specific challenges. In particular, some severely psychotic and/or paranoid clients may be at increased risk of self-harm associated with using plastic or glass taken from digital devices (e.g., computers), highlighting the need for guidance and procedures for prevention and management for working with high-risk populations via psycho-technologies (Sales, McSweeney, Saleem, & Khalifa, 2018).

5 | WHAT DOES THE FUTURE HOLD?

As we confront the COVID-19 pandemic, we are faced with unprecedented community-wide need for psychological support. At the same time, we have unprecedented restriction of access to clinics due to government dictates about physical distancing that impede the ability

to conduct face-to-face sessions. At times such as these, psychotherapists need to be creative in finding ways to step up and address these new needs.

With the combined forces of rapidly unfolding technology-based health care options and increased consumer demands and expectations, it is vital that psychotherapists meet the challenge of using these instruments to advance our practice. Regardless of our personal preferences, if we do not grasp the challenge of shaping the future of psychotherapy in the context of a technology-driven world, we will find that increasingly the lead is taken by nonprofessionals who offer online/internet-based services and psychological advice. Opportunities are arising to facilitate the development of a more expansive role in which psychological therapists can play a more active part in the context of 'virtual' multidisciplinary services across both general health and mental health services (Maheu, Pulier, McMenamin, & Posen, 2012). We can no longer hold-off by using the rationale that technology-based services might not be as effective—the evidence base is growing and is strongly in favour of technology-based services, both in terms of effectiveness of outcomes, therapeutic rapport and patient satisfaction (Richardson, Frueh, Grubaugh, Egede, & Elhai, 2009; Simpson & Reid, 2014a; Stubbings, Rees, Roberts, & Kane, 2013; Sucala et al., 2012). As psychotherapists, we need to consider that if we do not utilise the technologies now available to us for the provision of psychotherapies, this may constitute neglect of our responsibilities as practitioners to meet the requirements for best practice (Lazarus, 1994; Richardson & Simpson, 2015; Simpson & Reid, 2014b). The question is no longer whether or not technologies have a place in the world of psychotherapy, but how we can galvanise ourselves to foresee the potential benefits and risks ahead and equip ourselves to meet the challenge both to deal with the acute mental health needs associated with COVID-19, and beyond.

The COVID-19 crisis has fast-tracked the challenge for public health services to embrace new and innovative ways of utilising psycho-technologies to improve access, efficiency (cost and clinical) and outcomes in public health service settings. For psychotherapists, the exponential growth of psycho-technologies provides significant opportunities for providing online assessments and treatments and for engaging new clients (Andersson, 2016; Andersson & Cuijpers, 2009) as well as extending our services beyond what was previously possible through combining technologies to match client need (e.g., Castelnuovo et al., 2014; Richards, Simpson, Bastiampillai, Pietrabissa, & Castelnuovo, 2016). High-quality research is urgently needed into the effectiveness of different forms of technology as alternatives and adjuncts to current practices, particularly in times of crisis. Even after the COVID-19 emergency has abated, we will be faced with addressing the far-reaching mental health impacts of the climate crisis (Pietrabissa & Simpson, 2020). There is already substantial evidence indicating that many people are currently experiencing trauma inflicted by extreme weather events, conflict and forced migration. Videotherapy will be required to evolve in order to play a role in addressing the mental health needs of those affected by this emerging crisis. It is critical that as practice continues to evolve in this space, psychotherapists create opportunities for ongoing peer (and client) consultation and review, whilst taking advantage of online training opportunities. In adapting to the 'new normal', it will be imperative for us to creatively and collaboratively develop new practices and apply basic principles and clinical reasoning to new innovations rather than simply adopting established protocols.

Research should also focus on identifying the factors that enhance therapeutic alliance in the context of utilising the range of psycho-technologies in order to maximise curative potential and to reach parts of clients' lives that often remain disconnected from the confines of the therapeutic hour in traditional therapy settings. Further research is also required to generate guidance on how and when to best integrate different technologies alongside videoconferencing. Social media sites and other online forums provide a mechanism by which we can both access large samples of specific client groups/diagnostic categories and expedite multisite trials, thereby providing increased opportunities for collaboration between researchers.

6 | CONCLUSIONS

The arrival of the coronavirus (COVID 19) pandemic in March 2020 has presented us with both an unprecedented challenge of community-wide psychological distress and an inability to provide therapeutic services in the traditional face-to-face format for an extended period. It requires us to find new ways to meet our duty of care to current clients and to show leadership in providing access to therapeutic support for a new generation of mental health clients. In this rare case, the evidence base has predated the urgent need. Now we need to trust the evidence base.

There is growing evidence that the digital natives of the younger generation who have grown up with technology as an integral part of everyday life and interpersonal connectedness are increasingly demanding services that match their needs and the world as they experience it. Our current circumstances in confronting a global pandemic have required that the rest of us move quickly to also familiarise ourselves with these technologies. Our own future as professionals will be dependent on our ability to coordinate our efforts to exploit technologies in order to meet the psychological needs of clients and communities of the coronavirus age.

CONFLICT OF INTEREST

The authors report no conflicts of interest.

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