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PSYCHOTHERAPY WITH THE USE OF ICT SYSTEMS – ADVANTAGES AND CONTROVERSIES. THE PERSPECTIVE OF PATIENTS OF THE DEPARTMENT OF PSYCHOTHERAPY OF THE UNIVERSITY HOSPITAL IN KRAKOW AND A REVIEW OF THE LATEST LITERATURE

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remote therapy
COVID-19

Summary

Objectives: *The article presents the results of a survey carried out with a group of 38 patients of the Department of Psychotherapy of the University Hospital in Krakow. Due to the national quarantine at the time when the research was conducted, respondents participated in therapy remotely. The research mainly focused on the attitudes of respondents to this form of treatment and its perceived effectiveness.*

Methods: *The research took the form of a questionnaire administered via email with the patients' consent.*

Results: *The first experience with remote psychotherapy turned out positive for 55% of survey participants. Patients appreciated this formula because it helped them preserve the continuity of treatment, save time-related to transport or it gave them a greater sense of security that enabled breaking barriers with speaking about themselves and their problems. The predominant disadvantages were technical constraints, problems with focusing on the content of the conversation or achieving privacy and a deficit in therapeutic interventions based on non-verbal aspects of communication.*

Conclusions: *Psychotherapy based on the use of ICT methods has its advantages and disadvantages. After one month of participation in this form of treatment, 55% of the participants perceived its effectiveness as equivalent to therapy carried out in direct contact. 34% of respondents were of the opinion that this therapy was less effective than the traditional one. It still remains open what determines such perception of a specific person. At present, research on the evaluation of selected variables which may affect the assessment of attractiveness of remote treatment is in progress.*

Introduction

The COVID-19 pandemic which started in Poland in March 2020 brought about changes in many areas, including psychotherapy. Overnight, both patients and therapists faced the need to adapt to remote treatment. E-therapy has been a regular subject of scientific analyses for twenty years, as technology and Internet reach developed. Its beginnings date back to the 1990s when David Sommers, considered an online therapy pioneer, worked remotely (using computer software) with more than 300 people, testing the ability of that therapy form to build a therapeutic relationship [1]. Since then, the e-therapy study reviews have indicated that this has been a promising approach to treating mental disorders [2, 3]. There is growing evidence that e-therapy may be equally effective as the face-to-face one. There have been studies of e-therapy effectiveness when treating e.g. anxiety disorders [4], psychosomatic disorders [5] or depressive disorders [6, 7], mostly in the Cognitive Behavioural Therapy (CBT).

Advantages and disadvantages of remote therapy – literature review

Regardless of the paradigm applied, the therapeutic relationship is considered to be the most important therapeutic factor in psychotherapy, as documented by empirical studies [8]. It is described primarily using the terms of a therapeutic alliance [9], composed of an emotional bond between the therapist and the patient, the quality of their mutual cooperation and the ability to develop mutually acceptable work objectives and methods [10]. In the remote therapy context, Simpson and Reid presented an overview of 24 studies concerning therapeutic alliance in video therapy [11]. It proves that patients with different emotional difficulties expressed a similar opinion on the alliance quality of the face-to-face therapy and for the e-therapy.

Similar conclusions were drawn by Susan Simpson, Lisa Richardson at al. [12], indicating that there were no significant differences when building a therapeutic alliance between the over-the-phone therapy, video therapy and face-to-face one. What is more, there are research reports claiming that e-therapy may result in higher openness than face-to-face one. The patients declare that they feel safer and that they have an increased sense of partnership in the relationship with their therapist during remote contact [13]. Numerous studies confirm that according to patients video therapy is less confrontative, making it easier to express negative emotions and talk about difficult experiences [14, 15].

The e-therapy advantages and disadvantages are discussed broadly by many authors and are present in virtually any article on this topic. The e-therapy advantages include primarily comfort, easier access to therapy, reduced fear of assessment, and related improved freedom of exposing oneself. Susan Simpson, Lisa Richardson at all. [12] add also the aspect of a more neutral therapeutic environment which may foster the development of more significant transference reactions. There have also been research reports claiming that patients are more active during video therapy than during the face-to-face one which is related to a reduced sense of embarrassment and increased safety and accountability for one’s share of therapeutic work [11].

Markowitz at all. [16], on the other hand, are skeptical towards a remote therapy form. Apart from the most obvious aspects, including potential technical difficulties, relating to audio and video, and the Internet connection quality, as well as data encryption security, they pay attention to the presence of numerous distractors (background noise, information on the received SMSes or e-mails, the possibility to look at oneself during the conversation instead of at each other, etc.). Other disadvantages mentioned by them include also the ability to spy on the private life of both the patient and the therapist, no ability to make a full assessment of non-verbal patient's behaviours, or the emotional distance perceived as a less vivid experience of being in a relationship with somebody. It is also easier to avoid difficult experiences in remote contact (this refers e.g. to agoraphobic patients who do not have to leave home then).

The above reflections are partially shared by Lara Payne and Halina Flannery [17] who in their article mention e.g. the risk of excessive exposure when the patient is able to notice the personal belongings of the therapist on the computer screen. Moreover, they stress the risk of less formal contact and border transgression (in the context of e.g. session duration, changing times of the meeting, less formal clothes, etc.) and the presence of distractors, including family members, animals or background noise.

Markowitz at all. [16] present e.g. the conclusions from the review of 14 studies concerning an over-the-phone therapy. The authors of that review, Leach and Christensen [18], paid attention to the positive results of over-the-phone therapy, although control groups (including also patients who did not get any treatment) and the size of the studied group turned out to be a weakness of the reported studies — in some studies those were small pilot groups, other included several hundred patients which promoted accentuating the potential teletherapy richness. Summing up, it can be stated that the teletherapy studies' results turned out encouraging but they do not meet the strict criteria of reliable scientific research in terms of methodology. What is more, Markowitz at al. [16], referring to another review of studies offered by Berryhill [19], stress that the evidence confirming the effectiveness of video therapy which has conquered the market of psychotherapeutic services during the COVID-19 pandemic has been less convincing so far than the one proving the effectiveness of over-the-phone one. The quality of the above-mentioned video therapy studies was considered highly variable [20].

Markowitz at all. [16], however, refer also to studies that were carried out in line with the scientific requirements. Some of them confirmed the effectiveness of over-the-phone therapy when reducing depressive symptoms. The therapy comprised cognitive behavioural strategies for patients of primary healthcare who started antidepressant pharmacotherapy [21] as well, and also interpersonal therapy interventions in a group of HIV patients residing in rural areas and in a group of women suffering from postpartum depression [22, 23]. The article's authors declare that the conclusions concerning remote therapy should be approached cautiously as the studies of its efficiency usually comprise patients with less severe symptoms who stand a chance of earlier improvement in response to any treatment, including placebo [24]. Another problem is that the studies in that area may select patients and therapists who prefer teletherapy. What is more, in the available studies remote therapy

has usually been studied as an extension or addition to standard psychotherapy which, for obvious reasons, gives rise to the question of result generalisation in the context of treatment taking place solely remotely.

Therapeutic process organisation in the Department of Psychotherapy of the University Hospital in Krakow during the national quarantine

The patients of the Neurosis and Behavioural Disorders Treatment Outpatient Department of the Department of Psychotherapy at the University Hospital in Krakow who were forced to stay at home and switch to remote psychotherapeutic contact as a result of COVID-19 pandemic and lockdown received combined therapy forms. They had to face the unavailability of the former therapy method overnight, although their condition affected their coping abilities more than anything else, adding new challenges to the existing difficulties. Luckily, the introduced opportunity to provide healthcare services using ICT systems enabled the above-mentioned group of patients to continue psychotherapy. The psychotherapy formula had to be changed and the treatment focused primarily on remote individual therapy (in the psychodynamic therapy model) replacing the previous group therapy (based on psychodynamic and interpersonal paradigms). The possibility to run a remote therapeutic group was discussed in clinical studies. The decision was not an easy one and, eventually, the idea of remote group therapy was abandoned mainly due to two aspects. Firstly, in a remote group therapy context, it would be impossible to ensure the security of information disclosed by participants as it is difficult to verify if every participant is alone in the room during the session and the doubts relating to privacy disturb the sense of security and intimacy required to share the deepest personal content. Secondly, the formula of therapy offered in the Department pays significant attention to non-verbal communication of emotions between participants. It is observed and analysed who and how reacts to another person if they look at them and when, if they lean towards them etc. When it is impossible to observe such phenomena (being a highly important source of information for the patients themselves as well), it was decided that it would impoverish clinical work too significantly.

It should be mentioned that the groups are run in a semi-open formula (the group is joined by new people to replace the ones who leave because of the end of their contracted therapy term). Considering the phases of the group process, every group was in ca. the orientation phase right before the lockdown (the group was joined by new people shortly before changing to the remote formula).

It is worth stressing that patients who participated in the therapy programme comprising fifteen group therapy sessions and one individual therapy session a week before the national quarantine was introduced received the opportunity to continue therapy, as expected with the same therapist, in the form of two individual therapy sessions a week. The majority of patients continued therapy over the phone, and some of them preferred Skype. The therapy channel was selected based on the technical capabilities of patients and their autonomous choices. The patients who received pharmacotherapy during their stay in the Department kept it unchanged.

Method

After one month's remote therapy, some patients of the Department agreed to participate in a survey. They were informed of the opportunity to participate in it by their therapists who outlined the subject and objective of the study and provided contact details of the investigator. Eventually, more than one half of the people treated in the Department of Psychotherapy of the University Hospital agreed to participate in the survey. The patients expressed their interest in the study topic and the willingness to share their own perspectives to contribute to science which did not have an equally rich opportunities to verify remote therapy until the COVID-19 pandemic broke out.

In the survey, the patients answered questions on how much they had to change their habits and lifestyle relating to the stricter epidemiological regime and which areas of their life were most affected by the restrictions. They were also asked if they considered remote therapy effective before they actually started it and how long they used traditional face-to--face psychotherapy before they started the remote one, and in what form (individual or group one). They referred to their first impressions relating to changing from face-to-face psychotherapy to remote one, their assessment of its effectiveness after one month of taking part in it, psychotherapy disadvantages and advantages perceived by them, and whether the remote therapy changed their motivation to receive treatment in any way.

Results

38 respondents participated in the survey, including 24 women and 14 men. The average age of respondents was 34.4 years. The respondents included 22 people with MA/MSc degree, 4 with a BA/BSc degree and 12 secondary-school graduates.

Table 1. **Demographic structure of respondents**

Characteristics	n	%
Women	24	63.2
Men	14	36.8
Total	38	100.0
University degree (MA/MSc)	22	57.9
University degree (BA/BSc)	4	10.5
Secondary-school graduate	12	31.6

The majority of 38 study respondents had the diagnosis of personality disorders (F60.8 – 9 persons, F61 – 6 persons, F60.6 – 3 persons, F60.3 – 3 persons, F60.9 – 2 persons, F60 – 1 person). 14 people in that group were diagnosed, besides personality disorders, also with disorders belonging to: other anxiety disorders F41 (11 persons), obsessive-compulsive disorder F41 (2 persons) and adjustment disorder F43.2 (1 person). 13 people in the entire group of respondents had a single diagnosis of disorders belonging to F40–F48 group. There was also one person diagnosed with atypical bulimia nervosa (F50.3).

Table 2. **Clinical profile of respondents**

Diagnosis	n	% of all respondents
Personality disorders	24	63.16%
Personality disorders and other disorders from F40–F48 group (double diagnosis)	14	36.84%
Disorders from F40–F48 group as the only diagnosis	13	34.21%
Disorders from other groups (F50.3)	1	2.63%

8 people (physiotherapists, a programmer, a dressmaker, a corporation employee, a real estate agent, a salesman, and an unemployed person) responded that their life changed a lot relating to the pandemic. 13 people declared that this change degree was high, other 13 that it was moderate and 4 persons (an architect, a farmer, a babysitter and a construction worker) claimed that the change in their life was negligible.

Table 3. **Assessment of the perceived degree of life changes relating to the pandemic**

Observed change degree	n	%
Very significant changes	8	21.05
Significant changes	13	34.21
Moderate changes	13	34.21
Slight changes	4	10.53

For 16 people, the reason of the most significant changes relating to the pandemic faced by them were restrictions in everyday life (limits of shop customers, queues in front of shops, restrictions on public transport, restricted access to recreation sites). For 10 people, the shortage of opportunities relating to meeting friends and for 1 to meeting their family was a problem. 5 people pointed out that the most significant changes in their life resulted from the inability to visit cultural events and entertainment venues. 1 person suffered significantly from travel restrictions and one from more difficult access to religious cult venues. Only two people pointed to a significant life change caused by the inability to work, one by the reorganised employment situation and one by the need to take care of the child personally at home.

Table 4. **Areas of the most significant life inconveniences caused by the pandemic**

Area of the most significant inconvenience	n	%
Restrictions in everyday life (...)	16	42.1
Inability to meet friends	10	26.6
Inability to participate in cultural and entertainment events etc.	5	13.1
Inability/restricted ability to meet family	1	2.6
Travel restrictions	1	2.6
Restricted access to religious cult venues	1	2.6

table continued on the next page

Loss of employment	2	5.2
Reorganised employment situation	1	2.6
The need to stay at home due to the child's remote learning	1	2.6

People declaring that a lot changed in their lives relating to the pandemic (8 people altogether) included those with a psychotherapy history (only one person in that group did not have any earlier experiences relating to individual therapy, most of those people participated in such therapy for one year to 5 years; 3 people attended their first group therapy cycle when the quarantine was introduced, for 1 person this was the first psychotherapy experience, and for the remaining 8 people it was a subsequent group therapy cycle). The other respondents (30 people) also experienced face-to-face psychotherapy before (12 people had individual therapy for one year to 5 years, 9 of them had already completed several to more than a dozen months of group therapy, 18 out of 30 people had experienced solely group psychotherapy, lasting from a couple of weeks to 2 years).

The survey analysis revealed that the patients' opinions on remote therapy differed before they participated in it. 17 people considered this therapy formula to be potentially effective, 11 people had a rather negative opinion about it and 10 people did not have any specific opinion about it. When it turned out that they would have to continue therapy remotely, 19 people showed understanding but also anxiety about its effect on the treatment process. 9 people expressed understanding, but also a reluctance to remote psychotherapy. 7 people received the proposal with understanding and calmness, and 3 did not have a specific opinion. After one month's remote therapy, 21 people believed that it was equally effective as the face-to-face one, 13 people as less effective and 4 people did not have a specific opinion.

Table 5. **Remote therapy assessment in the absence of any previous experience relating to this therapy formula**

	n	%
Potentially effective	17	44.7
Rather ineffective	11	29.0
Don't know	10	26.3

Table 6. **Remote therapy assessment after one month's participation in this therapy formula**

	n	%
Equally effective as face-to-face therapy	21	55.3
Less effective than face-to-face therapy	13	34.2
Don't know	4	10.5

Discussion of the findings

Most respondents were women (n = 24), people with MA/MSc university education (n = 22) and diagnosed with personality disorders. Only 8 respondents believed that the COVID-19 pandemic changed their life a lot. They had different jobs, including the ones guaranteeing stable employment (i.e. a programmer or corporation employee). 3 respondents did not observe any changes in their previous life. Interestingly, they included representatives of sectors that could suffer most from the national quarantine, as would intuitively be believed, including a babysitter or a construction worker. The results suggest that the type of work performed or the place of employment had relatively little impact on the perception of changes caused by the pandemic. The fact that the survey was carried out in its initial period should not be neglected as well, as it does not enable us to observe the pandemic effects from a longer perspective for obvious reasons. Most people (16) declared that the area of the most significant inconveniences caused by the lockdown was the everyday life restrictions (limited number of customers in a shop, queues in front of shops, restrictions on public transport, restricted access to recreation sites). The majority of respondents had experienced face-to-face psychotherapy before the national quarantine was introduced and it became necessary to switch to remote therapeutic contact (they had completed from one year to several years of individual therapy and from several weeks to 2 years of group therapy). These experiences must surely be included in the conclusions concerning the potential value of e-therapy.

The first experience relating to remote therapeutic contact turned out positive for 55% of survey respondents. The patients appreciated that formula as they could continue therapy and as it was important support when the access to standard psychotherapy was impossible and the emotions relating to the crisis (pandemic) intensified.

For some patients, remote psychotherapy provided a significant time-saving option. They declared that they spent the time they would otherwise have to spend to reach the venue to reflect on what they would like to contribute to the meeting or to consolidate any conclusions reached during the meeting.

The group of satisfied patients got the impression that they worked more intensely although they participated in just two sessions of remote individual therapy a week, and not 15 group therapy sessions and 1 individual therapy session in the same timeframe, during the group therapy. Patients who had difficulty revealing their thoughts and emotions in direct contact with the group, e.g. because of their fear of assessment, experienced a higher sense of safety in remote individual contact which made it easier to overcome the obstacles to discussing oneself and one's problems. The specific anonymity experienced by patients during teletherapy enabled them to focus more on themselves, on what they feel, think and need. This reduced the reluctance to reveal any content particularly difficult, even embarrassing from the patients' perspective, bringing a sense of relief and improved frame of mind.

However, there were also opposite responses. 34% of survey respondents were less enthusiastic about remote therapy. The basic disadvantages, as mentioned by them, included technical limitations (connection quality, time delay of statements, noise in the phone,

etc.) and problems with ensuring privacy (those aspects were also mentioned by people who were positive about teletherapy). What is more, difficulties relating to focusing on the conversation (distractors present) and the possibility to relieve stress related to the discussed content by moving around the room, drinking, manipulating different objects (a pen, a hairband), and excessive gestures were mentioned. Most respondents observed that they miss therapeutic interventions based on non-verbal communication aspects (changing body language, tone of voice, tenser movements, eye contact) as they were either invisible (over-the-phone contact) or not visible well (video contact).

Although the article focuses on the assessment of remote therapy from the patients' perspective, it is worth mentioning comments provided by the Department psychotherapists with respect to the therapy. First, it was noticed that for the patients who live alone, in particular the socially isolated ones, the opportunity to meet others was even more important than the therapeutic work itself, and the gratitude for it promoted deeper relations. No clinically significant deterioration of the patients' condition was observed during remote therapy. Quite the opposite, there was a predominant sense of good contact and cooperation. Most therapists noticed that patients who found it difficult to work in the group before started gradually to bring in more and more personal, intimate motives, to open up which translated into their improved frame of mind. However, the return to therapeutic groups proved difficult especially for the people deprived of particularly meaningful dyadic contact. More binding conclusions based on regular observations concerning this aspect should be obtained during separate analyses and surveys which is not included in the scope of this article. Simultaneously, the absence of accurate data concerning the remote therapy assessment from therapists' perspectives impoverishes the perception of the discussed problem for obvious reasons.

Conclusions

The above-mentioned conclusions concerning the advantages and disadvantages of remote therapeutic contact overlap with the above-mentioned conclusions derived from the literature review. However, it is worth stressing that the study performed out of a sudden, in unprecedented circumstances of national quarantine, without preparing the project before, must have its limitations. They include, undoubtedly, the survey structure which comprised too few questions referring to the remote therapy itself which would enable to understand the patient's attitude to that therapy formula deeper and in a more individualised way (e.g. with respect to more precise determination of the impact exerted by previous therapeutic experiences on the remote therapy assessment).

The survey was carried out at the pandemic's beginning. The respondents could not predict the length of remote therapy, they were happy that they were able to continue treatment at all which, undoubtedly, contributed to the mostly enthusiastic perception of remote therapy. It is necessary to consider the change from group to individual therapy as well, since most participants considered the latter easier in terms of emotions and offering more "meaningful", exclusive contact with the therapist, with no need to go out. In this

aspect, the fact that most respondents were people diagnosed with personality disorders, including those with narcissistic traits who are particularly sensitive to social assessment, is particularly important. Little doubt that the contact enabling to avoid the discomfort related to social exposure was considered positive by patients belonging to that group.

Another vital limitation of the study is the number of respondents which makes the final conclusions highly difficult both in this study and in the aspect of analysing further collected data which are the subject of pending works. Nonetheless, the study is so unique that the decision to present some of its findings was made.

What is more, the study authors are aware of the multitude of factors which, apart from the considered ones, may affect the respondents' opinions (one of them is e.g. the therapist's behaviour in remote contact, i.e. what they brought in unconsciously in the process organised in that way). For this reason, it seems justified to ask questions concerning the variables which determine the ultimate, short – and long-term, assessment of this therapy formula. A preliminary assumption was made that the attachment style characteristic of a given person (as assessed based on the Revised Adult Attachment Scale) and the personality trait (as assessed based on the Structured Clinical Interview for DSM-5 Personality Disorders DSM V (SCID-5-PD)) contribute to the assessment apart from the above-mentioned factors. The majority of respondents agreed to participate in the study verifying that assumption. What is more, the respondents filled in the survey asking them to assess remote therapy, this time from the perspective of the entire remote therapeutic experience, again after they returned to their therapeutic groups. The collected data has been analysed in the Department of Psychotherapy of the University Hospital in Krakow at present.

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