Delivering Videocall Therapy During COVID-19: Counselling Psychologists' Experience

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Video-call therapy has been a burgeoning area of research and practice in recent years. While many therapists were already adding online modes of therapy delivery to their toolkits, the COVID-19 pandemic prompted their necessary and rapid uptake, whatever the therapist's pre-pandemic preferences. The present study explored counselling psychologists' experience of adapting to and using online video-call platforms to deliver therapy during the COVID-19 pandemic in Aotearoa New Zealand. Eight registered counselling psychologists in Aotearoa New Zealand were interviewed. Thematic analysis revealed four themes: (i) pre-pandemic hesitancies towards video-call therapy, (ii) managing the rapid transition to video-call therapy, (iii) integrating the learnings from the transition to video-call therapy and (iv) contextual factors. Pre-pandemic hesitancies included concerns that video-call therapy hinders the therapeutic relationship and misses subtleties. The transition process highlighted considerations around transparency and flexibility, in addition to practical considerations and peer support. Post-transition learnings included a more nuanced understanding of the shift from sharing physical space with clients to practicing from home; the mixed blessing of technology; the balancing versus merging of work- and home-life; and the impact on client progress. The fourth theme of broader contextual factors included the counselling psychology perspective, lockdown parameters, and cultural factors. Findings from this study are consistent with the literature on therapists' experiences of video-call therapy in general and add a unique counselling psychology perspective from the context of Aotearoa New Zealand. Findings also highlight considerations for therapists who are transitioning to video-call therapy, whether by choice or necessity.

Key words: *Online therapy, Teletherapy, Videocall therapy, Transition, Covid-19 pandemic, Counselling psychologists*

INTRODUCTION

The utilisation and development of technology-delivered psychological interventions have flourished in recent years (Kraus, Stricker, & Speyer, 2010; Richards & Viganó, 2013). One aspect of technology-delivered interventions is online video-call therapy, which offers clients the benefits of continuing therapy remotely, saving time and money otherwise spent for travel, while allowing for synchronous interactions of speech and body movement in real time (Simpson, 2009). As opposed to in-person therapy, client and therapist use the Internet to communicate with each other in real time (Sucala, Schnur, Brackman, Constantino, & Montgomery, 2013). As therapy occurs in an online environment, video-call therapy is not defined as a form of therapy but rather as a means to deliver therapy (Sucala et al., 2013).

Prior to the COVID-19 pandemic, studies have indicated that technology-based therapeutic tools are effective in treating a variety of mental health presentations including: mood disorders, eating disorders, post-traumatic stress disorder, obsessive compulsive disorder and chronic pain (Beintner, Jacobi, & Taylor, 2012; Loucas et al., 2014; Pozza, Andersson, Antonelli, & Dèttore, 2014; Sloan, Gallagher, Feinstein, Lee, & Pruneau, 2011; Varker, Brand, Ward, Terhaag, & Phelps, 2019). The working alliance in video-call therapies has been shown to be high (Norwood, Moghaddam, Malins, & Sabin-Farrell, 2018) and comparable to the alliance in face-to-face therapies (Bouchard et al., 2004), especially when rated by clients (Ruwaard et al., 2009).

Despite this pre-pandemic empirical support for video-call therapy, other studies have documented therapists' concerns that video-call therapy may detract from the therapeutic relationship (Aafjes–van Doorn, Békés, Prout, & Hoffman, 2022; Alqahtani et al., 2021; Jerome & Zaylor, 2000; Rees & Stone, 2005; Reilly et al., 2022; Van Kessel, Parr, & Feather, 2022), and therapists reported a generally neutral, conservative, or negative view towards integrating video-call therapy into clinical practice (Geller, 2021). Pre-pandemic reluctance towards video-call therapy was linked to a lack of training and lack of empirical evidence on the effectiveness of video-call therapy, ethical risk management and confidentiality concerns (Carper, McHugh, & Barlow, 2013; Van Kessel et al., 2022). The potential for technological glitches and other unforeseen challenges have also been noted in pre-pandemic studies (Aafjes–van Doorn et al., 2022; Al-Mahrouqi et al., 2022; Carper et al., 2013; Sherrill, Wiese, Abdullah, & Arriaga, 2022), and a New Zealand study found that counselling psychologists pre-pandemic generally perceived telepsychology as having a good fit with counselling psychology paradigm, yet also reported

the computer screen detracted from the therapeutic relationship, and could result in miscommunication and misinterpretation (Van Kessel et al., 2022). Amongst pre-pandemic research on videocall therapy, there is a noticeable underrepresentation of counselling psychology perspectives (Mallen & Vogel, 2005; Mallen, Vogel, & Rochlen, 2005), which is surprising given its strong emphasis on the therapeutic relationship (Manthei, Stanley, & Gibson, 2004).

Since the start of 2020, the COVID-19 pandemic accelerated the need for remote and flexible methods to deliver mental health care with large parts of the world in 'lockdown' conditions without access to face -to- face mental health care. Video-call therapy emerged as the primary tool for therapists to provide continuity of care, prompting the necessary and rapid uptake of video-call therapy, whatever the therapist's pre-pandemic preferences. Interestingly, there is a lack of general research exploring how psychologists experienced the necessary transition to video-call therapy during the pandemic, and more specifically within Aotearoa New Zealand.

The aims of this study were to explore and document the experiences of counselling psychologists delivering video-call therapy in Aotearoa New Zealand during COVID-19; develop an in-depth and context-based understanding and exploration of the complexities inherent to delivering video-call therapy within a COVID-19 context in Aotearoa New Zealand; and explore how video-call therapy could be integrated into the counselling psychology discipline.

METHOD

This study utilised a qualitative descriptive (QD) approach to understand counselling psychologists' experiences of delivering video-call therapy during COVID-19. As the primary focus of this study was to understand the unique experiences of counselling psychologists, a low-inference interpretation of data that is granted by QD methods was selected as an appropriate method. Although the description of data cannot be free of researcher interpretation, a QD approach encourages the researcher to stay closer to the data, words, and events described by participants compared to other ethnographic or narrative approaches (Sandelowski, 2000).

Participant Recruitment

Participants were recruited through professional network online forums and adverts as well as snowball sampling. Inclusion criteria required participants to be psychologists practicing within the counselling psychology scope and registered with the NZ Psych Board; reside in NZ; and have current or previous experience delivering online therapy during the emergence of the COVID-19 pandemic.

Eight counselling psychologists participated in this study: seven identified as female, and one identified as male. Five identified as New Zealand European, with the remaining three identifying as Tongan European, Māori, and Taiwanese, respectively. Their ages ranged from 26 to 56. Seven were registered counselling psychologists with the New Zealand Psychologists Board, and one was a registered counselling psychology intern. Their lengths of professional registration ranged from six months to eight years. Five worked for a not-for-profit trust, with the remaining three working in a government agency, a primary healthcare organisation, and private practice, respectively.

Data Collection

The method of data collection was through semi-structured interviews (SSI) conducted between 30th July 2021 and 21st September 2021. The SSIs were approximately an hour in length, which is the recommended length in order to minimise fatigue for both the interviewer and participant (Adams, 2015). A list of interview questions was developed prior to the interview process and were informed by current research and literature on video-call therapy, counselling psychology and the impacts of the COVID-19 pandemic. The primary investigator (CK) conducted all interviews using a videoconferencing platform to allow participants to save on travel time and cost of transport and parking, and CK then transcribed the digital audio recordings. Transcripts were checked multiple times to ensure accuracy, with each participant also being offered their transcript for them to review. CK undertook initial data coding and identified potential themes followed by a cross-checking process with two of the other researchers (KvK, EdP). CK developed initial themes' names and definitions and further feedback and clarifications from KvK and EdP were incorporated. Ethical approval for this study was granted by the Auckland University of Technology Ethical Committee (AUTEC) on the 26th of May 2021.

Data Analysis

Braun and Clarke's (2006) six-phase thematic analysis was employed to analyse the transcripts. Phase One (Immersion in the data) focused on becoming familiarised with the data through process of in-depth immersion in the data (Braun & Clarke, 2006). This included the primary investigator listening to the audio recordings of interviews and reading the transcripts of interviews to prompt the note-taking process. Notes were taken on potential themes which were based on emergence of participants' experiences, views, strategies, or approaches in relation to delivering video-call therapy.

Phase Two (Generating initial codes) represented the start of the systematic analysis of the data using a process of generating codes. Codes assist in identifying and providing a label for features in the data that are relevant to the research question (Braun & Clarke, 2006). The primary investigator generated codes by identifying interesting, relevant, and meaningful aspects of the data which were shared across participants (Braun & Clarke, 2006). A process of identifying similarities and differences between participants' experiences of delivering online also began, whereby corresponding codes were grouped together. Notes were also made in relation to the codes.

Phase Three (Generating themes) marked a shift from generating codes to generating themes. A theme refers to a label which captures important aspects of the data in relation to the research question and represents some level of shared responses or meanings within the interviews (Braun & Clarke, 2006). The codes from Phase Two were organised into potential themes. The themes were still developed in a descriptive manner to stay close to the

meaning and content of the participants' descriptions. Themes also corresponded to words used by the participants, or meanings they had attributed to their experiences.

Phase Four (Reviewing potential themes) represented a form of quality checking to ensure the potential themes aligned closely with the content and meaning of the data set, remained relevant to the research question, and reflected wider discourse (Braun & Clarke, 2006). To uphold external heterogeneity and internal homogeneity, a process of altering, keeping and discarding themes was required (Patton, 1990). A theme was valid if it was distinctively varied from other themes, whilst also containing subthemes within the theme that were related to each other. This phase prompted an interactive and reflexive process, where data sets were reconsidered to prompt new insights or relevance to a theme. To add to the rigour of the data analysis process (Braun & Clarke, 2006), a cross checking consultation with the other authors was conducted to ensure accurate representation of the data. In this cross-checking process, all authors collaboratively ensured that the themes were relevant to the research question and had good face validity in relation to the codes that comprised them and the discourse in the literature. The primary investigator ensured that the final themes remained aligned with the content and overall meaning of the data set.

In Phase Five (Naming and determining themes), each theme and relevant data extracts were re-read alongside allocating relevant and concise titles to themes and sub-themes. Care was taken to ensure the naming of the themes was close to the participants' own words as possible. The selected themes were chosen to represent central concepts to the phenomenon of delivering video-call therapy in a COVID-19 and clinical context.

Phase Six (Producing the report) included analysing themes individually, with supplementary evidence from the data set through the forms of excerpts being used to clearly demonstrate the theme and its meaning in the participants own language. The findings were grounded in discussions related to the research question, reference to literature, cultural and ethical factors, and implications of this research.

ANALYSIS AND COMMENTARY

Thematic analysis of the eight transcripts revealed four major themes: Pre-pandemic Hesitancy; Managing the Transition; Integrating the Learnings; and Contextual Factors. These are presented and summarised in Figure 1.

Theme 1. Pre-Pandemic Hesitancy

The first theme reflects participants' pre-pandemic hesitancy towards video-call therapy. When participants were asked to reflect retrospectively on their pre-pandemic attitudes towards video-call therapy, seven of the eight participants saw it as an adequate backup in some exceptional circumstances but were hesitant to use it unless necessary. The exceptional circumstances related mainly to accessibility issues

> *"It was a second-best option that was useful when… someone had a problem, and they couldn't leave the house or they had trouble with I don't know getting childcare" (P5)*

The belief that video-call therapy is not conducive to the therapeutic relationship was one of the main reasons participants saw video-call therapy as 'second best'. This appeared to be a particularly important concern during long assessment interviews and before a therapeutic relationship has been established. Additional hesitancies reported were difficulty noticing subtle processes such as non-verbal communication and unforeseen failures and obstacles that may arise from video-call therapy technology. The prevailing pre-pandemic perspective on video-call therapy was that it was: suboptimal in its ability to maintain and particularly to establish a therapeutic relationship; suboptimal in its ability to notice and use subtle therapeutic processes; prone to technological mishaps; but nonetheless useful as a backup given its accessibility advantages.

> *"A lot of us have been hesitant to do two- or three-hour assessments on video… not just because of the length of time on screen… You have to think about other ways to build that relationship, especially if it's the first assessment session" (P7)*

Theme 2. Managing the Transition

The second theme reflects how participants managed the necessary transition to video-call therapy. Lockdown restrictions imposed a sudden requirement to either stop therapy or transition to online platforms. This necessitated therapists to immediately prepare themselves to deliver therapy online, not just practically, but also psychologically and emotionally, while continuing to uphold ethical and competent practice throughout a disruptive and uncertain time. Four common considerations were identified in how participants adapted to this forced transition: practical considerations; peer support; transparency; and flexibility.

Practical Considerations: – Physical, Technological, Educational

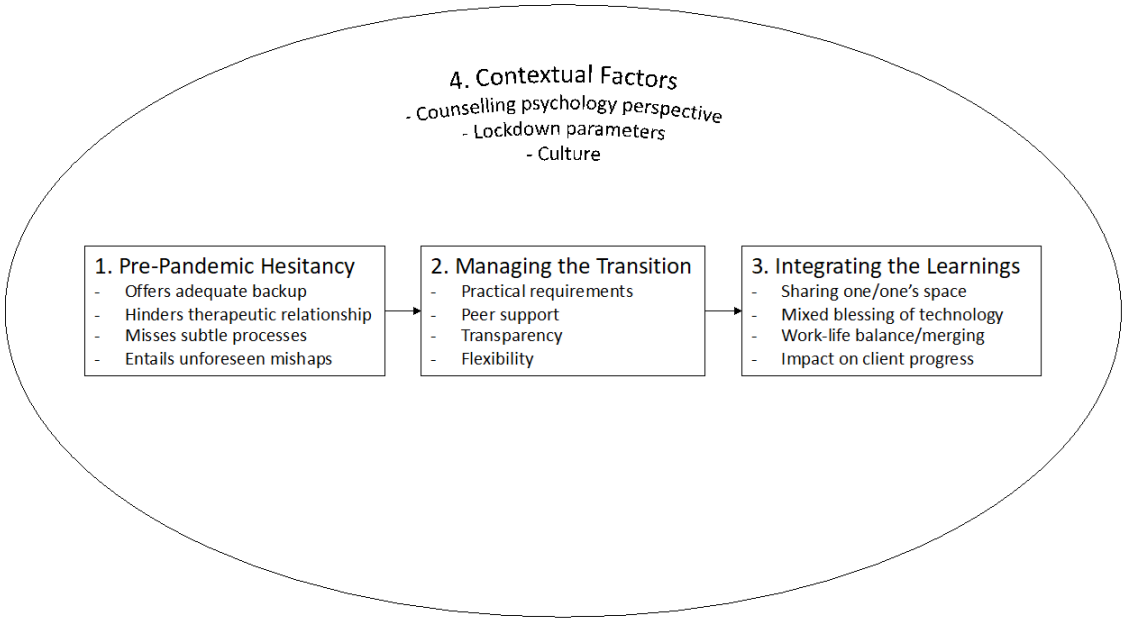
Participants viewed video-call therapy as having different physical, technological, and knowledge requirements than does in person therapy. Although the interaction occurs online, participants noted that the physical room in which the therapist sits is still important in its ability to convey meaning, create a desired atmosphere, and maintain privacy. Participants also noted the need to consider the technological requirements, such as adequate computer systems, internet connection, licenses for online platforms, even tripods and computer stands to enhance the online experience. Finally, participants reflected on their self-guided learning around how best to deliver video-call therapy. However, they also noted the need for more training resources and best-practice guidelines specific to video-call therapy.

> *"Maybe a bit more information and a bit more research… and just really accessible resources and information that is clear but not too lengthy" (P4)*

Peer Support – Connection, Solidarity, Learning

Participants reported the importance of peer support for their successful rapid adaptation to video-call therapy. Planning time to meet online with peers offered a sense of social connection, solidarity in the face of shared

Figure 1. *Major themes and main considerations*



challenges, and opportunities for informal learning from how others have navigated the new challenges. Five participants also reported the importance of solicited guidance from more experienced psychologists or supervisors, particularly in relation to maintaining ethical and culturally safe practice online.

> *"We've scheduled both formal and informal meetings. So formal meetings we talk about the client stuff and the informal meetings – it's Friday afternoon where we bring our snacks and drinks… and we just chat about life… or rant about work" (P7)*

Transparency – Keeping the Client in the Loop

Participants made sure to keep clients updated with what services they are offered during lockdown. Transparency also involved recognising that both the therapist and client were navigating an uncertain environment, both in terms of the pandemic response in general and the new way of doing therapy. Transparency in this context created an opportunity for collaboration and acceptance that some participants found useful.

> *"I think, overall, it became a positive experience because we made it that way… Between the client and I… we accepted 'okay this is the way it is, so how are we going to make the most of the situation?'" (P8)*

Flexibility – Overcoming New Challenges and Recognising New Advantages

The new challenges that therapists faced through their rapid imposed transition to video-call therapy were novel to the therapist and different for different clients, and required being open to creative solutions to each client's unique set of circumstances. Part of this entailed accepting that although everyone was going through the same pandemic, not everyone had the same experience or needs. Indeed, the transition required accepting that some clients chose to wait until face-to-face sessions resumed.

> *"[Therapists] are more mindful that maybe some clients don't want to show others their home, so [clients] just refuse video outright. So, I think from the therapist's side, you have to be willing to be more flexible" (P7)*

Flexibility not only describes the ability to manage oneself in a new set of constraints, but it also describes the ability to recognise new advantages within the new context. Exploring the affordances of online platforms allowed participants to change how they did therapy in ways that offered unique benefits.

Theme 3. Post-Transition Understandings – Uncovering Key Considerations for Effective Video-call Therapy.

The third theme reflects participants' understanding of video-call therapy following the transition phase. Through trial and error across repeated lockdowns, participants' pre-pandemic hesitancies towards video-call therapy transformed into a more nuanced understanding of advantages and challenges of video-call therapy and how to manage these in different contexts. Their reported experiences reflect that the characteristics of video-call therapy that are challenging in some respects are helpful in others. These trade-offs reveal that video-call therapy is not necessarily better or worse than in person therapy, but rather it is different. Four overarching trade-offs were identified within this theme.

From Sharing One Space to Sharing One's Space - Seeing Each Other in Our Home Environments

Transitioning from in-person to video-call therapy during lockdown entailed client and therapist no longer meeting in the same physical room, but rather meeting online from within their own personal living spaces. As noted, in Theme 1, participants expressed the pre-pandemic view that not sharing the same space will hinder

the therapeutic relationship and the non-verbal cues that support it. While it was generally acknowledged that this did have some impact, three participants were surprised at the depth of the connection fostered online. Some hypothesised that their therapeutic relationships were less impacted than expected because key elements of developing and maintaining the relationships were still possible online. Interestingly, more than half of the participants reported a different kind of intimacy granted by seeing each other in their own home environments. This was seen as particularly valuable for those who work with family system approaches, as being virtually in the client's own living space afforded an increased opportunity to engage with their family.

"You lose the intimacy of being in a room with someone, but somehow now there's this other intimacy that's there, in that I'm talking to a person inside their own home and they're seeing me inside my own home" (P4)

The shift away from sharing a physical therapy room meant the participants had less control over important aspects of the therapeutic environment, such as privacy and safety. Participants reported that some clients seemed more comfortable and open at home, particularly those for whom the closeness from sharing a room with a therapist may be uncomfortable. However, participants also recognised that these unique advantages applied only to the extent that the client experienced video-call therapy in their home environment as safe and confidential. Indeed, it was noted that some cases, such as those involving family violence, required serious ethical consideration around confidentiality and risk.

"I noticed in lockdown everybody's at home so my clients are having to talk really quietly or not being able to be totally authentic and honest because someone might hear. And just… I had a client in a domestic violence relationship… he was quite controlling of her [the client] so she wasn't able to go for a walk to chat with me" (P3)

Given that participants no longer had control over the safety and privacy of the therapeutic environment, the impact of this transition partly depended on the safety and privacy of the client's home and the extent to which they presented with risk.

The Mixed Blessing of Technology

Participants reported they appreciated the increased accessibility, and also found technological mishaps challenging, particularly when dealing with risk or highly sensitive content. Some participants learned that the technological interface itself enhanced their connection with some clients, and hypothesised that the distance from interacting online may feel safer for some clients. However, some participants noted that interacting through a screen for long periods of time made them feel more tired, citing possible reasons such as exerting extra energy compensating for the lack of non-verbal communication that is afforded by face-to-face therapy. Some therefore chose to either shorten their sessions or reduce the number of clients per day. Four participants also noted the effects of seeing themselves on the screen. Two found it distracting or became hyperaware of themselves (this can also add to fatigue), while the others found it insightful to notice and reflect on how they use non-verbal communication.

"I learnt a lot about how I move my hands, my own body language, sort of how I position myself" (P2)

The extent to which technology is a blessing, or the technological mishaps are a significant disruption, may be partly moderated by the therapist's and client's existing familiarity with using online communication tools. Some participants noted that this balance tended to be associated with age, with younger clients, such as university students, apparently having no issues with the technological side of video-call therapy.

Working from Home – Enabling Work-Life Balance and Blurring Work-Life Boundaries

Working from home was typically experienced as time-efficient, freeing up more time to engage in other meaningful activities. For some participants, this meant more time for other work-related tasks. For others it meant more time for self-care, contributing to a greater sense of work-life balance. The merging of therapist's personal and professional lives was sometimes reported as pleasant, such as feeling more comfortable doing therapy from home in comfortable clothes yet was also reported as challenging, such as when engaging in emotionally demanding work.

"The other challenge I guess is just personally like being in your home space and doing some quite heavy work… You're sort of sitting in people's trauma a lot and in your own home, in your own space. So I know I personally prefer to go to an office and then have this process of being able to leave that [work] in the office" (P5)

Perceived Impact on Client Progress

Participants noted that the efficacy of video-call therapy for their clients depended partly on their clients' presenting problems. Six participants noted that clients presenting with higher risk, post-traumatic stress disorder, or borderline personality disorder appeared to make less progress online than in person. Three participants noted that clients with social anxiety tended to feel better, but they were not sure if this was due to progress during video-call therapy or the general removal of their anxiety-provoking situations from lockdowns. Conversely, one participant had a client who struggled with online technology and who made better progress through the increased exposure to using video-call therapy. Finally, participants noted that some clients opted to wait until in-person therapy was available again, halting progress altogether.

"There are a lot of people who felt their anxiety was dropping because they no longer had to expose themselves to certain situations…So I felt with some of my clients it was actually kind of hard to measure progress" (P1)

Theme 4. Contextual Factors Influencing Experience of Video-call therapy

The fourth theme reflects participants' descriptions of broader contextual factors that influenced their experience

of video-call therapy during the pandemic: the counselling psychology perspective, lockdown parameters themselves and cultural factors.

Counselling Psychology Perspective

Participants noted that their counselling psychology perspective influenced how they approached the transition to video-call therapy. While their emphasis on the therapeutic relationship underpinned some of their reservations around whether an effective relationship could be established and maintained online, it also underpinned their continual effort to do so. Similarly, counselling psychology's emphasis on the context in which the client is embedded primed participants to notice the ways that video-call therapy enhanced their contextual and phenomenological understanding. The act of offering video-call therapy itself was seen as consistent with counselling psychology's systemic emphasis.

> *"I think that when we consider context, that can mean working in ways that considers the systems people are in. In particular, when we are going through lockdowns… there is genuinely a direct barrier to face-to-face therapy. So, in some ways, I see video-call therapy as being a really ethical choice, particularly through a pandemic, because we are considering systems in which people are now shifting and living their lives and this is removing a barrier to accessing care" (P1)*

If the systems in which a client is embedded impact their ability to access in-person therapy (in this case, a public health system mandating the use of lockdowns), then offering video-call therapy was considered a flexible way of meeting the client where they are at.

Lockdown Parameters – Restrictions and Repetitions

At a basic level, lockdown restrictions created the sudden need to transition to video-call therapy and required participants to do this from their living space rather than from an external location. Interestingly, the fact that there were repeated lockdowns was noted by participants and provided opportunity to acclimatise to video-call therapy and refine their approach with each successive exposure.

> *"Each [lockdown] has kind of gotten a little bit better… as we're more, I guess used to it or prepared for it" (P5)*

Culture

Many participants noted that the client's cultural identity and the therapist's cultural competence could influence the extent to which transitioning to online methods impacted the therapeutic relationship. Some participants described giving extra attention to exploring how to create a culturally safe environment online (flexibility), including attending cultural supervision (peer support).

> *"So for me it was really difficult like 'right, how do I facilitate an environment [online] where [clients] could feel comfortable bringing that cultural element into the session" (P2)*

One participant noticed a disproportionate reduction in their Māori and Pasifika client numbers during lockdown, hypothesising that they may have wanted more privacy around their therapy than their home environment could offer. Another participant noticed a similar trend with younger clients – namely that they wanted to keep their therapy more private from their parents (sharing one's space) yet younger participants also tended to take to video-call therapy more readily than did older ones.

> *"I mean, for millennial clients and younger clients, technology is great for them because they're all over it" (P4)*

Participants hypothesised this openness to video-call therapy was due to their youth culture's familiarity with online platforms (the mixed blessing of technology).

CONCLUSIONS AND IMPLICATIONS

This research sought to understand how counselling psychologists in Aotearoa New Zealand experienced online video-call therapy and the rapid transition to it during the COVID-19 pandemic. The findings suggest that participants' pre-pandemic hesitancies towards online video-call therapy morphed into more nuanced understandings of its advantages and challenges. These nuanced understandings, and the factors that influenced the transition process, offer considerations for others who are introducing more video-call therapy in their work.

From Pre-Pandemic Hesitancies to Post-Transition Understandings

Participants in the current study expressed pre-pandemic hesitancies consistent with the literature. In particular, the perception that video-call therapy is less conducive to developing a therapeutic relationship and noticing subtleties, such as nonverbal cues and transference/countertransference (Aafjes–van Doorn et al., 2022; Alqahtani et al., 2021; Reilly et al., 2022; Wray & Rees, 2003). Unforeseen challenges, particularly technological ones (Carper et al., 2013), and the anxiety or doubt around whether one is competent to manage them is also commonly reported (Aafjes-van Doorn, Békés, & Prout, 2021; Aafjes–van Doorn et al., 2022; Al-Mahrouqi et al., 2022; Sherrill et al., 2022). These concerns contribute to the perception that video-call therapy is sub-optimal though useful in certain contexts, such as when accessibility is limited (Reilly et al., 2022).

Interestingly, after repeated pandemic lockdowns in which therapy either had to go online or stop, participants in the current study developed a more nuanced appreciation and optimism towards video-call therapy's potential utility and effectiveness – a general trend shared by many studies documenting therapists' experiences of OT during the pandemic (e.g., Aafjes-van Doorn, 2022; Aafjes–van Doorn et al., 2022; Ahlström, Von Below, Forsström, & Werbart, 2022; Dowling et al., 2022; Emran, Smith, & Iqbal, 2022; Kotera, Kaluzeviciute, Lloyd, Edwards, & Ozaki, 2021; Reilly et al., 2022; Sherrill et al., 2022; Shklarski, Abrams, & Bakst, 2021; Tomaino, Viganò, & Cipolletta, 2022).

One of the most salient differences between in-person and online video-call therapy is that the client and therapist no longer sit in the same room. Findings from the current study suggested that an effective relationship

could still be maintained online even if it was different in some ways, consistent with other research (Aafjes-van Doorn et al., 2021; Aafjes–van Doorn et al., 2022; Banack, 2021; Fernández-Álvarez & Fernández-Álvarez, 2021; Gordon, Shi, Scharff, Fishkin, & Shelby, 2021; Reilly et al., 2022; Shklarski et al., 2021). Study participants' success in this domain may be partly attributable to the high importance counselling psychologists place on the therapeutic relationship (du Preez, Feather, & Farrell, 2016; Manthei et al., 2004; Stanley, 2013), combined with their attitude of openness and flexibility expressed towards working with the affordances of an online context.

It is noteworthy that participants in the current study did find online video-call therapy more tiring, which is consistent with other research (Aafjes-van Doorn, 2022; Aafjes–van Doorn et al., 2022; Ahlström et al., 2022; Békés, Aafjes–van Doorn, Prout, & Hoffman, 2020; Emran et al., 2022; Goldschmidt et al., 2021; Sampaio, Navarro Haro, De Sousa, Vieira Melo, & Hoffman, 2021; Shklarski et al., 2021). This fatigue may be partly explained by the extra effort spent on transferring relational skills to a two-dimensional screen, and by simultaneously managing the impact of the pandemic on oneself while supporting the client to do the same (Barry & Singer, 2022; Békés et al., 2020; Nuttman-Shwartz & Shaul, 2021). Research is emerging on how to foster and maintain therapeutic relationships online (Banack, 2021; Geller, 2021; Rodgers, Tudor, & Ashcroft, 2021). As these guidelines develop, and therapists become more familiar with online video-call therapy and managing its challenges, the perceived effort to establish and maintain relationships online may decrease. Indeed, research suggests that through exposure and experience, video-call therapy typically becomes less challenging over time (Sherrill et al., 2022).

The lockdown restrictions meant that client and therapist joined the online session from their own homes, entailing the sharing of their personal spaces with each other. Our participants noted that the privacy and safety of the therapeutic environment therefore depended on the privacy and safety of the client's home, which is a concern echoed in the literature (Al-Mahrouqi et al., 2022; Downing, Marriott, & Lupton, 2021; Emran et al., 2022; Goldschmidt et al., 2021; James, Schröder, & De Boos, 2022; Jurcik et al., 2021; Kotera et al., 2021; Reilly et al., 2022; Shklarski et al., 2021; Smith & Gillon, 2021; Tomaino et al., 2022). In cases where privacy is a concern, flexibility around timing (e.g., clients waiting for a private moment) and mode (e.g., texting or emailing for support rather than video calling) may be helpful.

Given the lack of therapist control over the safety of the client's home, some participants wondered if video-call therapy is not suited for higher risk cases, consistent with similar research (Appleton et al., 2021; Reilly et al., 2022; Smith & Gillon, 2021). In cases where the home environment is relatively safe, the glimpse into each other's private lives may actually improve some aspects of the relationship and offer a more direct understanding of the client's ways of relating to their environment, as found by many of our participants and other similar studies (Ahlström et al., 2022; Shklarski et al., 2021; Smith & Gillon, 2021; Tomaino et al., 2022). Participants in the current study noted that the ability to experience aspects of a client's context through online video-call therapy suited the counselling psychology approach, with its emphasis on understanding the systems of which the client is a part (du Preez & Goedeke, 2013).

Video-call therapy from home also entails a change in the boundaries between personal life and work life (Alqahtani et al., 2021; James et al., 2022; Reilly et al., 2022). The current participants appreciated the convenience of working from home because it freed up more time for other important aspects of their lives, such as self-care and personal or professional development, as found in other research (Al-Mahrouqi et al., 2022). At the same time participants noted that aspects of work could seep into their personal lives in undesirable ways, such as noticing residual uncomfortable feelings in their home after working with heavy content. Therapists transitioning to video-call therapy might wish to consider boundaries between their personal and professional lives. Although not an option during lockdowns, therapists working online at other times might wish to do so from their office, so that their usual rituals around putting on their professional persona and travelling to and from work remain intact. Alternatively, new rituals could be established to help enter in and out of work/therapy mode when working from home (Geller, 2021).

Participants in the current study felt that most clients who engaged in online video-call therapy during lockdown progressed well. However, they also noted that this mode of therapy suited some clients more than others. Conversely, participants expressed hesitation towards working online with clients at higher risk of self-harm or with higher severity disorders, which is a trend found in the literature (Aafjes-van Doorn, 2022; Appleton et al., 2021; Fernández-Álvarez & Fernández-Álvarez, 2021; Kotera et al., 2021; Melluish, Bhola, Gutierrez, Critchfield, & Atwood, 2022; Reilly et al., 2022; Smith & Gillon, 2021). Participants also wondered if online video-call therapy enabled the avoidance of social situations and therefore was less conducive to treating social anxiety symptoms, which is also echoed in the literature (Jurcik et al., 2021). Research is emerging on how to work with specific disorders online (e.g., Komariah et al., 2022; Stewart et al., 2021), and as this research grows, therapists may gain the confidence to work with presentations that have typically been considered challenging to work with online.

Contextual Considerations

Participants noted that the more nuanced understandings gained from video-call therapy experience intersected with cultural variation. Their observation that millennials and high school or university students seemed more comfortable communicating online, has been supported by other research (Dowling et al., 2022). In addition to age, political-economic considerations around inequity in the access to fast internet and laptops/smartphones may also influence the accessibility of video-call therapy for clients (Dowling et al., 2022; Goldschmidt et al., 2021; Melluish et al., 2022). Video-call therapy is generally viewed as more accessible, yet this may only apply to cultural and sociodemographic groups who hold adequate access to technology, internet, and private spaces to attend

video-call therapy sessions. Māori participants in a recent New Zealand study reported many benefits to telehealth consultations yet also mentioned barriers to digital access, which have the potential to widen disparities (Wikaire et al., 2022). Future research could explore factors which may restrict access to care/video-call therapy for certain cultural and socio-economic groups. The challenges in nurturing vā with Pasifika communities in online spaces during COVID-19 is not widely researched in the Aotearoa New Zealand psychology context, though this is a noticeable concern cited among related research (Faleolo, 2021; Matapo, 2021; Refiti et al., 2021).

The lockdown restrictions themselves were a shared context, for both the participants and their clients, that simultaneously provided the challenge and the opportunity to become more familiar with online video-call therapy and its affordances. As already outlined, a resounding pattern within the literature on therapist experiences of video-call therapy during the COVID-19 pandemic is one in which video-call therapy is "better than expected" (Dowling et al., 2022, p. 1). Sherrill et al. (2022) conceptualised this in terms of exposure for technophobia. The nature of recurring lockdowns in Aotearoa New Zealand created repeated exposure opportunities of video-call therapy, allowing participants to practice and consolidate their experiences and learnings of this means of delivering therapy.

Managing the Transition

The finding that participants felt the need to self-educate given the lack of explicit guidelines and training for how to do effective therapy online is also echoed in the literature (e.g., Aafjes–van Doorn et al., 2022; Ahlström et al., 2022; Al-Mahrouqi et al., 2022; Goldschmidt et al., 2021; Kotera et al., 2021; Reilly et al., 2022; Tomaino et al., 2022). This educational gap has started to be addressed, with recent research towards developing guidelines and training programs emerging for video-call therapy in general and in relation to specific modes of therapy and client presentations (e.g., Cavanagh, Gerson, Gleason, Mackey, & Ciulla, 2022; Dolev-Amit, Leibovich, & Zilcha-Mano, 2021; Foroughe, Soliman, Bean, Thambipillai, & Benyamin, 2022).

Transparency with clients was also found to help with the transition to video-call therapy. Given that both therapist and client were affected by the pandemic, some level of transparency from the therapist about how they were experiencing the pandemic may have helped to strengthen the relationship and normalise some of the client's own struggles (e.g., Shklarski et al., 2021). Participants in the current student described their ability to be flexible. Given the uncertainty around how the pandemic would unfold, the requirement to transition to online video-call therapy, and the pre-pandemic hesitancies towards video-call therapy, having an open and flexible attitude may have facilitated exploration of what online video-call therapy had to offer, increasing the potential for learning.

The propensity of our participants to embody a flexible and collaborative attitude is consistent with counselling psychology. Counselling psychology distinctively embraces contextual factors in a person's life, including those that constrain them beyond their control, while working towards empowerment within those constraints. In other words, it is often about helping people to do what is important to them using what is available to them. Therapists were similarly required to do what they could within the constraints of the pandemic. Continuing to be present, empathetic, relationship-centric therapists in clients' lives, given the markedly changed set of available means through which to do so, required precisely the kind of flexibility that counselling psychologists help clients to adopt in the face of their own challenges. Modelling this flexibility therefore became an opportunity for congruence between what therapists practice and what they preach.

Conclusion

As we live in a world that is increasingly characterised by online interactions, it is useful for counselling psychologists to competently meet clients in that space. The pandemic conferred a fast-tracked exposure to video-call therapy and stimulated rapid adaptations to it. As a profession, counselling psychologists can now take stock of what was learned and build on their understanding of how to be an effective online therapist and provide effective video-call therapy. An optimistic general message can be taken from his qualitative study with counselling psychologists in Aotearoa New Zealand during the COVID-19 pandemic. That is, online video-call therapy is not necessarily better or worse, but it can be used effectively, particularly when the therapist is flexible and open towards learning new ways of building relationships online, is willing to adjust workload depending on the fatigue they feel, can relinquish some of the influence over the physical environment for a given client, and is comfortable with exploring how to navigate a new set of boundaries between therapy and daily life. The pursuit of becoming competent with online video-call therapy is an extension of the same process that therapists are already embedded in. That is, continuing education so that psychologists may competently meet clients where they are at. This study has provided a practice-oriented understanding into counselling psychologists' experiences of video-call therapy and how the discipline impacts their delivery, views, and ideas about the ongoing integration of video-call therapy as part of their clinical practice.

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C**onflict of Interest statement**:
The authors have no conflict of interest to declare.

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