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PERSPECTIVES

Video counselling and psychotherapy: A critical commentary on the evidence base

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Abstract

Pre-pandemic research has suggested that video counselling is as effective as face-to-face practice. However, the mass migration of therapy to the online video domain as a result of the COVID-19 pandemic makes it essential to interrogate the evidence base. This paper provides a critical commentary on how video therapy is defined/labelled, the current evidence about whether video therapy is effective, and whether the working alliance and therapeutic relationship functions differently in video counselling. The paper concludes that while the evidence to date is promising, it is limited in quantity and applicability and hence generalisability. Lack of evidence is not evidence that video therapy is ineffective, but the large gaps in understanding highlight the importance, both ethically and empirically, of further research in this area.

KEYWORDS
counselling, online therapy, psychotherapy, video-conference, video-therapy

At the end of 2019, COVID-19 was confirmed as a potential pandemic. As incidents spread across the world, governments responded by imposing massive reductions in person-to-person contact. As a consequence, remarkable changes took place in the counselling and psychotherapy world. Therapy either ceased or stopped being face-to-face. While a gradual progression towards technology-based healthcare delivery was already under way, COVID-19 unexpectedly picked up the pace. A major problem with this was that the majority of practitioners were unfamiliar with the terrain and the evidence base for online therapies.

Research on the delivery of therapy in online environments (including text and email-based) spans the last 40 years. Over this period, methods of delivery have evolved, with webcams first appearing in the early 90s, Skype in the early 2000s and high-speed Internet rolling out over the last 15 years to many areas of the world.

The use of video-conferencing technologies is now commonplace, and the future of virtual realities in mental health a reality (Cieślik et al., 2020).

This active evolution in technology has provided a foundation for synchronous communication platforms and hence a way to continue counselling and psychotherapy during the pandemic. For practitioners, technologies which most closely mimic the in-room experience were understandably of greatest interest. Currently, *video counselling or psychotherapy* is probably the closest experience to being in the room with a client.

This paper aims to highlight some features of the extant research, some notable absences in the evidence and the challenges this presents to our understanding of our competencies and what we should do as counsellors and psychotherapists going forward. It draws from a rapid review of the research (PROSPERO 2020

CRD42020204705), carried out in 2020, which asked two questions: (a) What are client and practitioner experiences and perceptions of video therapy? (b) How effective is video therapy? (Roddy et al., in prep).

1 | DEFINITIONS AND TERMINOLOGY

One of the difficulties apparent when examining the research is the wide range of online and 'at distance' activities and the lack of semantic clarity describing interventions and modalities of delivery. Mental health, counselling, psychotherapeutic and psychological interventions are applied through a variety of media (e.g. telephone, email, video-conference), by a variety of practitioners (e.g. nurses, social workers, psychiatrists, counsellors), with different structures of delivery (e.g. asynchronous, synchronous, self-directed, intermittent and blended), different timing and boundaries (e.g. check in sessions of 10–15 min between activities, therapist on call) and with different aims (e.g. alleviation or management of symptoms, behaviour change, psychoeducation). The differences between these must be understood and taken in to account as the context for any research outcomes.

The range of therapeutic activities, which have been empirically examined, is further complicated by an absence of standardisation in the language used to describe them. In this paper, we use the term 'video therapy' to define: *synchronous, client-therapist interactions through video platforms which are structured in the same way as in-room counselling and psychotherapy*. In the literature, this practice has also been termed 'i-therapy', 'online therapy', 'e-therapy', 'cybertherapy', 'teletherapy' and 'cyberpsychiatry'. Similar terms are also used to describe support which occurs as an adjunct to therapy in between face-to-face sessions, so 'Internet support', 'blended therapy' and 'adjunct therapy' are all 'online therapy', but not 'video therapy'. Asynchronous text-based interactions between a therapist and client via email have similarly been classed as 'online therapy'. There is also a prevalence of 'online therapies' which are not interpersonal, including 'Internet-based' or 'Internet-facilitated' interventions (e.g. directed activities), which involve structured activities such as self-help modules and psychoeducation. These are often facilitated by therapists or nurses, and have been termed 'iCBT', 'therapist-assisted cybertherapy/e-therapy' and 'web counselling'. Poor semantic differentiation in technologically assisted therapies leads to confusion around defining its utility, use and outcomes. While there is evidence for 'online therapy', it is limited in the area of video therapy (as we are defining it), so this lack of clarity effectively hides the gaps and opportunities for essential work, as well as perhaps giving a false sense of security that all this work has been done.

2 | IS VIDEO THERAPY EFFECTIVE?

Is video therapy effective, or does it create poorer outcomes—as some counsellors and psychotherapists seem to have assumed

Implications for practice:

- Practitioners should understand the evidence base for video counselling and be aware of the gaps in our current knowledge
- Research priorities should be established which ensure video counselling is supported by a sound evidence base
- Video-counselling may not be suitable for all client groups and modalities

pre-pandemic (e.g. Békés & Aafjes-van Doorn, 2020; Russell, 2018)? A recent review of the pre-COVID research on online therapy was conducted by the Mental Health Policy Research Unit of the National Institute for Health Research (Barnett et al., 2020). This *umbrella review* is a systematic review of systematic reviews. It was conducted using a *rapid review* methodology: a systematic and transparent approach to searching the literature—but one that accelerates the review process to produce evidence in a resource-efficient way when compared to a non-rapid approach. The search focused on systematic reviews published from 2010 to 2020 and covered online therapies involving client–therapist interactions (i.e. excluding self-help, computerised e-therapies). Nineteen systematic reviews were located which met inclusion criteria; of these, 15 examined clinical effectiveness, with one examining outcomes of telephone therapy and the other 14 focusing on video therapy. The core finding of this paper in terms of the effectiveness of video therapy was positive:

> Across all patient populations, including patients with anxiety (K = 3), PTSD (K = 2), depression (K = 4; including in ethnic minorities [K = 1] and older adults [K = 1]), substance use disorders (K = 1) and multiple disorders (K = 4), videoconferencing interventions were reported to result in significant reductions in symptom severity, with outcomes comparable to face-to-face controls where these were included.
>
> (p. 6)

This positive judgement on video therapy was echoed by another recent (non-systematic) review (Thomas et al., 2021), which concluded that video-therapy is efficacious for delivery of behavioural and cognitive interventions, and highlighted the potential for integration of therapeutic activities into clients' everyday lives, and that clients rate the therapeutic alliance and satisfaction as highly as face-to-face therapy. Questions remain, however, about the generalisability of the pre-COVID evidence base.

2.1 | CBT focus of evidence base

To date, much of the evidence base for video therapy comes from CBT and there is limited evidence to support the delivery

of other therapeutic approaches online. For example, a recent systematic review of 'videoconferencing psychotherapy' for depression by Berryhill, Culmer, et al. (2019) included 33 studies, of which 24 were CBT/behavioural activation (BA) or CBT/BA with exposure therapy, and the remainder comprising therapies in the CBT/BA family (such as acceptance-based behavioural therapy and metacognitive therapy, variants of exposure therapies and problem-solving therapy). Just three studies assessed outcomes for multiple therapy models. Similarly, the studies reviewed by Thomas et al. (2021) included CBT or cognitive therapy ($k = 24$), cognitive-processing ($k = 4$), behaviour-activation/change ($k = 5$) and exposure therapies ($k = 9$); with two problem-solving therapies, one acceptance-based intervention, one 'Maudsley model' and six studies being described as having examined 'individualised' therapies. Our own rapid review of the research failed to identify any studies reporting outcomes for video-based humanistic therapies, such as the person-centred approach. Yet, estimates indicate over 80% of UK-based therapists have primary training in person-centred, humanistic or integrative practices (British Association for Counselling and Psychotherapy, 2021). This suggests that the current evidence of effectiveness for video therapy may not be applicable to most UK counsellors' practices.

2.2 | Focus of evidence base on specific populations

Pre-COVID research on video therapy tends to focus on populations for whom attending in-person therapy is challenging, such as older home-bound adults (Choi et al., 2020), people with social anxiety (Yuen et al, 2013), cancer survivors (Lleras de Frutos et al., 2020) and postpartum women (Yang et al., 2019). Research has also focused on the effects of video therapy for rural and remote geographical regions (Saurman et al., 2011; Scogin et al., 2018) and where intersectional needs make finding an appropriately qualified therapist challenging (e.g. Gray et al., 2015; Zheng & Gray, 2014). Hence, while the existing research evidences the value of video therapy for populations who may need to access therapy remotely, it cannot be assumed that these findings will extend beyond these specific populations.

2.3 | Online therapy may not be 'at home' therapy

The COVID-19 pandemic has required both clients and therapists to engage in counselling and psychotherapy from their home. However, in much of the extant research, clients or therapists will engage from an external location. For instance, in Berryhill, Halli-Tierney, et al.'s (2019) systematic review of video-counselling for anxiety, 14 out of the 21 studies involved clients accessing video therapy outside their homes: for instance, in clinic, school or hospital settings. Similarly, in Turgoose et al.'s (2018) review of treatment for PTSD in military veterans, 23 out of 41 studies involved clients travelling to local clinics for their appointments. In the 52 studies reviewed by Thomas et al. (2021), 16 were based on home-located clients, 26 clients were at a clinic, and 10 either did not state or had clients at mixed locations. These differences may be important. For instance, clinic-based video therapy may offer more scope for counsellors to hold a therapeutic 'frame' and to assure privacy and a lack of interruptions—the latter assumed to negatively impact therapeutic engagement (Weinberg & Rolnick, 2020).

3 | WHAT IS THE PROCESS OF CHANGE IN VIDEO THERAPY?

If video therapy does 'work', is it necessarily in the same way as face-to-face therapy? That is, is video therapy simply a different delivery method, or a different form of therapy itself? Differences in mechanisms of change could have important implications for training and practice. Yet, the evidence is limited here too.

3.1 | Clients' experiences of video therapy

Our review found no studies which ask clients about their perceptions or experiences of video therapy in any depth. This limits our ability to understand what is helpful and what is not in the online environment. Consequently, we may be at risk of assuming that evidence from the face-to-face field can be transposed to the video therapy field, or of inferring clients' experience from therapists' opinion.

3.2 | The therapeutic relationship

One of the most contentious issues is the impact of the on-screen environment on person-to-person interactions. Related to this is the relative importance of the therapeutic relationship and alliance in video therapy work.

One of the key features of effective therapy is the working alliance (Bordin, 1979) and a number of recent reviews indicate that being online does not reduce the ratings of the working alliance, with overall scores equivalent to face-to-face therapies (Berger, 2017; Richards et al., 2018) or even better (Holmes & Foster, 2012; Reynolds et al., 2013; Simpson & Reid, 2014; Watts et al., 2020). In their 2014 review of the therapeutic alliance in video therapies, Simpson and Reid (2014) examined 20 research reports and three PhD dissertations, the majority of which examined CBT (13 of 23 studies) and structured interventions (e.g. PTSD assessment, schema therapy). Their conclusion was that, overall, video therapy had positive potential on the alliance if particular barriers such as therapist confidence, assumptions and experience, along with client and issue suitability, were recognised and accommodated (Simpson & Reid, 2014). More recently, Watts et al. (2020) found evidence that clients undertaking module-based CBT rated a stronger alliance online than face-to-face.

While this may build confidence in the delivery of video therapy, the research on the working alliance is drawn from a range of online delivery modalities, which may not translate to video therapy. For example, Reynolds et al. (2013) examined the use of emails; Holmes and Foster (2012) captured online therapy as a collection of synchronous, asynchronous, telephone and video modalities; and Richards et al. (2018) examined the use of technological adjuncts to face-to-face therapy, rather than as a replacement of it.

In their narrative review of the online therapeutic relationship, Berger (2017) indicates that the delivery platform and modality of therapy may not allow positive evaluations of the therapeutic alliance to translate or be generalisable. While the therapeutic alliance has traditionally been a good predictor of positive therapy outcomes (e.g. Horvath & Symonds, 1991), there is an indication that it may fail to predict positive outcomes in online interventions (e.g. Holmes & Foster, 2012; Knaevelsrud & Maercker, 2006).

Overall, it appears that this evidence base has implications for more relational therapies where there is a centrality in the change process of psychological contact, trust, along with a sense of intimacy and relational depth (Mearns & Cooper, 2017). Counsellors themselves have expressed a number of key concerns and barriers to video therapy work (Sucala et al., 2013; Roddy et al., in prep). Relationally, the 'distance' between counsellor and client may be increased, with a reduced 'window of access' into the client's psychological experience. Here, the attunement gained in in-room therapy from facial expression, physical gesture, vocal tone, prosodic rhythm and matching may be missed (Alvandi, 2019; Ramseyer & Tschacher, 2011). In addition, aspects of the therapeutic relationship related to clients' feelings of safety, trust and attachment—along with the counsellor's ability to co-regulate emotional experience—may need adaptations (Alvandi, 2019; Simpson & Reid, 2014). There is some evidence that therapists and clients already adapt by enhancing or exaggerating non-verbal expression (e.g. Bischoff et al., 2004), or changing communicative dominance (who gets to speak and for how long) and active engagement (Day & Schneider, 2002; Simpson & Reid, 2014), but these areas have not been closely examined.

4 | CONCLUSION

Given the relative newness of video therapy, and despite some positive reviews (e.g. Thomas et al., 2021), it is understandable that the research base is limited in both size and scope. It is questionable whether the existing evidence of processes can be generalised to the kind of video therapy work typically conducted by therapists—including during the COVID-19 pandemic.

With the pandemic, the counselling profession is already online—and likely to remain there in some form post-pandemic. Hence, we have an ethical obligation to critically examine the outcomes and processes of this work.

5 | RECOMMENDATIONS

Although the evidence base is encouraging, we believe it is essential to establish:

- Agreed terminology for synchronous 'video therapy', distinguishing it from other types of online therapy (e.g. asynchronous text-based, synchronous audio-only), computer-mediated/self-help therapies and in-room therapies.
- More research into the outcomes of video therapy, with a particular focus on client perspectives, non-CBT modalities and populations that have currently been under-studied. As part of this, research is also needed into the populations and presentations that may be contraindicated for video therapy, as well as those for whom video therapy might be *more* effective than face-to-face.
- More research on video therapy processes and the role of the therapeutic relationship in online therapy.
- More research—along with therapist and client recommendations—into strategies to help improve the outcomes of video therapy. For example, in the expression and recognition of empathic responding (Grondin et al., 2019) and therapist presence, and 'in the moment' verbal and non-verbal responding and awareness (Geller, 2020).
- More research must also be done to capture the client experience of video therapy, broadly and in terms of the perceived acceptability of video therapy, given that during the pandemic the switch to video therapy occurred due to circumstance and not client choice.

As new evidence emerges, there will be a need to consider its implications for training and competency guidelines (British Association for Counselling & Psychotherapy, 2021), for service commissioning and delivery (e.g. to reduce implementation barriers; Muir et al., 2020) and for counsellors themselves (such as potential fatigue and stress; Mc Kenny et al., 2021). Given how much we need to know, we hope that this commentary will stimulate research activity in this area.

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