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PSYCHOTHERAPY DURING SOCIAL ISOLATION CAUSED BY COVID-19 – THERAPISTS’ AND CLIENTS’ PERSPECTIVES

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COVID-19
remote psychotherapy
online psychotherapy

Summary

Objectives: The article presents the results of a survey conducted on a group of 155 respondents — 54 psychotherapists and 101 psychotherapy clients. The subject of the study was their attitude towards remote psychotherapy in a situation of social isolation, which forced them to conduct therapy sessions remotely. The study also looked at the perception of difficulties and advantages of remote psychotherapy and changes in the therapist-client contact in such therapy.

Methods: The research was conducted in the form of an online questionnaire sent by e-mail and posted on the profiles of thematic groups on the Facebook platform.

Results: The vast majority of respondents continued psychotherapy during social isolation, despite the fact that most of them had not had contact with this form of therapeutic work before. The most frequently chosen method of holding sessions by both psychotherapists and clients was contact via an audio-video connection, less often by telephone. The greatest difficulty indicated in both of these forms was the lack of direct contact with the interlocutor. However, psychotherapists pointed out that remote psychotherapy may be more convenient for the client than traditionally conducted in direct contact. Most of the respondents agreed with the statement that during social isolation they became convinced about remote psychotherapy, although they do not consider it to be a better form than the traditional one.

Conclusions: Social isolation caused by the SARS-CoV-2 virus has forced a sudden change in the form of psychotherapeutic work in Poland, for which most of its participants were not prepared. The results showing the most important limitations and advantages of remote psychotherapy may be a guide to educating future generations of psychotherapists, who — as the current situation shows — must also be prepared for the form of remote assistance.

Introduction

The article discusses the results of a study aimed to identify the ways of providing psychotherapy as well as the reactions to them in the first weeks of social isolation associated

with the COVID-19 pandemic. The lockdown in Poland, introduced by the government in March and April 2020, noticeably changed the possibilities of providing psychotherapy. The previous negative evaluation/opinion of some psychological associations on the use of remote psychotherapy required reconsideration and issuance of new guidelines, adequate to the situation. On March 16, 2020, the Board of the Psychotherapy Research Section of the Polish Psychiatric Association (PTP) issued recommendations concerning the work of psychotherapists and supervisors in an epidemiological situation, advising them to limit direct contact to a necessary minimum. The PTP website has published a statement in which it affirmed that it is acceptable to conduct online therapy during the pandemic in cases of patients in long-term therapeutic care. The authors of the entry, aware of the controversies sparked by this form of therapy, emphasized that the pandemic situation is a justified exception, and relevant institutions should make every effort to ensure that online therapy is available during the epidemiological threat. At the same time, it was pointed out that online psychotherapy of first-time patients is only possible if, due to the patient's condition, the start of treatment cannot be postponed [1]. Similar to the PTP, other psychotherapy associations involved in different models of therapy referred to the PTP recommendations or formulated their own guidelines, albeit similar in content [2]. One of the few exceptions was the Polish Association for Psychodynamic Psychotherapy, which strongly recommended its members to work with clients in direct contact [3].

Although the first references to the use of remote tools in psychotherapy appeared as early as in the 1950s [4], until recently, its effectiveness and related ethical issues were fiercely discussed amongst its proponents and sceptics. Initially, the debate was focused on providing assistance in the form of letters, e-mails, or discussion forums [5] but as technology developed, synchronous psychotherapist-client contact also became a possibility. The number of international publications on online psychotherapy has systematically increased due to its growing popularity, especially in highly developed countries with ubiquitous access to the Internet, such as the United States, Great Britain, Norway, Canada, or Sweden. In the United States, this phenomenon has become so popular that separate codes of ethics for e-therapists have been established [6].

In Polish literature, the concept of e-mental health, *i.e.* using information and communication technologies in treatment, appeared at the beginning of the 21st century, [7] and in 2008, the first attempts to study this phenomenon in psychotherapy were made [8, 9]. Polish researchers have addressed topics such as the ethical issues of online psychotherapy and the lack of legal regulations in this area [6], cyberspace-specific conditions of online psychotherapy that may disrupt its course and effectiveness [10], or the differences in preferences and attitudes toward online help between psychotherapists and clients [11]. In 2017, Wojciech Drath and Szymon Nęcki conducted a survey among Polish psychotherapists who are members of the Psychotherapy Research Section of the Polish Psychiatric Association, regarding the attitudes towards the phenomenon of online psychotherapy [12]. Although its results indicated that the majority of respondents (77.4%, $n = 193$) believed that remote psychotherapy is acceptable in exceptional cases, some respondents were still completely against this form of practice. In

2017, only 12.2% of the psychotherapists surveyed were willing to use online psychotherapy as the sole route of contact with clients, and 24.9% would not consider conducting online psychotherapy under any circumstances. At that time, 32% of the surveyed psychotherapists had experience in conducting psychotherapy by remote methods, while as many as 68% had no such experience at all [12]. At that time, no one could have expected that just three years later the social situation would force the introduction of remote psychotherapy in order to adapt to the requirements of a global epidemic. It is, therefore, worth noting that studies and publications on online psychotherapy that have emerged before March 2020 only considered remote psychotherapy as a potential choice, and not the only possible solution.

The research that forms the basis of this article was conducted in April and May 2020. It took the form of a Google Forms online questionnaire sent to participants via a link in an e-mail. The questionnaire was also made available on the personal profiles of psychotherapists in Kraków and Gdańsk as well as psychotherapy thematic groups on Facebook. This approach ensured the anonymity of the collected data. Personal data was not processed by the authors. The questionnaire was addressed to psychotherapists and psychotherapy clients.

The study was exploratory in nature. Its aim was to find out the current attitudes of Polish psychotherapists and clients towards remote sessions. The researchers attempted to recognize both the difficulties of remote contact during therapy sessions, as well as the possible potential of this form of contact between therapist and client.

Method and research sample

The survey consisted of 22 questions, with the first one prompting the participant to identify whether they are a therapist or a client. The next ones concerned demographic variables (gender, age), the length of professional work experience and the represented psychotherapeutic paradigm as well as the clients' education. Depending on which version of the survey was chosen, some of the questions differed slightly (*e.g.* the question for the psychotherapist was "In which model of psychotherapy do you work?" while its counterpart for the client was expressed in the form of "Which model of psychotherapy do you use?" or "How long have you been working as a psychotherapist?" versus "How long have you been in psychotherapy?"). The next questions were related to how and where the sessions were held and previous experiences with remote sessions.

Remote psychotherapy was classified into two categories: as psychotherapy over the phone and as online psychotherapy, specifying that online therapy refers to the synchronous form in real-time audiovisual contact made possible using videoconferencing tools such as Skype, Zoom, Messenger, or Google Meet, excluding asynchronous ones such as e-mail or chat, which, although some researchers have classified as remote psychotherapy [13-15], were not considered in this study.

In the questionnaire, we asked about the difficulties and positive aspects of such sessions, the differences in therapist-client contact during remote sessions compared to face-to-face

sessions, the intensity of the topics discussed and related emotions, and the feeling of trust in the remote form of sessions. The last question was open-ended and gave respondents the opportunity to comment on issues that they felt were important for remote psychotherapy but were not covered in the survey questions.

The survey initially had 175 participants. 20 surveys were excluded from the analysis because they involved respondents who had suspended (17 clients and one psychotherapist) or completely terminated (2 clients) psychotherapy with the onset of social isolation. When it came to the question of specific forms of remote psychotherapy, the sample size was further reduced, since not all respondents have experienced it. Responses from these individuals were excluded from the analysis. Fifty-four (34.8% of the total respondents, $n = 155$) of the respondents were psychotherapists of varying seniority, practising in a variety of psychotherapy models. In order to obtain the greatest possible heterogeneity, the group of psychotherapists was not limited to those certified by Polish psychotherapeutic associations. The demographic characteristics of psychotherapists are consistent with the gender proportion and professional experience of Polish psychotherapists presented in the research of Suszek, Grzesiuk, Styla and Krawczyk, whose studies have shown that psychotherapy in Poland is mainly conducted by women (80%), with an average of 9.8 years of experience (Table 1). [16]

Table 1. Characteristics of psychotherapists surveyed ($n = 54$)

CHARACTERISTICS	n	%
DEMOGRAPHIC CHARACTERISTICS		
Gender		
Female	46	85.20
Male	8	14.80
Average age in years (SD)	40.44	(9.77)
Age in groups		
25–35 years	19	35.20
36–55 years	32	59.30
56 years and over	3	5.60
WORK EXPERIENCE		
Seniority		
1–5 years	22	40.70
6–10 years	9	16.70
11–20 years	19	35.20
21 years and over	4	7.40
Therapeutic approach		
Integrative	17	31.50

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Psychodynamic/psychoanalytic	12	22.20
Cognitive-behavioural	10	18.50
Systemic	6	11.10
Humanistic-existential	5	9.30
Other	4	7.40
Total	54	100.00

Respondents who chose the customer version of the survey comprised a group of 101 individuals (64.7% of the total respondents, n = 155) (Table 2).

Table 2. **Characteristics of surveyed customers (n = 101).**

CHARACTERISTICS	n	%
DEMOGRAPHIC CHARACTERISTICS		
Gender		
Female	91	90.10
Male	9	8.90
Other/Don't want to specify	1	1.00
Average age in years (SD)	29,90	(7.65)
Age in groups		
19-24 years	31	30.70
25-35 years	41	40.60
36-55 years	28	27.70
56 years and over	1	1.00
Education		
University degree	64	63.40
Studying	28	27.70
Secondary	9	8.90
Duration of psychotherapy		
<1 month	1	1.00
1-6 months	14	13.90
7-24 months	38	37.60
25-60 months	32	31.70
>60 months	16	15.80
Total	101	100.00

Results

The mode of delivery of sessions and previous experience of remote contact

While the social isolation associated with COVID-19 prevented face-to-face contact between psychotherapists and clients (as per government recommendations in Poland from mid-March 2020 to the end of May 2020), remote psychotherapy, enabled by online communication tools and telephone connections, became a helpful solution.

Most of the psychotherapists conducted online sessions via audiovisual connection (Skype, Messenger, Zoom, Google Meet, *etc.*). This form of session delivery was also chosen by the vast majority of clients. Many psychotherapists opted for a mixed form, with some clients meeting virtually through an audiovisual connection and others talking on the phone. Some respondents in this group conducted some sessions in a traditional, face-to-face form (Table 3).

Table 3. Choice of psychotherapy form by psychotherapists and clients during social isolation caused by the SARS-CoV-2 virus

Form of psychotherapy	Participants			
	psychotherapists		clients	
	n	%	n	%
Exclusively via video connection (Skype, Messenger, Zoom, Google Meet, <i>etc.</i>)	26	47.30	76	75.20
Exclusively via telephone call	2	3.70	18	17.80
Exclusively through direct contact	0	0	7	6.90
With some of the clients remotely, with some of them in direct contact	7	14.80	–	–
With some of the clients via video connection, with others on the phone	19	35.20	–	–
Total	54	100.00	101	100.00

The vast majority of respondents in both groups had no experience of telephone sessions, as stated by 47 psychotherapists (87%, $n = 54$) and 96 clients (95%, $n = 101$). In the case of audiovisual sessions conducted online using Skype, Messenger, Zoom and other platforms, the responses in the two groups differed: the majority of psychotherapists have had previous experience with this form of session (36 respondents – 66.7%, $n = 54$), while only 15 clients (14.9%, $n = 101$) have participated in online sessions before the isolation.

33 of the surveyed psychotherapists (61.1%, $n = 54$) reported that fewer people wanted to start therapy during the pandemic, 13 psychotherapists (24.1%) noticed no change, while 7 respondents in this group (13%) noted that more people wanted to start therapy during social isolation.

The absolute majority of clients (92 respondents – 91.1%, $n = 101$) attend remote sessions from their homes. This also holds true for the majority of psychotherapists (35 re-

spondents – 64.8%, n = 54), while 13 work from an office (24.1%), and 6 work partly from home and partly from an office (11.1%).

Difficulties and positive aspects of remote therapy

When answering the question regarding the difficulties with having therapy sessions over the phone and online, both groups of respondents were able to choose more than one answer.

25 of the surveyed psychotherapists had never conducted psychotherapy over the phone and were therefore excluded from the percentage analysis of the statements about this form. Among the clients, 59 respondents have never participated in telephone psychotherapy sessions and thus they were also excluded from the percentage analysis. Both groups of respondents stated the lack of eye contact and the lack of direct contact as the most frequent inconveniences in having sessions over the phone. Additionally, there were concerns amongst the psychotherapists that the clients may not be provided with sufficient intimacy during conversation. This was also evident in the clients’ statements mentioning the difficulty of maintaining intimacy in their residential settings (Table 4).

The study has shown that this type of remote psychotherapy also has positive aspects. The most favourable aspect of conducting psychotherapy over the phone is that it saves time by removing the need to commute (according to more than half of the respondents). The 7 answers given by the psychotherapists indicate that the telephone allows for more openness in contact with the client than traditional face-to-face psychotherapy, which is confirmed by the clients who admit that it is easier for them to open up to the psychotherapist over the phone (11 answers) (Table 4).

Table 4. Difficulties and positive aspects of telephone therapy from the perspective of psychotherapists and clients (n_{psychotherapists} = 29, n_{clients} = 42)¹

	Number of responds2			
	Psychotherapists		Clients	
	n	%	n	%
DIFFICULTIES				
Lack of eye contact	17	27.00	13	15.70
Lack of direct contact	17	27.00	26	31.30
Housing conditions that do not provide sufficient intimacy	16	25.40	17	20.50
Difficulty concentrating	7	11.10	12	14.50
Poor connection causing interference	6	9.50	6	7.20

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¹⁾ The sample size is smaller since only some of the respondents had experience with the form of therapy studied. The table presents the results for the multiple-choice question, so N and % refer to the number of answers given, not the number of observations (respondents).

No apparent difficulties	0	0.00	9	10.80
Total	63	100.00	83	100.00
POSITIVE ASPECTS				
Time saved in travelling to therapy location	16	31.40	26	70.30
More openness in contact	7	13.70	11	29.70
Possibly more convenient form for the client	17	33.30	–	–
Access to specialists for a larger group of people	11	21.60	–	–
Total	51	100.00	37	100.00

As two of the psychotherapists among the respondents do not provide this form of remote therapy, they were excluded from the percentage analysis of responses to questions concerning difficulties presented by online audiovisual sessions. In both groups of respondents, the greatest number of answers concerned the discomfort of not having direct contact. The psychotherapists were also worried that the client might not have sufficient intimacy during the conversation (Table 5).

Both groups of respondents considered the biggest advantage of online psychotherapy via instant messaging to be saving the time spent on travelling to the office. More than half of the responses given by the psychotherapists conducting psychotherapy over the phone indicate that this form of psychotherapy can be more convenient for the client. 22 responses given confirm this form of therapy as more accessible to a larger group of clients than the traditional one, and according to 13 responses, the psychotherapists perceived greater openness in online contact with their clients. 19 responses of the surveyed clients indicate that they feel safer and more comfortable in their own homes or other places where they have online therapy sessions than in their psychotherapist's office, and in 18 responses the respondents mention that it is easier for them to open up to the psychotherapist online (Table 5).

Table 5. **Difficulties and positive aspects of audiovisual therapy from the perspective of psychotherapists and clients ($n_{\text{psychotherapists}} = 52, n_{\text{clients}} = 83$)²**

	Number of responds ²				
	Psychotherapists		Clients		
	n	%	n	%	
DIFFICULTIES					
Lack of direct contact	33	31.70	45	32.60	
Housing conditions that do not provide sufficient intimacy	26	25.00	23	16.70	

table continued on the next page

²⁾ The sample size is smaller since only some of the respondents had experience with the form of therapy studied. The table presents the results for the multiple-choice question, so N and % refer to the number of answers given, not the number of observations (respondents).

Poor connection causing interference	25	24.00	23	16.70	
Difficulty concentrating	12	11.50	25	18.10	
No apparent difficulties	8	7.70	22	15.90	
Total	104	100.00	138	100.00	
POSITIVE ASPECTS					
Time saved in travelling to therapy location	30	32.30	64	63.40	idk
More openness in contact	13	14.00	18	17.80	
Possibly more convenient form for the client	28	30.10	–	–	
Access to specialists for a larger group of people	22	23.7	–	–	
Greater comfort and sense of security when having sessions in a place other than the office	–	–	19	18.8	
Total	93	100.0	101	100.0	

Psychotherapist-client relationship in remote therapy

When asked whether they noticed any changes in the psychotherapist-client contact during remote therapy as opposed to face-to-face sessions, the respondents provided some interesting answers (the question read: “Have you noticed any changes in the contact with the therapist/client during remote therapy in comparison to face-to-face therapy? If so, please describe them”). According to psychotherapists, clients are more likely to act less formally, for example, by asking personal questions, which they have not done before. However, acting informally is also associated with a positive aspect of remote psychotherapy, which seems to be greater freedom for clients to express their feelings. The impression of greater openness in online contact is repeated in the answers of the psychotherapists surveyed. There is also a predominant opinion among them that clients find it easier to talk about some issues during online contact. They also bring up more difficult topics and express themselves more freely about their relationship with the psychotherapist, and the usually more taciturn ones become more talkative. Respondents from the psychotherapist group conjecture that this may be because the clients feel safer in a natural setting such as their home than in an office. According to some of the psychotherapists interviewed, it is easier for them to have a meta-level of reflection about psychotherapy in online contact, and clients have more insight into their experiences. It also speeds up the process of building a therapeutic alliance, and clients develop trust in the psychotherapist more quickly than in the traditional form of face-to-face contact.

However, not all comments about remote psychotherapist-client contact sound so optimistic. According to some of the psychotherapists interviewed, some patients shallow the emotional contact with them, it becomes more difficult to maintain the relationship, and body-focused techniques become impossible. Among the comments of psychotherapists, there

are repeated statements about the need to set new rules in therapy and boundaries in therapist-client relationships, which are more difficult to maintain than in traditional psychotherapy.

The interviewed clients confirmed that during remote psychotherapy, it is easier for them to discuss issues that they would find difficult to talk about in face-to-face communication. Remote therapy makes it easier for them to distance themselves from their fears. Many of them also feel a closer relationship with their psychotherapist than in traditional contact. It is easier for them to open up, they are more at ease when constructing statements, and they express themselves more confidently when it comes to certain issues. They consider the possibility of seeing them in their natural, home setting as an advantage of this form of contact, as it can bring the therapist closer to the context of their problems. According to one interesting statement, online therapy thus becomes part of their daily life, as opposed to what can be described as a “snatched piece of reality on the run” that they experienced in face-to-face psychotherapy before social isolation. 13 clients note that they have better contact with the psychotherapist in the intellectual sphere, while there were also opinions that the therapeutic process is overly intellectualized. 21 clients do not feel much difference in their contact with the therapist, there are also some statements about the superficiality of this form of contact, the feelings of being less close and the sudden breaking of the contact at the end of the session: “Disconnecting is like a sudden severing of a thread for me. With in-office sessions, I didn’t have that feeling – as if saying goodbye, physically leaving the office and clinic and going home was a softer way out, a return to other things.”

Trust in remote psychotherapy

Responses regarding trust in remote psychotherapy tools and how it might change were placed on the Likert scale, spanning between the statements: “strongly disagree,” “disagree,” “hard to say,” “agree,” and “strongly agree.” When it came to the statement “I have never trusted remote therapy tools,” most of the therapists participating in the survey disagreed or strongly disagreed (34 respondents – 63%, $n = 54$). A similar trend of responses was observed among the surveyed clients, among whom 61 people (60.4%, $n = 101$) disagreed or strongly disagreed with the statement (Table 6).

The Mann-Whitney U test was used to verify the differences in the percentage of the obtained results. The results ($U = 2691.00$; $p = 0.889$) allow us to assume that the compared groups do not have statistically significant differences with respect to the statement “I have never trusted remote therapy tools (telephone/internet)” (Table 6).

Table 6. Number of comments regarding the statement: “I have never trusted remote therapy tools (telephone/internet)”

Answer	Participants				Total	
	psychotherapists		clients		n	%
	n	%	n	%		
I strongly disagree	12	22.20	35	34.70	47	30.30

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I disagree	22	40.70	26	25.70	48	31.00
It is difficult to say	9	16.70	12	11.90	21	13.50
I agree	10	18.50	14	13.90	24	15.50
I strongly agree	1	1.90	14	13.90	15	9.70
Total	54	100.00	101	100.00	155	100.00

Mann-Whitney U	2691.00	M rank	psychotherapists	78.67
P value	0.889		clients	77.64

An initial reluctance to remote therapy was declared by almost half of the psychotherapists (“agree” and “strongly agree”). Clients responded similarly to this question (Table 7).

The Mann-Whitney U test showed no statistically significant differences in the responses to the statement “During my social isolation, I was initially reluctant about the idea of remote therapy” between the study groups ($U = 2440.50$; $p = 0.269$) (Table 7).

Table 7. Number of comments regarding the statement: “During my social isolation, I was initially reluctant about the idea of remote therapy”

Answer	Participants				Total	
	psychotherapists		clients			
	n	%	n	%	n	%
I strongly disagree	13	24.10	23	22.80	36	23.20
I disagree	16	29.60	21	20.80	37	23.90
It is difficult to say	2	3.70	11	10.90	13	8.40
I agree	18	33.30	24	23.80	42	27.10
I strongly agree	5	9.30	22	21.80	27	17.40
Total	54	100.00	101	100.00	155	100.00

Mann-Whitney U	2440.50	M rank	psychotherapists	72.69
P value	0.269		Clients	80.84

In contrast, the vast majority of psychotherapists and clients came around to the possibility of participating in remote psychotherapy sessions (“agree” and “strongly agree”) (Table 8).

The Mann-Whitney U test showed no statistically significant differences in responses for the statement “I came around to the possibility of conducting remote therapy sessions” between the study groups ($U = 2483.50$; $p = 0.333$) (Table 8).

Table 8. Number of comments on the statement: “I came around to the possibility of conducting remote therapy sessions”

Answer	Participants				Total	
	psychotherapists		clients			
	n	%	n	%	n	%
I strongly disagree	5	9.30	7	6.90	12	7.70
I disagree	4	7.40	6	5.90	10	6.50
It is difficult to say	5	9.30	20	19.80	25	16.10
I agree	23	42.60	45	44.60	68	43.90
I strongly agree	17	31.50	23	22.80	40	25.80
Total	54	100.00	101	100.00	155	100.00

Mann-Whitney U	2483.50	M rank	psychotherapists	78.94
P value	0.333		Clients	77.50

Remote sessions were perceived as a hindrance by one-third of psychotherapists and slightly less than one-third of clients (“agree” and “strongly agree”) (Table 9).

The Mann-Whitney U test showed no statistically significant differences in the responses regarding the statement “I am able to have therapy sessions remotely, but it is a great inconvenience for me” between the study groups ($U = 2676.00$; $p = 0.844$) (Table 9).

Table 9. Number of comments regarding the statement: “I am able to have therapy sessions remotely, but it is a great inconvenience for me”

Answer	Participants				Total	
	psychotherapists		clients			
	n	%	n	%	n	%
I strongly disagree	13	24.10	28	27.70	41	26.50
I disagree	16	29.60	29	28.70	45	29.00
It is difficult to say	9	16.70	14	13.90	23	14.80
I agree	12	22.20	18	17.80	30	19.40
I strongly agree	4	7.40	12	11.90	16	10.30
Total	54	100.00	101	100.00	155	100.00

Mann-Whitney U	2676.00	M rank	psychotherapists	78.94
P value	0.844		clients	77.50

Less than 10% of the psychotherapists surveyed considered remote therapy to be a better form than traditional therapy, and clients with similar opinions made up a slightly larger percentage (“agree” and “strongly agree”) (Table 10).

The Mann-Whitney U test showed no statistically significant differences in responses regarding the statement “Remote therapy is better for me than traditional face-to-face therapy” between the study groups ($U = 2402.500$; $p = 0.198$) (Table 10).

Table 10: Number of comments on the statement: “Remote therapy is better for me than traditional face-to-face therapy”

Answer	Participants				Total	
	psychotherapists		clients			
	n	%	n	%	n	%
I strongly disagree	22	40.70	37	36.60	59	38.10
I disagree	23	42.60	32	31.70	55	35.50
It is difficult to say	4	7.40	18	17.80	22	14.20
I agree	4	7.40	9	8.90	13	8.40
I strongly agree	1	1.90	5	5.00	6	3.90
Total	54	100.00	101	100.00	155	100.00

Mann-Whitney U	2402.500	M rang	psychotherapists	71.99
P value	0.198		clients	81.21

No difference in the quality of therapy between face-to-face and remote contact was stated by a little more than one-tenth of psychotherapists and as many as one-third of clients (“agree” and “strongly agree”) (Table 11).

The results obtained in the Mann-Whitney U test ($U = 2092.00$; $p = 0.014$) allow us to assume that the compared groups differ statistically in the distribution of responses concerning the statement “I do not perceive any significant difference in the quality of therapy between face-to-face and remote sessions.” In addition, the obtained mean rank values confirm significantly higher agreement with the statement in the group of surveyed clients ($M_{rank} = 84.29$) than in the group of surveyed psychotherapists ($M_{rank} = 66.24$) (Table 11).

Table 11. Number of comments regarding the statement: “I do not perceive any significant difference in the quality of therapy between face-to-face and remote sessions”

Answer	Participants				Total	
	psychotherapists		clients			
	n	%	n	%	n	%
I strongly disagree	13	24.10	21	20.80	34	21.90
I disagree	25	46.30	26	25.70	51	32.90
It is difficult to say	8	14.80	19	18.80	27	17.40
I agree	7	13.00	27	26.70	34	21.90
I strongly agree	1	1.90	8	7.90	9	5.80
Total	54	100.00	101	100.00	155	100.0

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Mann-Whitney U	2092.00	M rank	psychotherapists	66.24
P value	0.014		clients	84.29

More than one-third of psychotherapists and only one-fourth of clients expressed their willingness to continue remote sessions after the end of the forced isolation (“agree” and “strongly agree”) (Table 12).

The results obtained in the Mann-Whitney U test ($U = 2030.00$; $p = 0.007$) allow us to assume that the compared groups are characterized by statistically significant differences in the distribution of responses concerning the statement “When the forced social isolation ends, I am willing to continue with remote therapy sessions.” In addition, the obtained mean rank values confirm significantly lower compliance with the statement in the group of surveyed clients ($M_{\text{rank}} = 71.10$), while in the group of psychotherapists, the results were more like a normal distribution ($M_{\text{rank}} = 90.91$) (Table 12).

Table 12. Number of comments regarding the statement: “When the forced social isolation ends, I am willing to continue with remote therapy sessions.”

Answer	Participants				Total	
	psychotherapists		clients			
	n	%	n	%	n	%
I strongly disagree	8	14.80	34	33.70	42	27.10
I disagree	14	25.90	29	28.70	43	27.70
It is difficult to say	12	22.20	12	11.90	24	15.50
I agree	13	24.10	19	18.80	32	20.60
I strongly agree	7	13.00	7	6.90	14	9.00
Total	54	100.00	101	100.00	155	100.00

Mann-Whitney U	2030.00	M rank	psychotherapists	90.91
P value	0.007		clients	71.10

Discussion of results

Verifying any hypotheses related to the research findings presented above proves difficult, as the social isolation in the second quarter of 2020 was unprecedented and there are no previous experiences to which we can refer. Nevertheless, analyses of the collected material revealed themes worth discussing.

The largest number of therapists and clients surveyed during social isolation in Poland chose online audiovisual contact. The second most popular choice, with significantly fewer responses, was taking psychotherapy sessions over the phone. Interestingly, in a similar study conducted by Thomas Probst, Peter Stippel and Christoph Pieh in Austria at the beginning

of the pandemic, the opposite was true, with psychotherapy sessions over the phone being significantly more popular in that country [17]. Perhaps the Austrian public had previous experience with psychotherapy sessions conducted over the phone and therefore, in a crisis situation, they reached for a familiar tool, whereas in Poland, there is no tradition of remote psychotherapeutic work, and the few cases that do exist involved online meetings rather than telephone conversations. Moreover, the Austrian study yielded opposite results when it comes to the willingness of clients to start psychotherapy – in Austria, during the pandemic, the percentage of new psychotherapy clients increased significantly, while according to the psychotherapists in this study, that number did not increase. These differences are particularly interesting because Austria, not being too geographically distant from Poland, has many socio-cultural similarities with our country. We can assume that Poles, fearing the economic consequences more than focusing on their mental health, were less likely than Austrians to plan new expenditures related to psychotherapy. However, to identify the actual reasons for these differences, it would be necessary to investigate these issues further.

When asked about the difficulties related to remote psychotherapy sessions, psychotherapists cited the lack of eye contact for sessions over the phone and the lack of face-to-face contact for online sessions as the main negatives. Remarkably, clients did not find the lack of eye contact in telephone sessions as bothersome but seemed more bothered than psychotherapists by the lack of direct contact in online therapy. This implies that clients strongly recognize the need for real, unmediated contact with the therapist. The respondents are also concerned about the disruptive nature of remote sessions due to poor housing conditions that do not provide sufficient intimacy. Changes in setting caused by social isolation and remote working introduced significant differences concerning the physical space in psychotherapy: what was previously the responsibility of the therapist (providing safe, intimate space and confidentiality of the conversation) instead became the responsibility of the client. It became the client's job to provide themselves with spatial conditions resembling those in a therapist's office. On the one hand, this may be an additional burden for the client, on the other, it partially deprives the psychotherapist of control over the therapeutic process.

Among the positives, the most frequently mentioned were convenience and time-saving, as there was no need to commute. Other repeated answers referred to more openness in contact and were in accordance with the data from literature and previous studies [18, 19]. Both groups of respondents were generally similar in their opinions about more openness in the psychotherapist-client relationship. The results of the study confirm previous statements made by professionals about the unblocking effect in online communication [20]. There are therapeutic processes in which the client, for various reasons, does not bring up certain topics (*e.g.* related to the relationship with the therapist or his own experiences) in direct contact with the psychotherapist, but instead manages to do so over the phone or online. We may assume that clients who experience tension in face-to-face contact feel less threatened in remote contact. This may therefore indicate contact difficulties and resistance to therapy.

The psychotherapists interviewed pointed out that clients who are usually reticent become animated and speak more often in online contact. This may be due to the aforementioned reduction of anxiety and fear in remote contact but there may also be another explanation of this behaviour. In remote therapy, silence is more difficult, and clients may feel the need to “fill out the void,” which may be more embarrassing in remote sessions and does not serve as important a function as silence in the office.

Remote psychotherapy is also characterized by a greater tendency of clients to meta-reflect on therapy, to conceptualize problems, and to be able to distance themselves from them and look at them from a different perspective. Among the respondents, there were also negative statements referring to the limited emotional contact or abrupt ending of the session with a click instead of the ritual of saying goodbye to the psychotherapist and returning to everyday matters. The latter was also pointed out by other researchers [9], indicating that clients undergo a kind of “transition” process, mentally preparing themselves for the meeting with the psychotherapist on the way to the office. When a psychotherapist in remote therapy enters the client’s life via Skype or Zoom, this important element of the therapeutic process is taken away from the client, not giving them any time to “warm up” before the session nor to “cool down” after it.

When asked if their attitude towards using remote communication tools during psychotherapy sessions has changed during the COVID-19 social isolation, the respondents overwhelmingly stated that it has changed to a positive one. While opinions on remote therapy after the end of social isolation are divided among the surveyed psychotherapists, the clients would most like to return to the traditional form of holding face-to-face sessions. These differences can be explained by the fact that models that focus on the body and physicality are deprived of an important dimension in remote therapy. Additionally, psychotherapists for whom the main healing factor in therapy is the therapeutic relationship and its analysis (*e.g.* in psychoanalysis or the psychodynamic approach) are also deprived of very important aspects (*e.g.* physical presence). In contrast, some others (*e.g.* the behavioural-cognitive approach) do not rely as much upon the therapeutic function of the therapeutic relationship. It seems understandable, however, that regardless of the approach of any particular therapist, clients in a remote relationship feel deprived of important elements that are dependent on direct contact and experiencing the presence of the other person.

Two points seem to be worth emphasizing in the results of the presented research. Firstly, almost half of psychotherapists and clients declared that they were initially reluctant to participate in remote therapy. However, because of the lockdown, many of them have changed their mind about this form of therapy, despite their previous reluctance related to either standard dictated by psychotherapeutic approaches or their own beliefs. This does not imply the willingness to make this kind of change without being forced to do it by external circumstances, but has now become a possibility that many had not considered before. There were repeated statements by psychotherapists that remote therapy could become more accessible to a larger group of clients. The authors of this article would formulate this statement slightly differently: remote therapy is more accessible to a different group of

clients. This is because it is also exclusionary to people who are not digitally competent. But thanks to remote therapy, a group of clients that so far has been excluded from psychotherapy (due to physical disability, poor mobility, illnesses that make it impossible to leave the house, being a carer for people constant care, puerperium, fears that make it difficult to move independently in public spaces, living in places far away from specialists, *etc.*), can more easily benefit from psychotherapy. One could perversely say that because of the pandemic situation and the related social isolation, barriers that seemed insurmountable for years have been removed in Poland.

The lockdown in Poland has obviously forced a certain way of providing psychotherapy in all therapeutic orientations. Both psychotherapists and their clients had to make a choice whether to suspend or continue psychotherapy and, if they have chosen to continue, which working tools allowing remote contact they would use. These choices entailed many decisions that they had to make. They involved renegotiating the contracts with clients, establishing new rules regarding, for example, the price of therapy, joint choice of communication tools, and sometimes changing the number of clients. We can assume that many psychotherapists were not prepared to conduct remote sessions. Also, clients who were not technologically literate needed to get more training to avoid losing contact with their therapist.

This article certainly does not provide exhaustive answers to all the proliferating questions about the quality of the changes that have occurred in psychotherapy, and this topic requires further research. The results of the survey presented above were based on a sample that does not allow for generalizing the results to the whole population of Polish psychotherapists and clients. However, it can be noted that the results are comparable to other, similar surveys conducted in other countries, with a much larger number of respondents [7]. It should also be considered that the questionnaire was sent out online, and therefore was directed to respondents who use remote work tools on a daily basis. The reluctance of some people to participate in remote psychotherapy may be caused by the fact that they are not familiar with or rarely make use of modern technology, which excluded them from the group of potential respondents. The inability to use remote communication tools is a separate problem which, in the situation of social isolation, makes it impossible for clients who need contact with a therapist to satisfy their needs. The lack of digital competencies is currently a major social problem, associated with exclusion and lack of access to various services. This problem requires systemic solutions for the digital education of adults.

Another point to note is the timing of the study, which fell within the first weeks of the pandemic and was associated with almost complete social isolation. In June 2020, when the restrictions established by the Polish government were loosened, some psychotherapists and clients returned to the traditional form of holding therapy sessions face-to-face, so the proportion of sessions conducted remotely, as well as opinions about them, may have changed. We cannot forget about the problems of questionnaire-based research, such as the declarative character of the data, the subjectivity of the answers and the lack of control over the conditions of the research.

Summary

In conclusion, the social isolation caused by the COVID-19 pandemic has changed the way psychotherapy is provided in Poland. While before lockdown, face-to-face psychotherapy was the most common form of treatment, during social isolation, its place was taken by online psychotherapy, followed by telephone psychotherapy. The practical implications of this situation point to the need for further competence development in the use of remote communication tools by both psychotherapists and clients, as well as the formulation of specific, more detailed guidelines for remote psychotherapy based on the already gained experience. Time will tell whether remote psychotherapy will become a permanent form of psychotherapy. Nevertheless, in view of the current situation, even if it is temporary, it is important to build up a new way of working in the psychotherapist–client pairing. Stefano Bolognini summarized this strange moment for psychotherapy as follows: “I would compare this situation to having to move into a tent during an earthquake. It is not a delightful alternative to living in a house, but tents may be necessary to find shelter in for a while” [21].

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APPENDIX

The survey entitled “Psychotherapy during the social isolation related to COVID-19 pandemic” used in the study

T – question for the therapist

K – question for the client

Questions without a marker are addressed to both groups of respondents

I confirm that I have read the information about the study. I am taking part in it in an informed way and I agree to processing my data for research purposes.

T and K 1) How do you participate in psychotherapy?

- a) I am a psychotherapist
- b) I am a client/patient of psychotherapy

Y and K 2) Gender

- a) Female
- b) Male

Y and K 3) Age

T 4) In which model of psychotherapy do you work?

.....

K 5) Which model of psychotherapy do you use?

- a) Psychodynamic psychotherapy
- b) Psychoanalysis
- c) Cognitive behavioural psychotherapy
- d) Systemic psychotherapy
- e) Gestalt psychotherapy
- f) Humanistic-existential psychotherapy
- g) Process oriented psychotherapy
- h) Do not know/cannot remember
- i) Other:

T 5) How long have you been working as a psychotherapist? Please answer in years

.....

K 5) How long have you been in psychotherapy? Please give the answer in years and months (e.g. for 1 year and 8 months, please write 1;8)

.....

T 6) Have you noticed a change in the number of people willing to start psychotherapy since the period of social isolation began?

- a) Yes, recently there have been more people willing to start therapy

-
- b) I have not noticed any change
 - c) Yes, recently less people want to start therapy
- K 6) Education
- a) Elementary
 - b) Vocational
 - c) Secondary
 - d) Studying
 - e) Higher
- T 7) How do you currently hold psychotherapy sessions?
- a) With all clients by phone
 - b) With all clients via video connection (Skype, Messenger, Zoom *etc.*)
 - c) Depending on the client's preference – partly over the phone, partly online
 - d) Depending on customer preference – partly remotely, partly in person
 - e) I have suspended all therapy sessions for the period of social isolation
 - f) I have suspended some sessions during social isolation
 - g) I conduct therapy in a traditional way, with personal contact with the client
 - h) Other:
- K 7) How do you currently hold psychotherapy sessions?
- a) Phone
 - b) Video call (Skype, Messenger, Zoom *etc.*)
 - c) I have suspended my therapy sessions for the period of social isolation
 - d) I have completely withdrawn from therapy
 - e) I attend therapy in a traditional way, meeting directly with a therapist
- T and K 8) Before social isolation, did you ever have therapy sessions over the phone?
- a) Yes
 - b) No
- 9) Before social isolation, did you ever attend online sessions (Skype, Messenger, Zoom *etc.*)?
- a) Yes
 - b) No
- T 10) From what location do you conduct therapy in the absence of face-to-face contact with the client?
- a) Still from the office
 - b) From home

- c) I do not conduct therapy sessions in this form – I have suspended sessions or still conduct them face-to-face
- d) Other:.....
- K 10) From what location do you attend remote therapy (via phone/online) when you do not see your therapist in person?
- a) From home
- b) From my workplace
- c) Other:
- T 11) What do you find most difficult about having sessions over the phone? (You can choose more than one answer)
- a) Lack of direct contact with the client
- b) Lack of eye contact with the client
- c) I have trouble focusing
- d) I do not feel like the other person is listening to me
- e) My home/office environment makes it difficult for me to feel intimate in a conversation
- f) My telephone connection is weak and interferes with my conversations
- g) The model of therapy in which I work does not allow for remote contact
- h) I am not experiencing any obvious difficulties
- i) I am afraid that the client may not have sufficient intimacy
- j) I do not provide this kind of therapy
- k) Other:.....
- K 11) What do you find most difficult about having sessions over the phone? (you can choose more than one answer)
- a) Lack of direct contact with the therapist
- b) Lack of eye contact
- c) I have trouble concentrating
- d) I do not feel that the other person is listening to me
- e) My home environment makes it difficult to have intimate conversations
- f) My Internet connection is poor and interferes with my conversations
- g) I feel uncomfortable using online tools
- h) The model of therapy which I use does not allow for remote contact
- i) I do not have any apparent difficulties
- j) I do not attend have this kind of therapy
- k) Other:

- T 12) What do you find most difficult about having an online session? (You can choose more than one answer)
- a) Lack of direct contact with the client
 - b) I have trouble concentrating
 - c) I do not feel that the other person is listening to me
 - d) My home environment makes it difficult to have an intimate conversation
 - e) My Internet connection is poor and interferes with my conversations
 - f) I feel uncomfortable using online tools
 - g) The model of therapy in which I work does not allow for remote contact
 - h) I do not have any apparent difficulties
 - i) I am concerned that the client may not have sufficient intimacy
 - j) I do not provide this kind of therapy
 - k) Other:.....
- K 12) What do you find most difficult about taking sessions online? (You can choose more than one answer)
- a) Lack of direct contact with the therapist
 - b) I have trouble concentrating
 - c) I do not feel like I am being listened to
 - d) My home environment makes it difficult to have an intimate conversation
 - e) My Internet connection is poor and interferes with my conversations
 - f) I feel uncomfortable using online tools
 - g) The model of therapy which I use does not allow for remote contact
 - h) I do not have any apparent difficulties
 - i) I am not doing this form of therapy
 - j) Other:.....
- T 13) Do you see any positive aspects of telephone therapy? (You can choose more than one answer)
- a) Remote therapy is a hassle for me
 - b) I save time driving to the office
 - c) I am more comfortable in my own home/place other than the office
 - d) I like the interaction over the phone
 - e) I believe that this form provides access to specialists for a larger group of people
 - f) It may be more convenient for the client
 - g) More openness in contact
 - h) Other:.....

-
- K 13) Do you see any positive aspects of telephone therapy? (You can choose more than one answer)
- a) Remote therapy is a hassle for me
 - b) I save time commuting to therapy
 - c) I feel safer and more comfortable in my own home/other place where I receive therapy
 - d) I enjoy phone interaction
 - e) I find it easier to open up to my therapist
 - f) I have not used this form of psychotherapy
 - g) Other:.....
- T 14) T 14) Do you see any positive aspects of online therapy? (You can choose more than one answer)
- a) Remote therapy is a hassle for me
 - b) I save time travelling to the clinic
 - c) I am more comfortable in my own home/place other than the office
 - d) I like the interaction in an online format
 - e) I believe this form provides access to specialists for a larger group of people
 - f) It may be more convenient for the client
 - g) More openness in contact
 - h) Other:.....
- K 14) Do you see any positive aspects of online therapy? (You can choose more than one answer)
- a) Remote therapy is a hassle for me
 - b) I save time commuting to therapy
 - c) I feel safer and more comfortable in my own home/other place where I receive therapy
 - d) I enjoy online interaction
 - e) I find it easier to open up to my therapist
 - f) I have not used this form of psychotherapy
 - g) Other:.....
- T 15) Have you noticed any changes in your interaction with clients during remote therapy, compared to face-to-face therapy? If so, please describe which (if you do not conduct remote therapy, skip this question).
-
- K 15) Have you noticed any changes in contact with the therapist during remote therapy, compared to face-to-face therapy? If so, please describe which (if you are not doing remote therapy, skip this question).

-
- T 16) Have you noticed your clients experiencing the following emotions more often in remote versus face-to-face therapy? (You may select more than one answer)
- a) Fear
 - b) Anxiety
 - c) Anger
 - d) Frustration
 - e) Heightened tension
 - f) Sadness
 - g) Relief
 - h) Contentment
 - i) Reduced tension
 - j) Acceptance
 - k) Joy
 - l) Other:.....
- T 17) Have you noticed an increase in addressing the following topics in therapy in recent weeks? (You may choose more than one answer)
- a) Anxiety about my health/life
 - b) Anxiety about health/life of loved ones
 - c) Workplace worries
 - d) Financial worries
 - e) Anxiety about the future
 - f) Anxiety about children's future and education
 - g) Loneliness
 - h) Suicidal or self-destructive thoughts
 - i) Exacerbation of symptoms in clients with addictions
 - j) Problems with concentration
 - k) Putting off important activities
 - l) Other:.....
- K 16) Have you noticed that the following topics have been brought up more often in therapy recently? (You may choose more than one answer)
- a) Anxiety about my own health/life
 - b) Anxiety about the health/life of loved ones
 - c) Problems with work situation
 - d) Financial worries
 - e) Anxiety about the future
 - f) Anxiety about children's future and education

-
- g) Loneliness
 - h) Suicidal or self-destructive thoughts
 - i) Exacerbation of symptoms in clients with addictions
 - j) Problems with concentration
 - k) Putting off important activities
 - l) I have not noticed any of these themes more often
 - m) Other:.....
- T 18) Have you noticed any changes in the functioning of most of your patients over the past few weeks?
- a) Most patients have improved significantly
 - b) Most patients have gotten better
 - c) I have not noticed any change
 - d) Most patients' symptoms have worsened
 - e) Most patients' symptoms have gotten much worse
 - f) Difficult to say, it depends on the patient
- T 19) Refer to the following statements by indicating the appropriate item on the scale (strongly disagree, disagree, hard to say, agree, strongly agree)
- a) I have never trusted remote therapy tools (telephone/internet)
 - b) During my social isolation, I was initially reluctant about the idea of remote therapy
 - c) I came around to the possibility of conducting remote therapy sessions
 - d) I am able to have therapy sessions remotely, but it is a great inconvenience for me
 - e) Remote therapy is better for me than traditional face-to-face therapy
 - f) I do not perceive any significant difference in the quality of therapy between face-to-face and remote sessions
 - g) When the forced social isolation ends, I am willing to continue with remote therapy sessions
- K 17) Please relate to the following statements by indicating the appropriate item on the scale (strongly disagree, disagree, hard to say, agree, strongly agree)
- a) I have never trusted remote therapy tools (telephone/internet)
 - b) During my social isolation, I was initially reluctant about the idea of participating in remote therapy
 - c) I became convinced that remote therapy sessions are a real possibility
 - d) I am able to have therapy sessions remotely, but it is a great inconvenience for me
 - e) Remote therapy is better for me than traditional face-to-face therapy

- f) I do not perceive a significant difference in the quality of therapy between face-to-face and remote contexts
- g) After the forced social isolation ends, I am willing to continue therapy sessions over the phone/online
- h) I am thinking about suspending/terminating my therapy because I do not like the remote therapy

K 18) How has the severity of your symptoms changed over the past few weeks?

- a) My condition has improved considerably
- b) I have gotten better
- c) I have not noticed any difference
- d) My symptoms have worsened
- e) My symptoms have significantly worsened

T and K 20) Is there anything else you would like to add?

.....

T and K 21) Do you agree to be contacted, if necessary, for the second part of the study, after social isolation? If so, please provide your email address in the next question.

- a) Yes
- b) No

T and K 22) If you agree to be contacted for the second part of the survey, please provide your email address

.....