

In person online: What trainee psychotherapists discovered about online clinical work¹

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Abstract

During the 2020 lockdown in response to COVID-19, students in the Master of Psychotherapy at the Auckland University of Technology (AUT) were required to rapidly move their clinical work online. We surveyed these students about their experience of working clinically online. We used a mixed-methods approach and analysed qualitative data using grounded theory methods. Students found the move online difficult, with technological challenges, the loss of a professional clinical space, and having to establish and maintain the therapeutic alliance in the unfamiliar online setting. They showed a strong preference for in-person clinical work, along with scepticism about the efficacy of online therapy, though some acknowledged its convenience and others its currency and relevance. Most expressed a need for more specific training in online therapy. Students rated their technological skill level higher than their levels of interest in online communication. This suggests that preferences, rather than technical skill, influenced their hesitancy for working clinically online. While online therapy can impose increased strain on clinicians and directly impact their capacity to manage online clinical work, the literature finds strong and consistent evidence that online therapy has equivalent outcomes to in-person therapy. There is significant emphasis in the literature on the disjunct between the outcomes evidence and therapist expectations. This is modified somewhat by training and experience in online therapy. We recommend that research-active psychotherapists engage actively and collaboratively with the profession, through professional bodies, to encourage research-informed professional development and practice for clinicians; and that further research is conducted into effective strategies for training in online clinical delivery.

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Whakarāpopotonga

Ko te urupare i a Kōwhēori -19 te wā o te mohoa 2020 i whakahauhia kia tere te neke a ngā ākonga o te Tohu Tuarua Hinengaro o te Te Wānanga Aronui o Tāmaki Makau Rau i ā rātau mahi haumanu ki runga tuihono. I rangahauhia e mātau ō rātau wheako mahi tuihono. I whakamahia he tātai tikanga-kōrori ka huri ki te ara kari ariā hai aromatawai i te rarau kounga. He tino uaua te neke ki te mahi tuihono ki ngā ākonga; huitahi atu ki ngā wero hangarau, te kore ātea haumanu mahi, me te hanga te tiaki i te mahitahinga haumanu i roto i te wāhi tuihono tauhou. Ko tā rātau whiringa matua kia mahi kanoho ki te kanohi, me te kore e whakapono i te pai o te haumanu tuiono; engari i whakaae ētahi i tōna pai me ētahi i tōna uara me tōna hiranga. Ko te nuinga i whakaputa i ō rātau hiahia mō tētahi whakangungu arotika pā ki te haumanu tuihono. I tohua nuihia ake e ngā ākonga ō rātau pukenga kōeke hangarau i ō rātau kōeke aronga whakawhitiwhiti kōrero tuihono. E mea ana tēnei ehara nā ō rātau pukenga hangarau engari nā ngā whiringa kē i awe ai ō rātau hokirua ki te mahi haumanu tuihono. Ahakoa utaina te rahi haere ake o te uaua mahi haumanu tuihono ki ngā kaihaumanu ka whakaaweawe tōtikahia ō rātau kaha ki te whakahaere mahi haumanu tuihono, e kitea ana e ngā tuinga te kaha me te pūmau o te taunaki he rite tonu ngā huanga o te haumanu tuihono ki te haumanu ā-kanohi. He tūtohu hira kai roto i ngā tuinga mō te wehewehe i waenga i ngā hua taunaki me ngā wawata o ngā kaihaumanu. Mā te whakangungu me te wheako ki ngā haumanu tuihono tēnei e āhua urutau. E whakatau ana mātau me tū ngangahau, mahi tahi i te taha o ngā mātanga me ngā rōpū mātanga te ngangahau-rangahau, hei whakakipakipa mātauranga-rangahau whanake mātanga me te whakawai mā ngā kaihaumanu; me te whanohanga rangahau atu anō hei rautaki pono hei whakangunguhanga haringa haumanu tuihono.

Key words: clinical; in-person; online therapy; trainee psychotherapist; student; COVID-19; pandemic.

Introduction

In Aotearoa New Zealand in 2021, management of COVID-19 is stable relative to most other countries, thanks to effective strategic political decisions. Last year, though, with the event of our first national lockdown, we were having to acclimatise to the risks and constraints brought about by this novel coronavirus, to learn new health protocols and a whole new language around this defensive way of living. Terms such as social distancing, contact tracing, viral shedding, long COVID, Delta variant, and superspreaders are part of our everyday lexicon, for now.

Along with such shared experiences, each of us will have had unique experiences of the impacts of this virus on our lives. In the profession of psychotherapy (and in other allied health professions) we have had to make adaptations to our practices to accommodate a change in the number of clients, and our mode of working with them. For student psychotherapists in the Master of Psychotherapy programme at AUT, the timing of lockdown required an abrupt move from seeing their clients in person to seeing them online. For staff in the department, the urgent work was to support that move as best we could, in the context of working from our own homes and with an increased workload.

Online psychotherapy is by no means a recent phenomenon. At the time of the first lockdown, however, our students generally had not been familiar with online therapy, nor had they been trained to work online. By contrast, we had previously had our own experiences of being in therapy online, and we both consider it equally as effective as in-person therapy. In addition, we both have private practices that include online clients and during lockdown we each moved our practices entirely online. The usual relational components of psychotherapy can, with skill and experience, all remain operational: the working alliance, transference and countertransference, unconscious processes, embodied awareness, and working at depth. This experience has support from the research literature, as we describe below. This is the background and perspective we brought to the task of preparing our students for online work.

On 27 March last year, two days after the first Level 4 lockdown started, we developed guidelines for our clinical students, together with links to resources and workshops. The guidelines included how to prepare for online sessions, information about relevant technology (especially platforms on which to work) and issues relating to the therapeutic frame. We acknowledged the challenges of this time and left it to students to decide when to begin seeing their clients online. This allowed time to familiarise themselves with the guidelines and other related resources about online work, to set up a suitable space in which to work, and to attend to pressing family matters. We advised that they did not need to take on new clients at that time and that they could suspend therapy with existing clients, while keeping in mind their clients' needs. In the transition to working online, students also had the support of their clinical supervisors and the clinical educators in the AUT Psychotherapy Clinic, based at AUT Integrated Health (AIH). At the end of the semester, we tailored the usual round of feedback processes to ask students about their experience of working clinically online.

This article reviews current research on working psychotherapeutically online and describes how our students experienced this move. We take this into a wider exploration of the concerns, complexities, and opportunities for beginning psychotherapists working online.

Given the lack of consistency regarding the terminology to describe internet-delivered interventions (Smoktunowicz et al., 2020), we predominantly use the term "online therapy" because it fits with the context within which our students work with their clients in the online space. The current and common uptake of this term has been influenced by Colón (1996), a leader in the field of therapy online (Stasiak et al., 2018). By online therapy, we mean therapy delivered in real time via video conferencing, using platforms such as Zoom, where therapist and client can see each other. In some cases, a decision may be made to turn the cameras off, in order to remove the distraction of the image on the screen and thus to enhance the focus on internal processes; we include this also under the term "online therapy". For the purposes of this article and, again, in the context in which our students work with their clients, this does not encompass other media platforms, such as apps or chat programs.

Online Therapy: The Literature

Earlier research into online therapies (including asynchronous services) has found benefits from this mode of delivery of therapy. These include accessibility, convenience, reduction in stigma and inhibition around the uptake of clinical services, increased client control of the

process, and the potential for keeping a recording of the process (Wright, 2007). There has been a rapid development in the literature on online therapy since the emergence of the COVID-19 pandemic in support of its equivalence with in-person therapy, in relation to effectiveness and outcomes. Poletti et al. (2020) reviewed 18 studies, published between 2015 and 2020, and found that, despite some scepticism, telepsychotherapy is a “trustworthy alternative” (p. 1), ensures continuity of therapy, provides often much-needed psychological support in an uncertain and traumatic time and, importantly, is effective in treating common mental health disorders.

Specific research on the therapeutic alliance and client outcomes in psychotherapy overwhelmingly confirms that these are similar, regardless of whether the therapy is in person or online. Simpson and Reid (2014) conducted a review of research studies over the preceding 23 years, measuring the therapeutic alliance. They found that clients rated bond and presence in online therapy “at least equally as strongly” (p. 280) as in-person therapy. Berger (2017) reviewed studies assessing the therapeutic alliance online and found that clients’ alliance scores were “roughly equivalent” (p. 511) to alliance ratings for in-person therapy. In a systematic review of 15 studies exploring the differences between the use of telephone and in-person therapy, Irvine et al. (2020) found little difference in terms of therapeutic alliance, disclosure, empathy, attentiveness, and participation. Fisher et al. (2020) cited randomised controlled trials that show online therapy as being equally effective as in-person therapy in the areas of patient satisfaction, therapeutic alliance, treatment outcome, and symptom improvement.

Békés et al. (2020) reported on survey responses from 190 analytic therapists as they transitioned to online therapy at the beginning of the COVID-19 pandemic. They found that therapists believed they were able to maintain as strong, authentic, and emotionally connected a presence online as in person. This led to the therapists viewing online therapy in a more positive way than they had earlier, although a majority of therapists still believed that online therapy is less effective than being in the room with the client. This is a commonly held view, and there are likely to be several reasons for it. Békés and Aafjes-van Doorn (2020) noted that most therapists pre-COVID had little or no experience or training in working online and that many held the unsubstantiated view that online therapy is less effective than in-person therapy. There may be prejudices about, or difficulties pertaining to, being in the online space, which then impact therapist perceptions. A striking illustration of bias emanating from negative expectations of technology is provided by Berger (2017). In a laboratory experiment, two separate participant groups of clinical psychologists were shown an identical therapy session; however, it was shown as though it were an in-person session to one group, and to the other as though it had taken place online. The participants who believed the session was held in person gave much higher ratings for the quality of the therapeutic alliance than those who believed it had been held online.

The extent to which therapists’ negative perceptions of online therapy have been influenced by the additional demands of providing therapy during a pandemic is unclear. Scharff et al. (2020) found that trainees consistently needed to manage their emotional distress to be able to empathise with their clients; they noted the increased likelihood that therapists working during a pandemic would struggle more to separate their clients’ issues from their own. Aafjes-van Doorn et al. (2020) surveyed the experience of 141 therapists who

transitioned to working online during the pandemic. They noted that therapists with more online experience had lower levels of anxiety and self-doubt about providing online therapy and felt more positively about it, including thinking that their clients viewed it positively. Their recommendation was to provide more training in online therapy, to ensure a better experience and more effective use of the medium.

In addition to training needs, there are particular challenges associated with a move to working online, and particularly during a pandemic. Therapists report feeling more tired than usual, and may be coping to varying degrees with their feelings of loss and anxiety relating to the pandemic (Geller, 2020). The home environment can be distracting, and clients may be in the same environment with the people they are having issues with (Geller, 2020). In a mixed-methods survey investigating the experiences and challenges of 335 psychotherapists working online during the pandemic, McBeath et al. (2020) found that, despite most therapists considering online therapy to be effective, and intending to persist with it, they often struggled with feelings of isolation and fatigue, professional self-doubt, and loss of confidence. There were also concerns relating to technical issues. This was echoed by Aafjes-van Doorn et al. (2020), who found that therapists were concerned about the impact of technical issues that inevitably arise. Beyond the technical, concern extended to how to maintain confidentiality, and fears that the therapeutic alliance might suffer. These concerns are not supported in the literature. While the therapeutic alliance is not rated highly in the online setting by therapists (Simpson & Reid, 2014), clients of online therapy rate the quality of the therapeutic alliance highly (Berger, 2017; Norwood et al., 2018; Simpson & Reid, 2014). Moreover, Simpson and Reid (2014) found that clients do not generally have a preference between being online or in person. This evident disjunct between client and therapist perceptions of the effectiveness of online therapy, alongside our experience of supporting our students to move their clinical work online, prompted us to consider what they might tell us about their experience online as trainee psychotherapists.

Method

We conducted the current research using a mixed-methods approach in order to get data on students' experiences of the move to online clinical work. Alongside qualitative questions directed towards understanding their experience, we wanted quantitative data that may elucidate the factors contributing to that experience, such as their prior skill level in online communication in everyday life.

We developed an online survey of 10 questions:

1. How would you rate your interest in online communication in your everyday life?
2. How would you rate your skill level in online communication in your everyday life?
3. How would you rate your experience of seeing new clients online?
4. Where applicable, how would you rate the experience of moving online with existing in-person clients?
5. What challenges, if any, did you experience working clinically online?
6. How adequate was guidance from staff, clinical educators, and clinical supervisors for working clinically in the online space?

7. What extra training, if any, would have been helpful?
8. This question is about the level of intimacy you find possible between you and your clients in the online space, compared with in person. On the scale of 0-100, is online intimacy lower (0-39), similar (40-60), or higher (61-100) than with in-person clients? If you have not worked in both ways, please skip this question.
9. How would you rate the strength of the therapeutic alliance online, compared with in-person?
10. Overall, do you prefer online or in-person clinical work, or are they more or less the same to you? Please write your preference, and brief reason, in 50 words or less.

Seven questions required responses on a 100-point Likert scale, and three required open-ended responses of 50 words or less.

Participants

We used a convenience sampling of students who were already assigned clients in the psychotherapy clinic at AIH. These students were in the first and second year of the Master of Psychotherapy programme and were seeing clients in the clinic as part of their course-work requirement. We contacted students through the university's Learning Management System, inviting them to complete an anonymous online survey about their experience of the move online. We set a three-week turnaround timeframe without either enticement or requirement to participate. Students were reminded of the survey in class, and many expressed an interest in having their say about their experiences of online clinical work. Out of the 36 invited students, 26 (72%) responded.

Quantitative Findings

Quantitative data were gathered in seven research questions (RQ) from the survey (RQs 1-4, 6, 8, and 9). In the 100-point Likert scale used for each question, 0 represented the lowest and 100 the highest rating. For question 8 (see above), we described the range more specifically.

From the quantitative data, students' levels of interest in online communication in everyday life averaged 65%, though their self-assessed skill level averaged 73%, showing a rating based slightly more on preference rather than skill level for working clinically online. They rated the satisfaction with their experience of seeing new clients online at 42% and a higher rate (53%) for their experience of moving online with existing in-person clients.

Perceptions of the levels of intimacy possible between student therapists and their clients in online clinical work rated significantly lower (38%) than the intimacy possible between students and their clients in in-person therapy. However, the strength of the therapeutic alliance was rated at an average of 42% online, compared with in-person.

Qualitative Findings

Qualitative data were gathered in three research questions from the survey (RQs 5, 7, and 10). These were analysed through a process of open, axial, and selective coding. We drew on a

grounded theory process (Charmaz, 2014, 2017) to analyse our data because it best matched our intent to make sense of the responses from our students to inform policy and curriculum development within the Master of Psychotherapy programme. Rather than seeking to co-construct a theory from the data, we sought to find one narrative (among possible others) for the phenomenon under investigation—trainee psychotherapists’ experiences of working clinically online for the first time. We did this by exploring relationships between the properties and codes from the data (Carmichael & Cunningham, 2017).

During the initial coding process, both authors separately coded different research questions. We identified properties in the data and used an interpretive axial process to code them according to their relationships to each other and to the question overall. Then we coded the properties by using gerunds to generate nouns from key verbs in the data. For Charmaz (2014, 2017) the use of gerunds for coding is preferable as its focus on actions rather than concrete statements can help prevent conceptual leaps before thorough analysis is completed, and it supports the social action orientation of grounded theory approaches to research.

After initial coding of separate research questions, we checked each other’s coding against the data. Throughout this analysis phase we met to discuss co-emergent meanings, to enquire into what might be being described in the data and what we might be missing. Constant comparison was used to establish the relationships between data, properties, and codes, resulting in a synthesis of the co-constructed meanings in the data. This synthesis is represented in the axial codes, which articulate relationships between open codes, and the selective code, which captures the core of the enquiry.

Research Question (RQ) 5: What challenges, if any, did you experience working clinically online?

Twenty-five of the 26 survey respondents answered RQ5. The responses to this question generated six open codes and one axial code relating to challenges of working clinically online. In ascending order of influence, the challenges were found to be spatial, technical, and relational.

Spatial challenges were identified by just under half (11/25) of the respondents. These challenges included lack of privacy for client and/or student clinician (“Not having my own separate professional working space at home”). Both were at risk of being overheard or disrupted, and the student clinician was at risk of feeling intruded upon by having their personal space visually accessible to clients. Respondents also had concerns around the lack of a safe space for clients in their home (“Clients leaving as don’t have safe space at home”), as well as a sense that the therapeutic frame was weakened, and therapeutic effect limited, by the lack of a separate and neutral professional space dedicated to clinical work (“The therapeutic aspect of providing a space to be in was removed”). Overall, respondents expressed a sense of wanting the boundaries provided by a professional working space.

Technical challenges were discussed by around half (12/25) of the respondents. These challenges included user skills and bandwidth limitations, or at least a weak and disrupted internet connection (“Problems with either the clients or my internet cutting out disturbed sessions, sometimes significantly”). This resulted in “loss of connection in our *kōrero*”. Online therapy was found to be more demanding energetically than in-person therapy, with

some feeling “Zoomed out”, and identifying a need for more breaks. Technological skills and resources were understood as necessary support for the therapeutic process (“Learning new technology like Zoom”).

Most respondents (16/25) identified relational challenges in online clinical work. They expressed a need to see and feel the presence of the whole person of their client in therapy, and felt “something missing” in the online space (“The communication is not as rich,” “Not being able to read their body language,” “Unable to read as many nonverbal cues”). Specific challenges included having only partial views of each other, and a reduction in sensory information, nonverbal cues, eye-to-eye contact, and somatic sense between the client and therapist, which are needed to support attunement and countertransference (“My felt sense of the client, and of myself, was impeded”). Client preferences needed to be considered and some were distracted online (“Client less committed to the session, tempted to do other things while in session”). Others were reportedly unwilling to attend online therapy, preferring to wait until in-person therapy became an option (“One client was very averse to online sessions and did not want to meet unless in person. They were happy to wait”; “Only three out of 10 clients found online sessions convenient”). Respondents understood these challenges as hampering relational connection (“Could be harder to connect on an emotional level at times, felt more distant with some clients”), and at times reducing the depth of the work (“Consideration of how deep/challenging material explored,” “Harder to hold clients in distress or when in touch [with] painful affect online”). In summary, respondents’ experiences of relational challenges online led to a preference to see and feel the presence of the whole person. In addition, these challenges required that respondents consider client preferences, and develop more capacity for online presence.

RQ7: What extra training, if any, would have been helpful?

The responses to RQ7 by three quarters of respondents (19/26) generated four open codes and one axial code relating to training needs.

Respondents expressed a need to be, and to feel, resourced to provide effective relational clinical work in the online space (“Training around empathy, embodied awareness, countertransference, creating alliance, while online”), and to be able to use online technology effectively and ethically (“Having a class or several class sessions to explore the benefits, pitfalls, ethics, and how to work online would be great”). Respondents here indicated a need for training in being present in the online space (“Techniques for staying grounded and present in sessions”), holding the therapeutic frame, establishing and maintaining the therapeutic alliance, understanding therapeutic risks and benefits of the online space, and clarity around the distinct ethical consideration for the online space (“It comes with its own ethics and rework of therapeutic practices in the new field and space”). Respondents represented a general need for a facility with the practical aspects of using technology for effective therapy (“A ‘class’ on the practical aspects of going online, setting up space, etc.”; “Boundaries are very different too and the frame evolves depending on quality of technology, internet connection, lighting”). Respondents’ requests here were expressly around how to manage payment, boundaries, physical space, safety, and privacy for clients.

Respondents varied on the degree to which training was needed. Several respondents assessed that they were adequately prepared from previous experience or guidance offered

by our program (“Guidance was not really that needed since I had been working online already”; “I paid for an online training that [staff] emailed a link to which was helpful”; “In the circumstances it was adequate, there were helpful hints provided”). Four respondents were either satisfied with or not sure of what they needed (“There were a lot of resources made available to us... I can’t think of what else I would have needed”).

Others, however, expressed a clear preference for learning experientially and for mentoring from experienced practitioners. There were requests for practice opportunities to embed the learnings (“Role plays!”), as well as for guidance from online experienced supervisors (“Supervisors who were more empathic to the differences and adjusted their supervision style to online therapy”) and from online experienced clinicians (“Insight from clinicians familiar working in this medium would have been welcome, with deeper exploration of therapeutic implications, risks and benefits”). Overall, respondents expressed a need for comprehensive, guided experiential training and practice for skilful online presence.

RQ10: Overall, do you prefer online or in-person clinical work, or are they more or less the same to you?

The responses to RQ10 by all of the respondents (26/26) generated two open codes relating to preferences for online or in-person clinical work.

For this question, we asked respondents if they preferred online or in-person clinical work, or if these were “more or less the same” to them. Almost all respondents preferred in-person clinical work (24/26). The reason they gave was that it is easier to have a felt sense of being with the client when they are there in person. This included being more easily able to monitor nonverbal communication, to attune to the client, and to establish and maintain a strong therapeutic alliance. Some respondents said that because they are a beginning therapist, they believe that being physically in the room is crucial for learning at this stage, particularly learning to attune to the other. Respondents also highlighted differences between new clients and existing clients. Their experience was that it was easier to be online with clients they had seen for some time, rather than beginning online with a new client (“My client of two years fared much better than my client of four weeks”). The difficulties that respondents experienced online included problematic external distractions (that can occur when therapist and client are online) and concerns about safety and privacy. Overall, the responses indicated that the students found being physically present with their client easier and more clinically effective.

Some respondents saw working online as simply a necessity when it is not possible to be physically in the room, with one student viewing it as “the last resort,” another declaring it “better than nothing,” and yet another stating they would “be happy to never do another online therapy session”. However, there was also a general acknowledgment of the advantages and value of working online and a recognition of the need to develop online skills in an environment where it is becoming increasingly expected that therapists will be able to work effectively in this way. This includes continuity in therapy when the unexpected happens, such as, for example, a pandemic outbreak. Respondents’ comments relating to the benefits and advantages of online therapy included: seeing the value for younger clients who are more familiar with being online; online being more accessible for some clients (e.g., it cuts

down on travel time); and logistical ease and convenience for both therapist and client (e.g., faster to set up and finish sessions). As a counterpoint to comments that it is easier to work online, respondents also mentioned the increased difficulty of this way of working (“Requires more ability from both the therapist and the client”). Despite a clear preference from the respondents for being physically in the room with their clients, there was an acknowledgment of the flexibility, accessibility, convenience, and contemporary relevance of online therapy.

Following the coding of the three RQs, we generated axial codes and the overarching selective code. Through this we found that respondents experienced technological, spatial and relational challenges in transferring their clinical work to the online space during lockdown due to the pandemic. Although they prefer in-person clinical work, they are mostly willing to engage in the online space; and to do this well they expressed a need for comprehensive, guided experiential training and practice to develop skilful online therapeutic presence.

Discussion

At the beginning of the lockdown, our students were unfamiliar with working online with their clients. They had been seeing clients in person in the psychotherapy clinic at AIH and also in their community placements. Added to the stress of beginning to find out how to live in a pandemic, they were faced with suddenly needing to transition to providing therapy online. It is hardly surprising under these circumstances that many challenges were encountered. These challenges were perhaps exacerbated by negative perceptions of working online. Some students believed that therapy online was “not as good” or “not as effective” as therapy in person. We heard examples of students offering a fee reduction, giving as a reason that the online therapy would be inferior to in-person. Given that the assumption that online therapy is not as effective as in-person therapy is not evidenced by research, this may have arisen from fear of the new, from concrete thinking about what constitutes relationship, and from beliefs about definitions and boundaries of self.

We wondered how lecturers and supervisors might support students to move online and how to model changing practice. There were wider questions about how the profession of psychotherapy supports ongoing development. The psychotherapy profession has been at times a late adopter of change, and has a conservative cast around some key issues relating to educational developments. For example, entrenched views on the “therapeutic frame” have in some cases been slow to evolve under these changing and novel circumstances. Useful and well-informed guidelines that have developed from clinical practice over the decades can easily translate to becoming inflexible rules. Meister Eckhart’s (as cited in Symington, 2012, p. 395) words resonate here: “To regard as primary what is secondary is the root of all fallacy.” We consider, along with the common factors research findings (e.g., Duncan et al., 2010; Wampold, 2010), that what is primary in psychotherapy is the therapeutic relationship and how therapist and client work together within an ethical relationship in the interests of the client’s growth and wellbeing. In this regard, Scharff (2019) has noted that physical presence is less important than affect and imagination, and that closeness in the therapeutic alliance is engendered more by integrity and commitment than by literal physical proximity.

Although the therapeutic alliance is not compromised in the online space, there are clear challenges to negotiate in this medium. Technological difficulties, including glitches with internet connections and inexperience with technology, can result in a momentary or cumulative lack of connection between therapist and client. The effectiveness of therapy can suffer where there are technical difficulties or unfamiliarity with web-based communication (Poletti et al., 2020; Simpson & Reid, 2014). Beginning practitioners, such as our students, face particular challenges in providing therapy online. Aafjes-van Doorn et al. (2020) and Békés et al. (2020) found that less-experienced therapists suffer increased levels of self-doubt and anxiety when they work online, particularly those working at home with young children or other family responsibilities. It can be difficult for students to find a suitable space in their home in which to work and this becomes even more complex where they are balancing childcare and wider family responsibilities. These can impact on their capacity to be present and empathise with clients.

Being online for long periods, particularly with the stress load of a pandemic, leads to increased tiredness and fatigue, or, in the words of one respondent, being “Zoomed out”. Zerbe (2020) describes as “pandemic fatigue” (p. 476) the phenomenon brought about by the experience of living through a crisis that shakes one’s sense of safety, and produces feelings of insecurity, loss, disorientation, irritability, exhaustion, and feeling “unmoored” (p. 476). There are also the physical and psychological impacts of spending an increased amount of time in the online world. If sufficient non-screen activities are not included in the therapist’s day, then they are likely to suffer from disconnection and exhaustion. More time between and after sessions needs to be scheduled (Geller, 2020). Simpson and Reid (2014) note that therapists likely need to work harder online, for example, to compensate for sound problems or to actively convey empathy; and it takes time to learn the skills necessary for working online. In advice to psychotherapists, Essig et al. (2020) also emphasised the tiredness resulting from online therapy and noted that therapists have to work harder to capture and reflect nonverbal aspects of the therapy. Given this extra load of working online, an increased focus on self-care supports therapists to remain well and work effectively (Geller, 2020; Scharff, 2019).

While technical and spatial difficulties of being online were mentioned, the majority of responses spoke to the relational challenges of working online. Research shows that the essentials of the therapy process, including the therapeutic alliance, are maintained in online therapy (Fisher et al., 2020; Merchant, 2016). However, the findings of Scharff et al. (2020) that trainees rely more than experienced clinicians on nonverbal clues were borne out by our respondents. They mentioned that being physically in the room meant that it was easier to see the whole person and thus their body language and nonverbal communication. Mention was made of a stronger therapeutic alliance being possible in the room — including connection and intimacy — and that something is “lost” in not being in the physical presence of the other. Differences between new clients and existing clients were highlighted by a number of students, who pointed to better outcomes in online therapy with clients who they had previously been seeing in person. This raises an important issue in relation to the developing therapist and was echoed by other respondents, who referenced their current status as beginning learners. For example, one said that working in person is “crucial for my learning”. The reason given was that students are still learning how to feel and to attune in

the space together and that, according to them, this cannot be done online (“Sitting with a client and learning to feel and attune in the space together is my focus, which I can’t do online”). One respondent commented that the learning feels diminished by being online, while another acknowledged that with the right training they believed they would become effective in online treatment.

Our students had not previously delivered therapy online, nor had training for online therapy. Due to the short notice of our university closure during the lockdown, preparing students to deliver therapy online was carried out with urgency. In response to this, students have expressed a desire for comprehensive and guided experiential training and practice for online therapy. This includes specific guidance on online holding, how to stay grounded and present, advice on the spatial aspects of online therapy (setting up space, lighting, technology), how to ensure safety and privacy for clients, and exploring benefits, pitfalls, ethics, and boundaries in the online space. Mentoring from online-experienced practitioners is important to them, along with supervisors being more accommodating of online therapy and adjusting their supervision style accordingly. These expectations are borne out in the literature.

Merchant (2016) stresses the importance of professional development for practitioners delivering online therapy. With the right training, therapists without much experience can make the adaptations needed in communication and learn to work with the technology (Simpson & Reid, 2014). Important skills development includes developing an online presence (Geller, 2020) and epistemic trust (Fisher et al., 2020). Geller (2020) argues for the cultivation of therapeutic presence for the establishment and maintenance of effective therapeutic relationships, and for clinical training to support this cultivation of presence for online therapy. Guidelines recommended in the literature for transitioning therapists online include “ethical considerations and concrete issues related to the treatment settings and boundaries, for both traditional dynamic psychotherapy (Scharff, 2018), and protocol-based interventions” (Fisher et al., 2020, p. 4). McBeath et al. (2020) found that many therapists expected online therapy to become part of their core service to clients and that therapy training should include online working skills as a core subject. It has been found that therapists’ attitudes towards online therapy, and confidence in practising it, are increased by training and experience (Aafjes-van Doorn et al., 2020).

Limitations and Recommendations

Our survey did not differentiate between student year levels (ie., Master’s year one and Master’s year two). In retrospect, making this differentiation may have given a more granular picture of the specific stressors for each level of training. Nor did we elicit specific data on cultural and gender identifications, which may have brought useful dimensions to the meanings we have co-created from this research. A more specific demographic component to research in this area may yield useful insights for planning and policy. In particular a kaupapa Māori research methodology may have yielded more nuanced findings about the experience for Māori and Pasifika students. As it stands, there is a significant gap in the literature about the cultural implications of online therapy for tangata whenua and Pasifika populations (Classen et al., 2021).

However, within the horizon of uncertainty about the extent of the pandemic and the lockdowns ahead, we aimed to hear from our students as a single cohort, in order to support a quick response for the purposes of planning training for the next semester. This justified for us the reduced scope of the research in this instance.

While there is strong and consistent evidence that online therapy has equivalent outcomes to in-person therapy, the challenge is to translate this evidence into a change in the assumptions of service providers and consumers. Such a change requires us to understand and address the “factors of ambivalence... which pose a barrier to wider implementation” (Irvine et al., 2020, p. 120). To this end, we recommend that research-active and academic psychotherapists engage actively and collaboratively with the profession, through peak bodies, to encourage research-informed professional development and practice for clinicians. In addition, as our findings may be transferable to other tertiary institutions, we recommend further research into effective strategies for training psychotherapy and allied health students in online clinical delivery.

Conclusion

In the rush online during lockdown, our students had to rapidly come to grips with online therapy. Although they reported levels of interest in online communication at only about 65%, they rated their skill level higher. This rating suggested that students’ preferences, rather than their technical skill level, influenced their hesitance for working clinically online. Their perceptions of the levels of intimacy possible in online therapy were significantly lower than for in-person therapy. They found technological, spatial, and relational challenges in online therapy and expressed a need for comprehensive, guided experiential training and practice to develop online therapeutic presence. This finding is generally borne out by the literature. Although preferring in-person clinical work, the students are willing to engage in the online space and understand the push factors for the need to do this.

There is a significant emphasis in the literature on the disjunct between the outcomes evidence and therapist expectations. This is seen to be modified somewhat by training and experience in the practice of online therapy. Our psychotherapy curriculum had not previously incorporated training for online therapy, but we are integrating the suggestions from our students to provide relevant and comprehensive content for this mode of therapy. The need for this is evident in an environment of persisting and heightened uncertainty. Moreover, there is increasing recognition by both students and staff that online therapy is a critical growth area that provides increased flexibility, accessibility, convenience and contemporary relevance, and that therapists need to be skilled and competent to work in this way, beyond lockdowns.

During their transition to the online space — and as a result of their experiences and their engagement with research — students have generally reported an increased openness to working online. There are signs that initial antipathies are yielding to a willingness to enquire into the base of their own assumptions about differences between in-person and online therapy. Together we may be discovering how it is possible to be in person online.

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