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Patients' experiences of home-based psychotherapy via videoconference: A qualitative study

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ABSTRACT

The aim of this study is to explore adult outpatients' experiences with home-based psychotherapy via videoconferencing in a Danish mental health service. Participants found videoconferencing-based psychotherapy for preventive relapse sessions very useful, and they believed that it was possible to maintain a good therapeutic relationship via videoconferencing when they knew their therapist in advance. However, experiences with more in-depth psychotherapy are more unclear as some felt alienated and preferred other ways to communicate. In general, participants found videoconferencing-based psychotherapy to be less personal but worth considering when travel hassles outweigh the need for meeting in person.

Introduction

There are several barriers to accessing mental health services, such as long distance to services, patients having transportation difficulties, long waiting times and the need for social distancing, which recently happened during the COVID-19 pandemic (United Nations, 2020). Access to video consultations has the potential to break down these barriers (Bleyel et al., 2020; Chakrabarti, 2015). Evidence suggests that equal clinical outcomes exist between videoconferencing-based treatment and in-person treatment for depression, anxiety disorders, post-traumatic stress disorder and eating disorders (Berryhill et al., 2019; Chakrabarti, 2015; Fernandez et al., 2021; Norwood et al., 2018), and patients and providers are generally satisfied and find the services acceptable (Christensen, Moller, et al., 2020; Hubley et al., 2016). The therapeutic alliance in videoconference-based psychotherapy is, moreover, highly rated by both patients and therapists (Simpson & Reid, 2014; Stubbings et al., 2013).

While previous studies have focused on effectiveness and satisfaction measured using different questionnaires, few have used qualitative approaches to understand what satisfaction means for the individual. Qualitative studies may help to illuminate some of the barriers and facilitators experienced by patients to inform person-centred care, and more of these studies have been requested (Serhal et al., 2020). The few qualitative studies of home-based psychotherapy via videoconference exploring the patients' views show that it is an acceptable and workable way to receive treatment. Some had the option of flexible scheduling that permitted patients to take less time off from work (Ashwick et al., 2019), and some benefitted from more frequent contact with their therapist, which enhanced the patients' engagement with their treatment (Christensen, Wilson, et al., 2020). Others could choose for each session whether they wanted to use videoconferencing or attend in person, which eased access and enhanced the patients' sense of control (Hensel et al., 2020; Tarp & Nielsen, 2017). Patients also felt more comfortable being in their own homes (Ashwick et al., 2019; Christensen, Wilson, et al., 2020; Tarp & Nielsen, 2017). In general, patients found that it was possible to create a good therapeutic relationship, but some found it more impersonal and that communication was less intense than in-person sessions (Ashwick et al., 2019; Christensen, Wilson, et al., 2020; Frank et al., 2017; Hensel et al., 2020; Tarp & Nielsen, 2017). The studies included adult patients who were diagnosed with post-traumatic stress disorder (Ashwick et al., 2019), alcohol abuse disorder (Tarp & Nielsen, 2017), postpartum women with mood or anxiety symptoms (Hensel et al., 2020) and elderly patients diagnosed with depression (Christensen, Wilson, et al., 2020; Frank et al., 2017).

More studies that cover a wider range of diagnoses and settings are needed to support, clarify and enhance these findings. The aim of this

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study was to explore adult outpatients' experiences with home-based psychotherapy via videoconferencing in a Danish mental health hospital. Better understandings of this could lead to the development of higher-quality services and improved treatment by guiding therapists in their decision on when and how to offer this medium for therapy.

Methods

Study design

As this study explores participants' experiences, a systematic text condensation was used, which is a systematic thematic cross-case analysis. It is descriptive in its approach, presenting the experiences as presented by the participants (Malterud, 2012).

Research setting

In the Mental Health Service in the Region of Southern Denmark, the organisation that is responsible for psychiatric hospitals in the area, therapists have had the option to offer videoconferencing sessions in the outpatient services since 2015. It is fully up to the individual mental health professional to decide when and for whom they will offer this. Treatment interventions follow national clinical guidelines (Danish Health Authority, 2021). It is diagnosis specific and consists of a predefined number of sessions that encompasses assessments, psychoeducation, psychotherapy, supportive conversations, medication management and preventive relapse sessions. Any of these sessions can be converted to a video session if the therapist and patient agree. Psychoeducation, psychotherapy, supportive conversations and preventive relapse sessions are typically given by postgraduate mental health nurses with continuing education and in-service training in cognitive therapies. Outpatient clinics in the Mental Health Service are distributed across the region, with specialists residing in the four major cities. Most patients living in rural areas in the region will have less than a one-hour drive to a clinic. However, some patients live on small islands and are dependent on ferries, which could increase traveling time further.

Psychotherapy via videoconferencing will prospectively be referred to as video conversations, since the latter is the colloquial term used with patients.

Procedure

Mental health nurses working with adult (20–70 years) outpatients asked their current patients with whom they had used video conversations if they were interested in being interviewed for research about their experiences. If the patient consented, their contact information was given to a researcher that contacted them by phone and explained what the interview was going to be about and asked if they still wanted to participate. Then a time for the interviews was scheduled. All interviews were conducted before COVID-19 restrictions, where the adoption of video conversations was low.

Participants were interviewed using a semi-structured interview guide, either via videoconference or telephone. The interview guide was developed to answer questions about how and why video conversations were used, how participants felt about communicating via video and how the personal contact was experienced (see Appendix A). The reason for interviewing participants via videoconference was to make the experience partially similar to video contact with their therapist, thus enhancing the participants' memory about video contact, and sharing the experience with the interviewer. It also had a practical reason in that it was easier for the participants to participate and enhanced their anonymity. The videoconference system Cisco Jabber was used, which is the same system they used with their therapist. Two of the participants were interviewed via telephone. One of them felt uncomfortable using videoconference, and the other had deleted the video program after ended treatment course.

To protect patients' anonymity and to comply with in-house regulations, interviews were not audio recorded. During the interviews, the interviewer took notes and included as many quotes as possible. To validate the meaning points, the interviewer would go through the points that were written down together with the participants to make them validate their statements. Right after the interview, a detailed written account was completed. In these accounts data were reordered and grouped into aspects that speak to a given issue.

Data analysis

After all interviews were finished, all of the written accounts were read to get a general impression of the whole and to establish preliminary themes. Then the accounts were systematically reviewed line by line to identify meaning units. The meaning units were then classified and sorted into the preliminary themes called code groups (Malterud, 2012). These steps were initially done by the first author. Subsequently, the second and third author reviewed the accounts, meaning units and preliminary themes, and then the code groups were discussed among all authors. The meaning units of the code groups were then sorted into subgroups and analysed by reducing the content into a condensate which is an artificial quotation maintaining original terminology used by the participants. During this process, themes were adjusted according to the evolving understanding. Starting with the condensates and quotations, concepts and descriptions about the participants experiences with video conversations grounded in the empirical data were developed. Accounts were then read again to validate that the synthesis still reflects the original context (Malterud, 2012). The first author drafted the analysis while the second and third author reviewed it and gave feedback for revision of the themes.

Researcher reflexivity

The first author conducted the interviews. She has a background in Public Health and no clinical experience in the field of psychiatry. She may therefore be less capable of understanding certain patient issues. This position may also have been a strength, since it prevented the interviewer from knowing too much about the procedures, culture, and the participants narratives in advance. None of the authors have had any involvement in the participants' treatment course and did not know any of the participants beforehand.

Ethical considerations

The study was performed in accordance with the ethical principles of the Helsinki Declaration. Formal participant consent was given at the beginning of an interview, after the interviewer had explained the purpose of the research, how data was going to be collected and used, and the patients' rights as participants (see Appendix B).

According to the Regional Committees on Health Research Ethics for Southern Denmark, approval is not needed since the study is based on interviews and does not affect patient treatment (email correspondence dated 22 Feb 2016; the decision is filed under S-20162000-29). An approval of data storage was granted from the Danish Data Protection Agency through the Region of Southern Denmark.

Results

Participants

Seven patients participated. Of them, four used video conversations for preventive relapse sessions. These are sessions that follow a previous treatment course. Previously learned tools to deal with mental problems, for example negative thoughts, are discussed in regard to the patient's new situation. The four participants had previously been diagnosed with a depression and undergone a treatment course. In connection with a

pregnancy, three of them were assessed by their general practitioner to be in risk of relapse and referred to the Mental Health Service. The last person had a comorbid borderline personality disorder and had been in a prolonged therapy course that was to end, but due to being pregnant she was granted additional preventive relapse sessions. The last three participants were in a treatment course where they received psychotherapy for an anxiety disorder (see Table 1). Treatment courses with preventive relapse sessions are typically 12 sessions, personality disorder typically 56 sessions, anxiety disorders typically 15 sessions and post-traumatic stress disorder typically 34 sessions. All the participants were familiar with videoconferencing before using it in treatment. They were used to information technology, but their skills varied. Five installed the program themselves, and two had a family member helping them.

Findings

From the analysis, we derived four themes: 1) Easier everyday life, 2) strained meetings, 3) diverse sense of presence, and 4) attention to symptoms.

Easier everyday life

All the participants who used videoconference for preventive relapse sessions found that after having tried it, they liked it. They thought that it was possible to have meaningful conversations while obtaining the benefits of staying home. They could save at least 30 min of traveling to the clinic each way and time used on preparation, such as taking a shower. Since they all had small children, they emphasised that it made their everyday lives easier because the saved time could be spent with their families instead. One of these participants who summarised the benefits of using video conversations said:

> It's easier to use and makes everyday life work. Then I don't have to spend half a day on it. It's also easier when you've got a baby; it's better not to have to spend an hour on transportation.
>
> (Participant 2)

Another mentioned that: ‘when there is no transportation back and forth, you can easily get back to your everyday life and quickly get your thoughts away from the treatment again’ (Participant 4). They felt that they spend less resources on receiving treatment which made it easier and more relaxing attending sessions. One participant had experienced being called up by the therapist while still sleeping and then being able to get up and turn on the videoconference program, and another mentioned that it had been possible to meet despite of having a cold.

Strained meetings

Of the participants who used videoconferencing for psychotherapy, all found that they were not in favour of it. Two of the participants did not like to use video and believed that a telephone call would have been equally beneficial. They felt alienated by seeing themselves in the call and being on a camera. One of the participants explained:

> I do not like to watch myself on a video and prefer a telephone conversation. When using video conversation, I felt nervous and insecure. I feel uncomfortable being called up that way. So, I didn't attain what I wanted. I did not feel I could speak freely. I think being offered video conversations is a good thing, but I discovered that I didn't like it.
>
> (Participant 7)

This participant disliked video conversations as they made him nervous and uncomfortable, and thus intensified his anxiety. He did not like to use video conversations in other contexts either. The therapist had suggested using video since he lived far away from the clinic, but after having tried it, they decided to switch back to in-person sessions. The other participant had positive experience with video conversations from work but did not like using them therapeutically. She found that they could talk about the same things, but she did not like being on a camera. She believed that it was independent of how well she knew her therapist. They had established the video contact because the participant's symptoms sometimes made it impossible for her to attend in-person sessions, and the therapist thought video calls were superior to telephone calls. She accepted the video modality as a back-up plan to in-person sessions in the beginning and later as the planned meeting format. It gave her calmness and less unease when a video conversation was planned instead of an in-person session.

The last participant was initially very favourably disposed towards using videoconferencing, which she regularly engaged in with friends and family via her smartphone. She had asked the therapist if they could use video conversations every second time so she could save transportation costs. The therapist had agreed, but they had not matched their expectations, and the participant found that the therapeutic conversations were not similar in structure to the usual in-person sessions, since the therapist did not allow a similar amount of time for the video sessions. Additionally, they always had to be scheduled in the morning, as opposed to in-person sessions, where the participant tended to feel indifferent. This made the video conversations seem unimportant and impersonal: “you don't have the time to talk about that many things when there is not enough time set aside” (Participant 6). This lowered the participant's engagement in the conversations, and she explained that she prospectively only wanted to use in-person sessions.

Diverse sense of presence

All of the participants in preventive relapse courses had met their therapist prior to having their first video session. Two of them explicitly stated that they believed that knowing their therapist beforehand was beneficial. These participants also felt that the video sessions were less intimate and personal and preferred in-person sessions if all other things were the same. They explained:

Table 1
Participant characteristics.

ID	Gender	Age group	Diagnosis	Type of treatment received over video	Number of video sessions (VC)	Device used for video sessions
1	Woman	20's	Previous depression	Preventive relapse	5 last sessions were VC	iPad
2	Woman	30's	Previous depression	Preventive relapse	All sessions were VC	PC
3	Woman	20's	Previous depression	Preventive relapse	First session was in-person, the rest were VC	Tablet
4	Woman	30's	Previous depression and borderline personality disorder	Preventive relapse	4–5 sessions were VC	Tablet
5	Woman	50's	Post-traumatic stress disorder	Psychotherapy	5 last sessions were VC	PC
6	Woman	30's	Anxiety disorder	Psychotherapy	2–3 sessions were VC. Had alternating VC and in-person	Smartphone
7	Man	50's	Anxiety disorder	Psychotherapy	2–3 last sessions were VC	PC

> It's okay to be in the same room and have a natural presence. (…) You sense more when you're in a room with one another. You can just find a brochure or book and lend it to each other. It's easier to initiate or leave a conversation by engaging in chitchat than when talking over video. (…) When using video communication, you have to sit and wait for each other and this makes the conversation more formal. Meeting in person makes you feel less afraid of interrupting each other. However, those are trifles. It doesn't mean you shouldn't talk over video. It's just nicer to meet [in person].
>
> (Participant 1)

> These are tough issues that have a strong presence in you. There's a lack of personality, or contact, that you don't get on Jabber [the videoconference app], but you do get when you are sitting there [in person]. It's easier for me to dismiss things when I haven't seen you.
>
> (Participant 4)

The participants experienced that the intimacy they felt with their therapist affected how important they felt the conversation was. One of them mentioned that it was easier to remember what they talked about in person, and the other mentioned that she had more confidence in decisions taken with the therapist in person than over video. Even though the sessions felt less personal, one of them mentioned that they did talk about the same things over video as in person.

The two other participants did not think that the video format changed their contact with their therapist. One of them, who had known her therapist for two years before having a preventive relapse course with all her sessions over video, explained:

> I was sceptical at first because I've never been good at telephone conversations, so I wondered if it would be the same over video, but it's really great when you see the person you're talking with. (…) I was initially afraid that we would lose our personal contact and I wanted to meet in person, but after having tried it, I don't consider it a problem.
>
> (Participant 2)

The other participant had only met her therapist once before having the rest of her sessions over video. She thought it was okay talking over video and felt that she could relax more at home. She highlighted the value of seeing each other as opposed to what is possible in a telephone conversation:

> It is good that you can see the face. That makes it impossible to put up a facade. That's really nice. When you can see the face, the therapist can see if what you're saying is also what you mean, and that's important if you're a person who finds it difficult to be candid.
>
> (Participant 3)

She felt that seeing each other improved the communications and enabled the therapist to assess the participant's situation better and hence intervene more appropriately, e.g. when a patient found it difficult to open up to their therapist. Another participant, who could be hot-tempered when she had a psychological crisis, believed that seeing her therapist's face, as opposed to only hearing the therapist's voice, could make her calm down easier, since she would be able to read the therapist's attitude better.

Attention to symptoms

All the participants had been in a regular dialogue with their therapist about using video for therapy, and they felt comfortable and open discussing this. However, two of the participants, who used video conversations for preventive relapse sessions, speculated whether they would always feel comfortable and emphasised that they think the therapist should be attentive to the patients' severity of symptoms before offering it to patients. One participant elaborated:

> If you are very depressed, then sitting at home isn't so great. When you're depressed, then you feel like just staying at home, but once you've been outside, then it feels really lovely to have gone outside for a bit. The therapist should, therefore, assess whether the patient would benefit most from a meeting at the clinic or whether it would be just as good if they [the patients] sat at home.
>
> (Participant 3)

The participant worried that it would be easy to accept a video conversation during a period of depression even though leaving one's home would have a therapeutic effect. The other participant, who was diagnosed with a borderline personality disorder, worried that early introduction to video conversations would have had a negative effect on the relationship with her therapist and elaborated on this:

> It is important that the therapist assesses whether the patient is ready to use it. I would not be able to assess it myself, so if the therapist offered it, I would think that it was something I had to do. And it would be difficult to say no if I was unwell. If I had been offered video conversations too early, I would have accepted it but not collaborated. I imagine that I would have felt rejected if I had been offered video conversations early on in my course of treatment.
>
> (Participant 4)

To avoid the feeling that the therapist used video conversations to lessen their contact, it was important for this participant that the therapist should only introduce video conversations once the participant and therapist had succeeded in building a strong relationship of trust. The participant added:

> It's easy to turn off [the video app] if you get angry with your therapist, if you, for instance, do not agree [with the therapist] when you're an impulsive person like me. At the clinic, I feel forced to relate to the situation and the other person, and it's less easy to get up and walk out the door.
>
> (Participant 4)

She believed that it would be difficult to build a relationship of trust over a videoconference, among other things, because of the limited non-verbal language:

> There is significantly less eye-contact. The contact is not the same when sitting at home. The overview of the person you are talking with is smaller than in person and that can create the feeling of insecurity since you cannot read the other person as well and hence start placing different motives behind the other person's actions. (…) In addition, the therapist cannot see if I 'close up' over video. (…) I don't think you can see this over video, but in the [video] conversations we have had, I actually feel fine so it [closing-up] has only happened once where my therapist could tell based on my verbal story
>
> (Participant 4)

The participant worried whether negative incorrect interpretations of the therapist's actions would be noticed and appropriately corrected over video by the therapist, even though the participant had experienced that the therapist was able to do so. She was also satisfied with the video sessions she had had with her therapist, whom she had known for years before they started doing video sessions.

Discussion

The present study investigated adult outpatients' experiences with home-based psychotherapy via videoconferencing. Participants found

video sessions very convenient and useful for preventive relapse sessions and believed that it was possible to maintain a good therapeutic relationship via videoconferencing when they knew their therapist in advance. However, many also found that video sessions were less personal than in-person sessions, and some few preferred other ways to communicate.

The therapeutic relationship is considered one of the most important aspects of clinical improvement in psychotherapy (Horvath et al., 2011). Bordin (1979) has described this as a working alliance that consists of the patient's and therapist's ability to establish common goals, agree upon tasks and create a bond. In the present study, it was found that satisfaction with preventive relapse sessions were high. The sessions are sometimes referred to as follow-up sessions, and these are sessions where typically only issues that have previously been discussed are taken up. It may, therefore, be easier to establish common goals and agree upon tasks since the patient already has experience with it. It may also be that in these sessions less intimacy is required. Preventive relapse and follow-up sessions via videoconference seems, therefore, to be very acceptable as noted by patients in other studies (Christensen, Wilson, et al., 2020; Frank et al., 2017; Tarp & Nielsen, 2017).

Furthermore, it was found that some participants found video conversations more impersonal, and others did not find the sessions significantly different from meeting the therapist in person. These differences are commonly found in other studies as well (Ashwick et al., 2019; Christensen, Wilson, et al., 2020; Tarp & Nielsen, 2017) and indicate that it is individual how video consultations will affect the therapeutic relationship. Some of the participants in the present study believed that it was easier to establish a good relationship with their therapist in person and that it, therefore, is important to know the therapist before starting videoconferencing-based psychotherapy. This is found in other studies as well (Ashwick et al., 2019; Frank et al., 2017; Tarp & Nielsen, 2017). However, patients who never meet their therapist in person have nevertheless been satisfied and able to create a trusting relationship with their therapist (Simpson et al., 2015). These were patients living so far from the clinic that in-person sessions were difficult to achieve, and this might have motivated the patients to making the distance-therapy work.

In the present study it was also found that it is important that the therapist considers whether the patient would benefit from leaving home before video sessions are offered. In a randomised controlled trial of patients with depression receiving all their psychotherapy either via videoconference from home or in person at the clinic, small differences existed on depression score in favour of in-person sessions (Luxton et al., 2016). This suggests that for the majority of patients being treated for depression, meeting in person at some point may be beneficial. This may be related to the fact that people with depressive symptoms tend to isolate themselves and not function well in social contexts (Brown et al., 2011). It is therefore important to consider whether the use of video conversations would lead to further isolation, which appear to be dominant with more depressive symptoms (Brown et al., 2011).

Other studies have suggested that patients with anxiety symptoms feel more relaxed and in control at home and hence find videoconferencing very useable (Ashwick et al., 2019; Tarp & Nielsen, 2017). This was not the case in this study which underpin the notion that comfort with videoconferencing is not dependent on diagnosis. Instead, it appeared as if the patients' initial comfort with video conversations predicted how comfortable they would be during their first sessions. Comfort and preference might change with experience as found in Stubbings et al.'s (2015) case description of a patient with severe obsessive-compulsive disorder who initially was resistant to use videoconference but over time started to prefer it.

Implications for practice

This study supports the notion that therapists should consider offering video conversations when patients find it challenging to access the clinic. It is convenient and can ease everyday life for patients. It may lower the probability of late cancellations and can be used to gain more information about a patient when they have a crisis if used instead of a telephone call. It is important to be aware of how the patient might respond to being offered a video session and whether it could affect their therapeutic process. Regular dialogue about the video experience may reveal the inconvenience.

Study limitations

This sample consisted of seven participants who used videoconferencing-based therapy differently. They had different diagnoses, used it for preventive or regular therapy, and they had different therapists. It was thus possible to show variations of the phenomena. Nevertheless, including more participants would extend the field further and clarify patterns and associations.

Most of the interviews were conducted via videoconference. While this may have increased the participants' memories of their experiences, it might also make them feel less comfortable, and hence less open, since it can be harder to build a relationship of trust during a screen meeting. Interestingly, observations from the interviews showed that the participants appearances on screen underpinned their stated opinions about the intimacy during video sessions.

Moreover, the interviews were not recorded which reduced rigour in the data collection. However, participants did validate their statements insuring interpretive validity (Maxwell, 1992). Further, audio-recorded transcripts and interview scripts written directly after an interview have shown to be comparable in the detail captured (Rutakumwa et al., 2020).

Conclusion

As video consultations gain acceptance in mental health care systems, it is important to broaden our understanding of patients' experiences and perspectives on these services. This study found that adult outpatients find video consultations convenient and useful for preventive relapse sessions. These are sessions that follow in-depth psychotherapeutic courses which means that the patients already have experience with psychotherapy. In continuation, it was found that patients are more comfortable establishing a trusting relationship in person than over a video conversation. When the patients know their therapist, it still differs how personal they will find the video sessions. Ultimately, initial discomfort with videoconferencing does not appear to change after a couple of sessions. Based on this study, mental health nurses should feel confident in offering video consultations to patients that they already know. Future research should focus on how different communication and interaction skills affect the therapeutic relationship and felt intimacy in psychotherapeutic video sessions.

Declaration of competing interest

None.

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Appendix A

Interview guide [translated from Danish]

What is your general experience with the Mental Health Services?
How many times did you use video conversations?

Why did you choose to use video conversations?
Did you meet in person before the first conversation?
What do you believe is your therapist's role in offering video?
How did you find talking over video?
Do you experience differences in the way you converse when over video?/What differences?
What are your thoughts about the personal contact over video?
How important is the personal contact?
What advantages did you experience?
Is there something that you do not think works over video?
Are there particular conversations that do not work over video?
How did you experience the videoconference app/the technical aspects?
Is there anything you think could be different?
Is there anything you would like to add?
Is there anything that you find important that I did not ask about?

Thank you for your participation!

Appendix B

Consent [translated from Danish]

Was given verbally before the interview

Purpose: To explore the quality of video conversations, I will be talking with different users and make an overall analysis of how they experienced video conversations, what advantages they experienced, and whether they think something could be improved.
Data collection: I write down the things you tell me, and this will be used for the analysis. I will not be recording you.
Rights as participant: You participate anonymously. The only thing I know about you is your name, your phone number and that you have had at least one video conversation with your therapist. I will delete this information upon your participation. Your therapist will not be notified whether you participate or not. Participation does not affect your treatment course. Participation is voluntary, and you should only tell the things you want to tell. You are welcome to contact me afterwards if you have questions or would like to withdraw your statements.

Do you have any questions?
Would you like to participate?

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