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RESEARCH PAPER

THE THERAPEUTIC RELATIONSHIP IN VIDEOCONFERENCING PSYCHOTHERAPY: A QUALITATIVE STUDY OF THERAPISTS' EXPERIENCES

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Abstract

Objective: The growth of videoconferencing psychotherapy (VP) requires a closer conceptualization of the therapeutic relationship in VP. Therefore, we investigated the therapeutic relationship in VP from the clinicians' perspective.

Method: We conducted three focus groups with 27 Italian VP professional psychotherapists of different theoretical orientations, focusing on their experience of the therapeutic relationship in VP. Data analysis was conducted through inductive thematic analysis.

Results: The following themes emerged: (a) construction and management of the online setting (regarding the complexity of the therapeutic boundaries in VP and the efforts to manage this); (b) meaning construction of the request for help and the therapeutic process (regarding how patients and therapist represent the meaning of the therapeutic space and work in VP); (c) patient and therapist involvement in the online relationship (addressing the depth of the therapeutic relationship in VP in terms of intimacy, openness/closure, distance/closeness, and involvement); (d) new elements of the therapeutic relationship introduced by VP (regarding the source and nature of information about the patient and the effects of the technical environment on the relationship); (e) nonverbal aspects and corporeality in VP (dealing with how different aspects of para- and extralinguistic communication may impact the therapeutic relationship in VP); (f) differences in the quality of the emotional and relational level of VP (regarding the emotional attitudes and reactions of patients and therapists and the overall quality of the therapeutic relationship); (g) treatment satisfaction and drop-out (regarding ease of leaving the session, patient satisfaction, and difficulties in terminating therapy); and (h) personal characteristics of patient and therapist that influence VP (regarding the impact of patients personality and therapists training/approach on the progress of VP).

*Conclusions:*Results suggest that the therapeutic relationship in VP has specific features that distinguish it from face-to-face psychotherapy. Implications for practice, training, and research are discussed.

Key words: therapeutic relationship, videoconferencing psychotherapy, thematic analysis, psychotherapists, qualitative methods

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Introduction

In recent years, the use of online psychotherapy has risen in popularity (Hollis et al., 2015), particularly during the COVID-19 pandemic, whereby many clinicians resorted to online interventions, thus experiencing the resources and the limitations of online tools and consultations (Van Daele et al., 2020). Among the different ways of delivering online psychotherapy (e.g., telephone, chat, or e-mail), videoconferencing

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psychotherapy (VP) specifically refers to clinical consultations provided using real-time interactive video (Mair & Whitten, 2000). The main advantages of VP include the possibility of reaching people with conditions (e.g., geographical, medical) that hinder face-to-face treatment, overcoming initial resistances that could lead to avoid seeking help for fear of stigmatization, and facilitating access to different territorial mental health services (Backhaus et al., 2012; Van Daele et al., 2020; Muir et al., 2020). Furthermore, it represents a valid alternative to maintaining the continuity of treatment starting face-to-face if the patient or therapist must move to other places for a prolonged period (S. G. Simpson & Reid, 2014).

Several reviews and meta-analyses have highlighted that VP can be an effective way to provide psychotherapy (S. Simpson, 2009) and produces symptom reduction compared to face-to-face settings (Backhaus et al., 2012; Chen et al., 2022; Norwood et al., 2018) in the treatment of different psychopathological conditions (Berryhill et al., 2019a, 2019b; Dufour et al., 2022; Liu et al., 2020; Matsumoto et al., 2020; Thomas et al., 2021). Moreover, patients seem to show a high rate of satisfaction with VP (Backhaus et al., 2012; S. G. Simpson & Reid, 2014).

The therapeutic relationship in VP

Despite these promising results, little is still known about the VP process (and how this may lead to treatment outcomes). This is especially true regarding the therapeutic relationship, generally defined as "the feelings and attitudes that therapist and patient have toward one another, and the manner in which these are expressed" (Gelso & Carter, 1985, p. 159).

Quantitative research

Some authors have begun to investigate the therapeutic relationship in VP quantitatively. However, the results show considerable inconsistencies. For example, while some studies suggest that therapists and patients are typically able to develop a strong therapeutic relationship and working alliance in VP (Backhaus et al., 2012; S. G. Simpson & Reid, 2014; Thomas et al., 2021) that are comparable to face-to-face treatments (Germain et al., 2010), other studies highlight levels of working alliance inferior to in-person therapy, notwithstanding the outcome equivalence of VP compared to face-to-face settings (Norwood et al., 2018).

A possible interpretation of this is provided by Norwood et al. (2018), who suggest that traditional measures of working alliance developed in the context of face-to-face treatments might not adequately assess the therapeutic alliance's distinctive features in VP. Another hypothesis was advanced by Cataldo et al. (2021; see also Norwood et al., 2018), who suggested that electronic devices in VP represent a third party in the therapeutic relationship, thus changing the traditional conception of the latter and explaining clinicians' lower ability and confidence working in this setting.

Indeed, scholarly literature has started to support the view that different relational aspects may intervene in the therapeutic process in VP, such as the necessity of extensive use of ostensive cues (i.e., cues informing the addressee of the speaker's communicative intention; Fisher et al., 2020), greater disinhibition and openness or increased flexibility (Simpson et al., 2020; see also Cipolletta et al., 2017), as well as the difference given by the restricted possibility of observing nonverbal communication and corporeality (e.g., Cataldo et al., 2019). Results from different surveys have suggested that, in online settings, psychologists struggle to build a solid therapeutic relationship due to the absence of physical presence and the lack or reduction of conventional, signs and clues typical of face-to-face interventions (Cipolletta & Mocellin, 2018). Psychotherapists have also reported feeling insecure about their ability to communicate their empathy and build a strong therapeutic relationship in VP, along with feeling more tired, less competent and confident, less authentic or genuine, and less connected with patients during videoconferencing sessions (Aafjes-van Doorn et al., 2020; Békés & Aafjes-van Doorn, 2020).

It seems clear that the concept of the therapeutic relationship in VP should be further investigated and articulated. In this regard, there has been a call to further explore therapists' experiences of the therapeutic relationship in VP (for a review, see Cataldo et al. 2021).

Qualitative research

Some empirical studies have begun to adopt a qualitative methodology to better explore therapists' experiences in conducting VP, although these are still relatively scarce compared to quantitative studies. As stated by Békés et al. (2023), "for a more nuanced understanding of therapists' subjective, lived experiences, it is important to complement the quantitative studies with open-ended qualitative queries" (p. 3; see also Gelo et al., 2012).

A few of these studies have used online surveys containing open-ended questions (e.g., Feijt et al., 2020; James et al., 2022; McBeath et al., 2020; Stukenberg et al., 2022). However, this may limit the depth of the therapists' experiences being explored, which, on the contrary, should be a primary focus when conducting qualitative research (Békés et al., 2023). For this reason, some authors have turned to in-depth interviews (e.g., Aafjes-van Doorn et al., 2023; Ahlström et al., 2022; Békés et al., 2023; García et al., 2022; Ivey & Denmeade, 2023; Shoullis et al., 2023) and, only to a lesser extent, focus groups (e.g., Bambling et al., 2008; Burbach et al., 2022; Glasheen et al., 2015).

Overall, their findings revealed a variability in therapists' experiences. The relational dynamics were perceived by some therapists as more symmetrical (consisting of a reduction in role differences between patient and therapist), with the consequence that patient risk-taking could become more problematic (García et al., 2022). However, at the same time, such a symmetry could contribute to "positive shifts in power dynamics" (Burbach et al., 2022, p. 87), with a consequent sense of a more genuine and authentic connection (Békés et al., 2023). The online setting was perceived to reduce the quality of nonverbal communication (Ahlström et al., 2022; Békés et al., 2023; Burbach et al., 2022; García et al., 2022; Ivey & Denmeade, 2023), with negative consequences on the perception of intimacy and empathic connection and resonance (Ahlström et al., 2022; Békés et al., 2023), resulting in variability in the relational engagement of patients and therapists (Békés et al., 2023) and difficulties in accessing patients' inner-states and managing relational boundaries and emotional conflicts (Burbach et al., 2022). However, at the same time, psychotherapists have also experienced online settings as allowing more open communication (Burbach et al., 2022) and affording new opportunities to discuss relevant issues (Békés et al., 2023). Moreover,

the medium of communication in online settings was experienced as having both positive and negative effects on the feeling of trust in the therapeutic relationship (Fletcher-Tomenius & Vossler, 2009). Finally, some therapists did not experience any significant change in online settings (Békés et al., 2023).

The present study

Although the studies described previously have contributed to some interesting initial insights into clinicians' in-depth experience of the therapeutic relationship in VP, none of them – neither those conducted with in-depth interviews nor those conducted with focus groups – have explicitly addressed the therapeutic relationship in VP as a whole in its own right. Instead, the focus has been either on specific aspects of the therapeutic relationship in VP (e.g., trust [Fletcher-Tomenius & Vossler, 2009], therapeutic alliance [Shoullis et al., 2023], and intercorporeality [i.e., the bodily resonance between the patient and therapist; García et al., 2022]) or on more general aspects of psychotherapeutic work in videoconferencing (e.g., the transition to an online setting [Ahlström et al., 2022; Békés et al., 2023; Burbach et al., 2022], attitudes to online counseling [Bambling et al., 2008; Glasheen et al., 2015], therapists' future plans and trainees' experiences of learning and conducting VP [Ivey & Denmeade, 2023], and the ins and outs of teletherapy practice [Aafjes-van Doorn et al., 2023]).

Overall, these (and other) studies highlighted the need to better explore clinicians' experience of the therapeutic relationship in VP (e.g., Békés et al., 2023; Ivey & Denmeade, 2023) taking into account the different aspects which may impact on it, such as the therapeutic setting (e.g., Békés et al., 2023; Leuchtenberg et al., 2023; Shoullis et al., 2023), patients' and therapists' personal (and professional) background (e.g., Aafjes-van Doorn et al., 2020; Békés & Aafjes-van Doorn, 2020; see also Heinonen & Nissen-Lie, 2020), and nonverbal aspects of communication (e.g., Ahlström et al., 2022; Békés et al., 2023; Burbach et al., 2022; Cataldo et al., 2019; Cipolletta & Mocellin, 2018; Fisher et al., 2020; García et al., 2022; Ivey & Denmeade, 2023). Regarding the setting, for example, therapists have shown a preference for a face-to-face setting over a VP setting because it is perceived as more usual and familiar, offers fewer disruptions, and is considered to facilitate the therapeutic alliance (Leuchtenberg et al., 2023). However, they also recognized that the VP setting offers advantages in terms of flexibility of place and time. Similarly, the interaction with the screen can distract therapists with negative consequences for the therapeutic relationship (Békés et al., 2023). Still, it can also increase awareness of one's body movements and facial expressions (Békés et al., 2023; García et al., 2022). Regarding the patients' and therapists' personal (and professional) backgrounds, a meta-synthesis of qualitative research on face-to-face treatments showed that patients consider the formation of the therapeutic relationship to depend both on the degree of similarity between the patient's and therapist's personal background and life experiences and on the therapist's professional competence (Noyce & Simpson, 2018). Similarly, in the context of face-to-face psychotherapy, it has been shown that therapists' personal life experiences and their self-confidence and enjoyment of the therapeutic work predict therapists' ratings of the therapeutic alliance (Heinonen & Nissen-Lie, 2013). Furthermore, past experiences of therapists (e.g., theoretical orientation, overall clinical experience, and previous experience with VP) have been shown to influence therapists' attitudes toward VP, with a particular focus on the quality of the therapeutic relationship (Békés & Aafjes-van Doorn, 2020). As for patients' characteristics, some empirical studies suggest that demographic variables (e.g., gender, age, level of education) may affect the choice between VP and face-to-face psychotherapy (e.g., Mazouri-Karker et al., 2023; Sora et al., 2022; Varker et al., 2019). Finally, regarding the nonverbal aspects of communication, it has been argued that VP may imply a partial perception of gaze and body language, with consequences for therapeutic presence and alliance (Cataldo et al., 2019). Indeed, it has been shown that the reduced nonverbal information and intercorporeality in VP may be challenging for therapists (Ahlström et al., 2022; Békés et al., 2023; Cipolletta & Mocellin, 2018; García et al., 2022), who in turn should take these aspects into account more reflexively.

We believe that a broader focus on these latter interacting elements can contribute to better exploring how therapists experience the construction of the therapeutic relationship in VP. Moreover, we believe that focus groups, due to their interactional and collaborative nature, can provide a particularly rich context for exploring these experiences in depth (for a discussion, see Edley & Litosseliti, 2018).

The present study is intended to contribute further to the in-depth exploration of how psychotherapists experience the therapeutic relationship in VP through the conduction of focus groups analyzed using an inductive, data-driven thematic analysis (Braun & Clarke, 2006). More specifically, we aimed to understand how psychotherapists experienced the construction and management of the therapeutic relationship in VP by exploring their perceptions of the content and quality of the therapeutic relationship and the role played in it by the personal (and professional) background of patients and therapist, nonverbal communication, and the therapeutic setting.

Method

Participants

Therapists

Inclusion criteria were being a licensed psychotherapist as required by the Italian government (i.e., master's degree in psychology or medicine and at least 4-year training in psychotherapy), having at least one year of clinical experience in face-to-face settings, and having been delivering VP in the least six months in a continuative way (actually, no specific teletherapy training is required in Italy for delivering VP). Convenience sampling was applied. The therapists were recruited in April 2023 among the members of an Italian private agency (https://www.centronovamentis.it) that provides VP through an online therapy platform in addition to face-to-face psychotherapy (https://terapeutaonline.it/psicologi-online/). Members of the agency were asked to participate in the study through an email inviting them to focus groups to explore the characteristics of the therapeutic relationship in VP. Those who agreed to participate in the research and provided informed consent took part in online focus groups conducted in July 2023. The study was approved by the Ethical Committee for Psychological Research of the University of Salento.

Data collection (see next section) involved 27

psychotherapists (n = 23 [85.2%] female) from different theoretical orientations with an average age of 33.85 years (SD = 4.67) (see **table 1**). They had a similar amount of clinical experience in providing VP (M = 1.9 years; SD = 0.6) but differed more consistently in the amount of experience with in-person psychotherapy (M = 4.2 years; SD = 1.4). Literature on the conduction of focus groups (e.g., Acocella, 2012) suggests that homogeneous groups about work experience should be created if members belong to the same organization and know each other to allow for greater participant openness, group synergy, and the capacity for cooperation and confidence among group members. Therefore, we divided the participants into three groups based on their clinical experience in face-to-face settings in order to maximize within-group homogeneity: Group 1 (1—3 years; lower experience; M_{age} = 33.11, SD = 2.85), Group 2 (4—6 years; medium experience; M_{age} = 34.11, SD = 2.09) and Group 3 (more than 6 years; higher experience; M_{age} = 38.0, SD = 6.65).

Table 1. *Sample description*

Group 1 — Clinical experience: 1—3 years			
ID T	Gender	Age	Approach
T1	M	32	Cognitive-behavioral therapy
T2	F	30	Integrated cognitive-neuropsychological psychotherapy
T3	F	31	Cognitive-behavioral therapy
T4	F	30	Cognitive-behavioral therapy
T5	F	34	Cognitive-behavioral therapy
T6	M	35	Transactional analysis
T7	M	39	Cognitive-behavioral therapy
T8	F	34	Cognitive-behavioral therapy
T9	F	33	Gestalt therapy
Group 2 — Clinical experience: 4—6 years			
ID T	Gender	Age	Approach
T10	F	36	Systemic-relational and family therapy
T11	F	30	Cognitive-behavioral therapy
T12	F	35	Gestalt therapy with existential phenomenological orientation
T13	F	36	Metacognitive interpersonal therapy
T14	M	36	Cognitive-behavioral therapy
T15	F	32	Systemic-relational therapy
T16	F	33	Systemic-relational therapy
T17	F	35	Constructivist psychotherapy
T18	F	34	Systemic-relational therapy
Group 3 — Clinical experience: more than 6 years			
ID T	Gender	Age	Approach
T19	F	33	Systemic-relational and family therapy
T20	F	38	Cognitive-behavioral therapy
T21	F	43	Cognitive-behavioral therapy
T22	F	48	Metacognitive interpersonal therapy
T23	F	32	Systemic-relational therapy
T24	F	48	Cognitive-behavioral therapy
T25	F	32	Cognitive-behavioral therapy
T26	F	34	Cognitive-behavioral therapy
T27	F	34	Cognitive-behavioral therapy

Researchers

The authors and researchers involved in this study ascribe to a relational psychodynamic approach with a shared social constructivist epistemology (Eagle, 2011**)**. According to this, individual meanings and experiences are shaped within social exchanges through a process of interpersonal sharing and negotiation (e.g., see Gelo, Vilei, et al., 2015). Consequently, the therapeutic endeavor, including the therapeutic relationship, is considered an intersubjective process of meaning-making and knowledge co-construction between patients and therapists (Salvatore et al., 2009). The authors had no specific expectations of the therapeutic relationship in VP, except that it may exhibit characteristics that are partly specific and partly common to the therapeutic relationship in face-to-face settings.

Data collection

Data were collected during three focus groups (i.e., Group 1, Group 2, and Group 3; see **table 1**). Each focus group was conducted in two sessions via videoconferencing by two experienced psychotherapists, with each session lasting 2 hr (for a total of 4 hr for each group). A semi-structured interview protocol was developed based on the findings of previous empirical literature described in the introduction of this paper (Aafjes-van Doorn et al., 2020; Ahlström et al., 2022; Békés & Aafjes-van Doorn, 2020; Békés et al., 2023; Burbach et al., 2022; Cataldo et al., 2019; Cipolletta & Mocellin, 2018; Fisher et al., 2020; García et al., 2022; Ivey & Denmeade, 2023; Shoullis et al., 2023). The interview aimed to stimulate a discussion among participants about their experiences of the therapeutic relationship in VP and different aspects of VP that, according to the literature, seem to have a primary impact on it. Participants were asked to discuss the following main domains: (1) content and quality of the psychotherapeutic relationship in VP; (2) personal and professional background and the therapeutic relationship in VP; (3) nonverbal communication in the therapeutic relationship in VP; and (4) setting and the therapeutic relationship in VP (see Appendix A for the interview guide). Each focus group interview lasted approximately 2 hours and was recorded, anonymized, and subsequently transcribed by a psychologist (CU, fourth author of this paper) and checked and eventually corrected by two external supervisors (GL and OG, first and last author of this paper, respectively). Participants provided informed consent before the focus group.

Data analysis

We used inductive data-driven thematic analysis (Braun & Clarke, 2006) to analyze the transcribed text corpus of the focus groups. Thematic analysis was chosen for its epistemological and theoretical flexibility. We took an inductive approach because of the exploratory nature of our research question. Overall, we followed a realist approach to thematic analysis as it allowed for a more straightforward focus on therapists' experience.

A research team of three psychologists with experience in thematic analysis conducted the analyses according to the following procedure. First, they familiarized themselves with the data through repeated readings of the transcripts. Second, they segmented the text into *meaning units*, defined as the smallest portion of text referring to a single idea. Third, they assigned

a *code* to each meaning unit, which synthetically described its meaning while remaining close to the participants' language. Fourth, codes were compared with each other and clustered into *code families* based on their similarities and differences. Fifth, code families were compared and clustered into thematic categories based on their similarities and differences. Such a process of iterative and constant comparison at different levels of increasing abstraction allowed the creation of a hierarchy of thematic categories and continued until thematic saturation was reached. Over this process, the language used for labeling the emerging categories became progressively more abstract and influenced by the researchers' epistemological and theoretical background (see Wiltshire & Ronkainen, 2021).

Methodological integrity and credibility

Consistent with international standards for qualitative research proposed by the American Psychological Association (Levitt et al., 2018), the following steps were taken to increase methodological integrity and credibility. The three primary coders were regularly supervised and audited by two external supervisors—GL and OG. At each stage of the analysis, every coder first performed the required tasks independently. Then, weekly supervision meetings were organized to discuss the findings and resolve critical questions or disagreements on data analysis through a consensus-oriented procedure (Hill, 2015). During this process, the coders' expectations and biases regarding the emerging findings were reflexively accounted for under the guidance of the two supervisors.[1] This was done through memoing and collaborative self-reflexive discussions to promote coders' awareness of their own biases with the aim of ensuring that the analysis was adequately grounded in the data.

Results

The analysis produced a final system of eight core thematic categories. These emerged from 34 thematic subcategories, which in turn expressed 143 code families based on 632 codes. This section presents the eight core thematic categories and their 34 corresponding thematic subcategories. These are summarized in **table 2**, along with the group(s) – shown in brackets – that contributed to their emergence. In describing the thematic core categories and subcategories, reports of prevalence are made with respect to all 29 participants in the entire dataset. Interview excerpts, where provided, have been translated from Italian to English.

[1] Although we used a consensus-oriented procedure to ensure credibility and provided prevalence reports (see the next section), our approach cannot be strictly defined as consensual qualitative research, even if it is strongly inspired by it (Hill, 2015). Indeed, the latter provides frequency labels to the identified content or thematic categories in order to assess the extent to which each of them is general (i.e., it applies to all or most of the subjects), typical (i.e., it applies to more than a half of the subjects), and variant (i.e., it applies to less than a half of the subjects). On the contrary, in our approach, we did not report frequencies explicitly, and prevalence reports were made narratively to indicate how many subjects contributed to the emergence of the thematic category being described.

Core category 1: Construction and management of the online setting

This thematic core category concerns aspects of the setting construction and management and, specifically, the peculiar conditions of the VP online connection that "fluidified" the boundaries of the classic therapeutic setting. It also deals with the difficulties related to "staying within the boundaries" and the consequent adaptation efforts required from therapists. This thematic core category contains the following four thematic subcategories.

Subcategory 1.1: Responsibility and management of the setting more borne by the patient

Therapists perceived the construction of the setting as one of the most distinctive features of VP. During the session, clinicians must consider the co-presence of two different settings: one constructed by themselves and one constructed by the patient. The patient, in fact, is responsible for constructing their own space for the session, which is then combined with the space created by the clinician to constitute the *session setting*, which affects the course of the therapy. Clinicians highlighted the need to keep in mind the patients' increased responsibilities in this regard and the influence of this on the treatment setting that, differently from in-person psychotherapy, is not constructed only by the therapist. For example, one therapist stated, "As if it is us who come to him [patient], rather than him coming to us" (T22). Similarly, another therapist shared, "In face-to-face treatment, we are the ones who create the setting, while in online therapy it is as if there were two settings: one made by the therapist and one made by the patient" (T14).

Subcategory 1.2: The patient's ability to contribute to the construction of an appropriate setting

This thematic subcategory concerns therapists' reflections on patients' ability to co-construct the treatment setting. Opinions were mixed, but overall, most clinicians affirmed that patients can choose, construct, and use an appropriate environment for the session. As one therapist described, "I think that patients are very careful to build their setting, for example, closing all other applications before starting the session" (T10). However, other therapists perceived that initially, most of the patients usually join sessions from inadequate locations (e.g., car, beach). Most therapists shared this contrasting view. In addition, there was agreement that the level of confidentiality and privacy of the patient's environment is of paramount importance, and a clinician reported that they sometimes had to interrupt sessions due to the lack of suitable conditions:

I've done sessions with patients who were in their cars, with their phones while they were driving, while they were walking, or at the beach with traffic noises, so surely this really is a technical difference between the online and in-person session that is supposed to take place in an office, a more protected setting with a different privacy standard (T4).

Subcategory 1.3: Comparison of online and in-person settings and related difficulties

In the case of blended therapies, the clinicians from the lower and medium experience groups reported greater difficulties working during online sessions compared to exclusively online therapies. Most therapists attributed these difficulties to the impossibility of adapting and

Table 2. *Description of thematic core categories and subcategories*

Thematic core category		Thematic subcategory	
1.	Construction and management of the online setting *(L, M, H)*	1.1.	Responsibility and management of the setting are more borne by the patient *(L, M, H)*
		1.2.	Patient's ability to contribute to the construction of an appropriate setting *(L, M, H)*
		1.3.	Comparison of online and in-person settings and related difficulties *(L, M, H)*
		1.4.	Need for greater therapist flexibility *(L, M)*
2.	Meaning construction of the request for help and the therapeutic process *(L, M, H)*	2.1.	Awareness and construction of the therapeutic space *(L, M, H)*
		2.2.	Rigidity and urgency of patient demands *(L, M, H)*
		2.3.	Superficiality and vagueness in the request for help *(L, M, H)*
		2.4.	Patient beliefs, fantasies, and expectations about therapy *(L, M, H)*
		2.5.	Patient and therapist motivation *(L, M, H)*
3.	Patient and therapist involvement in the online relationship *(L, M, H)*	3.1.	Intimacy, openness, and fear of judgment *(L, M, H)*
		3.2.	Perception of distance and presence *(L, M, H)*
		3.3.	Therapist and patient distraction *(L, H)*
		3.4.	Depth of therapeutic work *(M, H)*
		3.5.	Speed and rhythm *(M, H)*
4.	New elements of the therapeutic relationship introduced by VP *(L, M, H)*	4.1.	New types of information that can be acquired online by the therapist about the patient *(L, M, H)*
		4.2.	Negative effects and positive functions of the picture-in-picture function *(L, M, H)*
		4.3.	Technical problems *(L, M, H)*
5.	Nonverbal aspects and corporeality in VP *(L, M, H)*	5.1.	Corporeality *(L, M, H)*
		5.2.	Eye contact *(L, M, H)*
		5.3.	Facial expressions *(L, M, H)*
		5.4.	Gestures *(L, M, H)*
		5.5.	Tone of voice *(M, H)*
		5.6.	Silence *(L, M, H)*
6.	Differences in the quality of the emotional and relational level of VP *(L, M, H)*	6.1.	Devaluing the therapist's role, setting, and lack of formality *(L, M, H)*
		6.2.	Negative and uncomfortable feelings of the therapist *(L, M, H)*
		6.3.	Emotional activation, arousal, and containment of patients' emotions *(L, M, H)*
		6.4.	Emotional acceptance of the patient by the therapist *(L, M, H)*
		6.5.	Therapists' difficulties in emotional attunement *(L)*
		6.6.	Quality of the therapeutic relationship and working alliance *(M, H)*
7.	Treatment satisfaction and drop-out *(L, M, H)*	7.1.	Ease of session drop-outs and treatment drop-outs *(L, M, H)*
		7.2.	Patient satisfaction and well-being *(L, M, H)*
		7.3.	Difficulties in concluding therapy *(M)*
8.	Personal characteristics of patient and therapist that influence VP *(L, M, H)*	8.1.	Patient and therapist characteristics that influence VP *(M, H)*
		8.2.	Therapist training and clinical experience *(L)*

Note. VP = videoconferencing psychotherapy. Groups contributing to each thematic (sub)category: L = lower experience group, M = medium experience group, H = higher experience group.

calibrating the working modalities to the setting due to the constant shifting between in-person and online: "If the setting is mixed, and it obviously has its own challenges, then in that case, the online [modality] might have deficiencies" (T15).

Subcategory 1.4: Need for greater therapist flexibility

The therapists from the lower and medium experience groups perceived that more flexibility is required in online settings to adapt to the relatively blurred boundaries of the setting, which is co-constructed with the patient. Moreover, some therapists from these two groups also reported the need to provide more time flexibility to adapt to patients' needs who, for example, live in different time zones abroad. "It is more complicated than in-office sessions; at home, you have to establish what boundaries and flexibilities you can allow in the setting" (T7).

Core Category 2: Meaning Construction of the Request for Help and the Therapeutic Process

This thematic core category refers to all those aspects related to how patient and therapist mutually represent the space and characteristics of VP in terms of beliefs and fantasies and emotional and practical implications in the setting of therapeutic work. This core category is made up of the following five thematic subcategories.

Subcategory 2.1: Awareness and construction of the therapeutic space

Therapists reported that patients requesting help via videoconferencing lack a real understanding of the meaning behind the therapeutic space, so clinicians need to focus more on both the meaning-making process of the therapeutic setting and path in order to co-construct a shared understanding of them with their patients: “When patients have no awareness but are overwhelmed by their negative emotions, they request help, but then everything else is missing ... [like] the awareness of an appropriate setting” (T19).

Subcategory 2.2: Rigidity and urgency of patient demands

Therapists reported that requests for help via videoconference are characterized by an extremely high level of urgency linked to the patients’ expectation of immediate availability from the therapists. Indeed, the therapists used the expression “psychological first aid” several times to describe their feelings regarding such pressures. A participant clearly expressed this theme: “Since everything in the online world is so instantaneous, so fast, I can’t create the time dimension in others; they want everything immediately, like an emotional emergency room” (T12).

Subcategory 2.3: Superficiality and vagueness in the request for help

The therapists felt that patients looking for help via videoconference tend to reflect less on the decision to consult a therapist in the first place, partly because it is easy to immediately book an online psychological consultation. As a result, patients often present an undefined and overly vague need for care, demonstrating a lack of awareness of distressing conditions that led them to seek psychological support. “They [patients] make the request, even at 10 or 11 pm, and substantially don’t even know what their problems are, so it’s important to work a lot on what they expect from therapy” (T2).

Subcategory 2.4: Patient beliefs, fantasies, and expectations about therapy

The therapists suggested that patients often approach their first online session with vaguer and unclearer expectations of VP than in face-to-face therapy. Furthermore, most therapists reported patients’ misconceptions about VP, such as that it is shorter and easier to deal with than in-person psychotherapy or less effective. Additionally, patients’ “fantasies” about the first encounter and the therapist in VP are also relatively less structured and informative of their mental functioning, maybe because they do not directly select the therapist but solely the agency that provides VP. For example, one therapist stated:

One of the things that I believe happens in online therapies, perhaps due to the medium used, is that they [patients] expect a shorter duration for the type of medium. In other words, perhaps one cannot expect to stay in online therapy for one year, two years, but one expects to do a few sessions [only] (T16).

Overall, therapists reported that in VP, they need to do more extensive and deeper preliminary work than in face-to-face therapy to explore these misconceptions and fantasies with the patient in order to signify and redefine them in a way that allows for the development of an effective therapeutic relationship.

Subcategory 2.5: Patient and therapist motivation

The therapists reported a relatively low initial motivation to work via VP, which increased as they mastered the use of virtual platforms and gradually abandoned prejudices about VP. These changes were often also considered to impact psychotherapy outcomes. Concerning patients’ motivation for treatment, most clinicians reported no differences compared to in-person psychotherapy. However, a few therapists noted higher levels of motivation for treatment in those patients who chose VP. This ambivalence concept was synthesized by one participant: “The most important factor is the motivation on both sides, which means that in the online setting, you progressively understand that there aren’t many differences to in-person treatments” (T10).

Core Category 3: Patient and therapist involvement in the online relationship

This thematic core category addresses the depth of the relationship experienced by patients and therapists in VP. Aspects related to levels of intimacy, openness/closure, perceptions of distance/closeness, and levels of involvement of members of the therapeutic dyad are discussed. This core category is made up of the following five thematic subcategories.

Subcategory 3.1: Intimacy, openness, and fear of judgement

The therapists argued that the sense of intimacy (i.e., the sense of emotional connection arising between patient and therapist as a result of the sharing and mutual exchange of thoughts and feelings) might be greater and faster to achieve in a VP relationship; moreover, no setting-related obstacles were considered to prevent the development of intimacy with the patient. Conversely, therapists’ opinions were mixed concerning patients’ level of openness (i.e., the therapist's perception that the patient reports or omits some issue) during online sessions: While most therapists considered that VP facilitates a higher level of patient openness, a smaller group perceived patients’ fears of being judged, and a reduced openness in online sessions, particularly during the early stages of treatment. This participant explained the majority’s point of view, however: “They [patients] can express everything they feel without any defense mechanisms. In person, it is as if they have already created some barrier” (T21). Conversely, another participant said, “Artificial distances and mechanisms of online therapy protect the patient from a *real* openness” (T8).

Subcategory 3.2: Perception of distance and presence

Although most therapists in this study claimed to experience a screen-induced feeling of distance from the patient and the necessity to develop new strategies to cope with it (e.g., increased inter-session communication via messaging apps), all but one of the

clinicians reported that they do not experience a reduced "presence" of the patient during online sessions. For example, one participant shared, "As if the screen was gone, as if we were together in-person, as if we were looking into each other's eyes … I was able to get this kind of contact" (T18). Finally, a single therapist reported the impression that the screen "distance" reduces the authenticity of the relational exchange during the initial stages of therapy: "I feel my presence in the therapeutic relationship, but compared to face-to-face therapy, I am more easily transported out of the platform and find the barrier presented by the screen" (T25).

Subcategory 3.3: Therapist and patient distraction

The therapists from the lower and higher experience groups reported being particularly distracted during online sessions compared to face-to-face sessions (e.g., due to computer notifications). Similarly, the therapists also noted that patients are frequently distracted (e.g., browsing other webpages during their sessions). One participant offered a clear summary of this: "In person, there's no distraction as there is online, on both the therapist's and the patient's side" (T24).

Subcategory 3.4: Depth of therapeutic work

The level of depth of the online therapeutic process seemed to be experienced differently by participants from the medium and higher experience groups. While some therapists considered it to be the same as the in-person process, a few therapists perceived that in VP, the process tends to be more focused on symptom management and consequently remains at a shallower level, as in this example: "The patient's request is focused on the possibility of obtaining concrete strategies to remove the symptom" (T5). At the same time, other therapists reported that online therapy allows participants to reach a deeper level. For instance, "Behind a screen, in one's own home or car, the patient feels more protected and often gets engaged earlier, and you can go deeper. In my opinion, you can go deeper than in person" (T27).

Subcategory 3.5: Speed and rhythm

Concerning the "rhythm" of the session and clinical relationship, many therapists from the medium and higher experience groups noticed a high speed in how themes and issues are presented and discussed by patients, which on the one hand leads to the possibility of dealing earlier with particular topics, but on the other hand carries the risk of an insufficient focus on particular issues. For example, some therapists mentioned that several patients asked to stay focused longer on some issues that they felt had been dealt with too quickly: "The difference that I feel is in the rhythm. Online is faster" (T14).

Core Category 4: New Elements of the Therapeutic Relationship Introduced by VP

This thematic core category encompasses all those statements concerning the modifications that, according to the therapists, the online setting has brought to psychotherapeutic practice. These modifications concern spatiotemporal aspects (with related problems) and specific representations and fantasies concerning how the medium both modifies the therapist's image and impacts their sense of mastery of the therapeutic process. This core category seemed to be central in therapists' reflections about VP—the core category that contains the most code families—and is made up of the following three thematic subcategories.

Subcategory 4.1: New types of information that can be acquired online by the therapist about the patient

The therapists suggested that VP modifies the kind of information that therapists may obtain by observing the patient. On the one hand, some therapists reported having fewer *landmarks* and sources of information on patients and their modalities (e.g., one clinician said that VP doesn't allow him to gain information on patient's behavior in social contexts); this was also because the therapy space and time are limited to the effective length of the session, resulting in the loss of data that can be acquired from exchanges that, in face-to-face settings, occur in the moments immediately preceding or following sessions. On the other hand, other therapists recognized that VP might provide more information about patients' daily lives, provide a visual of their living environments, and allow patients to recount their life events in the context where they really happen. Finally, most therapists also reported that how patients arrange their settings (e.g., make tea) can provide very useful information about how patients operate. About these themes, one therapist said:

Sometimes, I hear the expression "right now, at this moment, I feel that," maybe because it's uttered in the same context as it happens in the patient's [home] life. Maybe they [the patient] are in the room alone thinking, "right now I feel like this," maybe in my office he can't use these expressions, so he'll say, "when I'm in my room […]" (T20).

Subcategory 4.2: Negative effects and positive functions of the picture-in-picture function

This thematic subcategory concerns therapists' reflections on the role of *picture-in-picture* (i.e., the possibility of seeing oneself on the screen as well as the other) during VP relationships. Regarding patients, most therapists shared that it is a major source of distraction for the patient, taking attention away from what is happening during the session, so therapists often choose to remove this option. Some therapists allow patients to choose whether to leave it on or off, as the patient's choice provides useful feedback about them and their behavioral patterns. On the therapist's side, while some clinicians reported finding themselves distracted—even feeling irritated—several times during sessions due to the presence of their own picture on the screen, others referred to becoming familiar with this modality and integrating it as a working tool useful for both self-observation and calibrating their nonverbal language. Summarizing this argument, one therapist stated:

We also tend to look at ourselves while talking, so it's an element that differentiates us a lot from in-person settings. In person, I don't look at myself while speaking, but online there is this additional element (T21).

Subcategory 4.3: Technical problems

All the therapists agreed that technical issues should be considered and discussed with patients as part of the therapeutic contract, including indications on how to handle them if they occur. The therapists shared that technical problems may impair the quality of sessions (e.g., problems with audio, delays), making it difficult to address certain issues and have a real-

time exchange with patients. However, the participants reported that these difficulties and limitations may have more influence during the early stages of relationship development, whereas once the alliance is well established, they are easier to overcome:

Then I realized that if the connection doesn't go well, the other side [the patient] doesn't understand a word, so you have to repeat, which diminishes the session's quality. However, once the working alliance is established, connection issues don't affect the quality of our work with patients (T25).

Core Category 5: Nonverbal aspects and corporeality in VP

This thematic core category results from extensive discussions by therapists on aspects of nonverbal interaction. They discussed the differences between videoconferencing and face-to-face therapy by describing their own perceptions of how dyad members use face, tone of voice, and gestures to regulate the relationship. Reflections on the use of silence were also included. This core category is made up of the following six thematic subcategories.

Subcategory 5.1: Corporeality

This subcategory addresses the patient's body as a source of information in conveying communicative messages. Most therapists experienced a lack of being able to observe their patients' corporeality and extract information from it. One therapist also mentioned "missing" odors. In addition, some therapists shared that both this lack of nonverbal information and the awareness that patients see only a portion of the therapist's body may cause difficulties in regulating their nonverbal language. For example, one participant stated, "I still have this therapy ongoing and have achieved very good results, but I was very frustrated with the lack of corporeality" (T5). Conversely, other therapists did not experience this absence. They reported that, although certain dimensions of corporeality (e.g., body posture) are missing, these are "balanced" by new information and a greater focus on other aspects (e.g., eye contact):

It's like working with whatever there is rather than what's missing … then you, in fact, adapt your work; it's somewhat compensatory because we do not see some areas of the body, but we see more facial expressions, so you just focus on what's there (T23).

Subcategory 5.2: Eye contact

Most of the therapists claimed that eye contact represents the main channel for conveying nonverbal communication in online sessions, which is perceived as very focusing and intense in the sense that it allows for greater interpersonal engagement and intimacy than the face-to-face setting: "As eye contact is the main nonverbal communication channel available online, I give special attention to it" (T11). However, a minority of therapists referred to not being able to detect the possibility of establishing and maintaining "real" eye contact during online sessions.

Subcategory 5.3: Facial Expressions

Most of the therapists shared that in online sessions, one must be particularly focused on facial expressions to be able to overcome the lack of seeing other parts of the body:

In the online setting, there is a focus on the face. Indeed, micro-expressions are visible. Maybe this is an extra detail, versus in the face-to-face setting, that compensates for the lack of [seeing the] posture or the rest of the body. (T26)

Furthermore, some therapists referred to using their facial expressions as a "tool" for communicating some elements to their patients (e.g., support, closeness), so they often deliberately accentuate their expressions:

In VP, I tend to use the facial expression channel to provide a sense of welcome, recognition, and selective attention to the patient's internal states as well. I also do this through my body because it cannot be seen, so I pay more attention to my facial expressions (T08).

Subcategory 5.4: Gestures

Most therapists referred to control their gestures more during online sessions, partly because such gestures are used as a tool to demonstrate their presence and compensate for the screen distance. One therapist shared:

In my perception, I do it [more gestures in VP], I have the perception to stimulate, I try to move in the chair, to get closer, and I think it can effectively help the patient's emotionality to go in the direction that I want it to go (T20).

Conversely, some therapists used gestures less during online sessions: "I realized that in person I gesticulate more, I relax more, while online I control it more" (T12). Regarding patients' gestures, most therapists shared that they witness more gestures in VP than in face-to-face treatments.

Subcategory 5.5: Tone of voice

The therapists from the medium and higher experience groups highlighted the tone of voice as another important factor to consider. They shared that they control it—and sometimes accentuate it—more in online sessions to use it as a tool to convey nonverbal messages to patients. For instance, one participant stated:

In the online setting, I pay greater attention to modulating my tone of voice, as I use it as a tool to communicate to the patient that I am close to them despite the screen barrier (T19).

Subcategory 5.6: Silence

Silence in VP was perceived by participants in two different ways. About half of the therapists argued that, in online sessions, patients tolerate moments of silence more easily than during in-person sessions, while the other half reported the opposite. Considering the therapist's perception of silence in online sessions, most of the clinicians reported difficulties in understanding the reason for it, which might also originate from a poor internet connection: "In the online setting, there is a greater difficulty in identifying silence. Personally, sometimes I fear a disconnection: 'oh, maybe the screen has frozen'" (T7).

Most clinicians found silence to be extremely pervasive and difficult to manage in online sessions and described having to use different ways to manage it in VP versus face-to-face sessions. For example, one therapist affirmed:

I do not have difficulties in the management of silence but in the ability to use it for therapeutic work. In person, silence can lead to greater emotional attunement and elicit deeper insights by sharing how I feel in silence and thinking about how the patient

perceives it. In contrast, online, I cannot introduce a shared reflection in moments of silence. (T23)

Only one therapist referred to tolerating silence better in online sessions and being able to work with it more effectively.

Core Category 6: Differences in the quality of the emotional and relational level of VP

This thematic core category entails statements about the therapists' perception of online emotional and interpersonal levels and the quality of the therapeutic relationship established with patients. This core category is made up of the following six thematic subcategories.

Subcategory 6.1: Devaluing the therapist's role, setting, and lack of formality

Therapists shared that many patients exhibited inappropriate familiarity in approaching the therapist in the online setting, a lack of recognition of the therapist's status, and frequent behaviors of devaluing the therapist's role and the online setting. One participant voiced emphatically, "They [patients] behave as if they were dealing with second-class therapists. Some came in smoking or even drinking cocktails" (T13). Another participant shared, "Patients often become overconfident, calling me by my first name, assuming that we can call each other by our first names, [...] as if the relationship is much more equal than face-to-face therapy" (T23).

Subcategory 6.2: Negative and uncomfortable feelings of the therapist

Several therapists shared negative feelings experienced during online sessions; they sometimes felt judged, devalued, frustrated, embarrassed, perplexed about the possibility of establishing a good therapeutic relationship, more fatigued than in face-to-face sessions, and sometimes scared of being physically distant from the patient. "I have a patient that I meet both in person and online. Online I feel helpless, especially when he bows his head and cries and becomes desperate" (T8).

Subcategory 6.3: Emotional Activation, Arousal, and Containment of Patients' Emotions

The therapists described a lower duration and intensity of patients' arousal and emotional activation in VP compared to face-to-face settings. They also reported greater early difficulties in containing patients' emotions and the consequent need to find new strategies to manage emotional activation in the online setting:

I feel a bit of a distance, although I can effectively contain the patient. However, if I would compare [this] with in-person sessions, in a moment of major emotional engagement, even the simple giving of Kleenex, it's not that you embrace him, but it makes you feel closer, and they feel more supported (T16).

Subcategory 6.4: Emotional acceptance of the patient by the therapist

The therapists shared divergent opinions regarding their acceptance and ability to validate patients' experiences and feelings in VP. It refers to the therapists' perceived skills in recognizing and accommodating the emotional contents shared by the patient during the videoconferencing session. For some therapists, the online setting makes the acceptance of feelings more difficult: "For me, it's a bit more difficult; it requires more attention in the acceptance of pain and suffering, which in person, however, happens much more easily" (T7). Some other participants shared that patients may feel *more* accepted in the online setting: "Online it is easier to accommodate the patient's crying because it is more visible" (T22).

Subcategory 6.5: The therapist's difficulties in emotional attunement

Some therapists from the lower experience group shared concerns about their emotional attunement with patients in terms of the therapist's ability to connect and empathize with patients' feelings. The therapists reported more difficulties and fatigue in attuning to patients' emotions both in the initial stages and throughout treatment. For example, "Even when the patient cries, I can't tune in with them as I can in person, maybe because I'm not physically close" (T3).

Subcategory 6.6: Quality of the therapeutic relationship and working alliance

The therapists from the medium and higher experience groups reported that both the quality of the therapeutic relationship and the working alliance do not differ significantly from face-to-face therapy. For some therapists, building an effective working alliance may, in some cases, even be facilitated by a VP setting: "I also don't see much difference in the therapeutic alliance; *maybe* it's established earlier online" (T10).

Core Category 7: Treatment satisfaction and drop-out

This thematic core category addresses the level of satisfaction of patients who participate in VP, clinicians' perceptions of drop-out rates, and the characteristics that make these events occur in VP. This core category is made up of the following three thematic subcategories.

Subcategory 7.1: Ease of leaving the session

The therapists reported a marked sense of precariousness in online sessions caused by the feeling that the patient may choose to leave the session at any moment by logging out of the video call. These episodes can result in a definitive drop-out from treatment. One participant shared, "Like a logout, they disconnect and disappear in the dark. This, unfortunately, happens to me a lot" (T20). However, a few therapists explained that this possibility of easily leaving the session is perceived as reassuring by patients, allowing them to overcome resistance more quickly: "I have the impression that they will never use it as a defense mechanism, but I think that they know that they *can* use it, and this reassures them" (T24).

Subcategory 7.2: Patient satisfaction and well-being

Most participants reported that, despite initial preconceptions, VP patients feel comfortable and clearly perceive the therapeutic quality of the sessions once they begin treatment. Moreover, many therapists shared their patients' feedback of high satisfaction with the results achieved with VP. One participant noted, "They [patients] start with low expectations of results and then change their opinion. For example, one patient said to me, 'Doctor, I never thought that online therapy could have such effects'" (T5).

Subcategory 7.3: Difficulties in concluding therapy

Therapists from the medium experience group reported a perceived difficulty for patients in agreeing with the clinician on the conclusion of therapy. Specifically, they felt that the typical flexibility of VP might give patients the perception of "having their therapist in their pocket" and always being available to them, so most patients are reticent to terminate. Even a few therapists shared they often procrastinate on encouraging patients to end therapy. Additionally, both therapists and patients were described as often preferring to schedule appointments far in the future rather than end therapy definitively. An apparent synthesis of these difficulties: "There is a difficulty to disengage, you [patient] have the therapist in your pocket; somehow, they are there. In other words, you always have them with you" (T17).

Core Category 8: Personal characteristics of patient and therapist that influence VP

The last thematic core category consists of clinicians' statements regarding the impact of the patient's personality characteristics and specific aspects of the therapist's training/approach on the quality and progress of VP. This core category is made up of the following two thematic subcategories.

Subcategory 8.1: Patient and therapist characteristics that influence VP

The therapists from the medium and higher experience groups described some characteristics that make some patients more suitable than others for VP. A few therapists perceived younger patients as more confident in using new technologies and patients with anxiety-related problems more comfortable with an online setting. One therapist affirmed, "Often patients report, particularly in cases of social anxiety, that online therapy is really accessible, and that otherwise, they would not have started treatment at all" (T21). Another participant argued, "I observed that younger people often choose the online modality over in-person, as it is easier for them to adapt to this type of setting" (T17). However, many of the therapists shared that the treatment course is influenced by an array of patient characteristics not specifically tied to VP:

Probably, difficulties can exist both in face-to-face and online settings … I mean that there is always the mirroring between therapist and patient, also given by the characteristics of the patient himself, which in some way can change the course of the therapy and the arrangement of the setting (T14).

Subcategory 8.2: The therapist's training and clinical experience

Some therapists from the lower experience group shared that one's theoretical approach and level of clinical experience may affect one's ability to deal effectively with VP. Furthermore, using some specific techniques (e.g., tasks in cognitive-behavioral therapy) may increase difficulties in online sessions, as some therapists perceived that some patients do not possess the appropriate tools (e.g., pen and paper) to fully engage in some techniques.

At a general level, these therapists considered that the ways by which each therapist usually works—determined by theoretical orientation, clinical experience, techniques used, and personal characteristics of the therapist—determine one's ability to work effectively in the online setting. One participant affirmed:

Another extremely important variable is that there are as many therapies as patients. So, very often, it also depends on how we usually work; some of us are stronger, some are calmer, some are more cautious, some have skirt issues, and some get right to the point. I mean, it's not only a question of direction or therapy, but it's really related to the *way* each of us knows how to do therapy (T8).

Discussion

The purpose of this study was an in-depth qualitative exploration of psychotherapists' subjective experiences of the therapeutic relationship in VP. Overall, we identified eight core thematic categories (see **table 2**). These are discussed in the following pages.

Construction and management of the online setting **(Core Category 1).** Regarding this thematic core category, the "fluidity" of the online setting emerged as relevant, with implications for maintaining therapeutic boundaries. The importance of this aspect also emerged in the study by James et al. (2022), who identified different boundaries and different abilities to manage such boundaries in remote psychotherapy. Also, closely following the findings of Cipolletta et al. (2017), aspects such as the choice of a secure and reliable videoconferencing platform that guarantees data security and patient privacy, the creation of an appropriate environment to enhance patient privacy, the verification of the Internet connection to avoid interruptions, and the maintenance of non-verbal communication during sessions were also clearly thematized here. As it is agreed that all these elements characterize the construction of the therapeutic relationship (Cipolletta et al., 2017), the vision of a co-constructed setting proposed by the therapists involved in our focus groups appears interesting. Indeed, the clinicians offered valuable insights into the impact of patients' choices and behaviors on the setting and its construction, their increased responsibility in this regard, and the need for greater therapist flexibility in managing the complex boundaries of the VP setting.

Meaning construction of the request for help in the therapeutic process **(Core Category 2).** This thematic core category indicates that the therapeutic pathway originates in the first moments of contact between patient and clinician, those in which a request for intervention is made explicit, and what we might call the development of the patient's commitment (Salvatore & Cordella, 2024) takes place. While it is evident that patients consciously lodge a request to be helped, they do not often preface this with a reflection about the therapeutic space, predominantly seen as a condition already "given" independently of them. In addition, our interviewed clinicians reported that the predominant presence of negative emotions that patients evince substantially frames their request for help and compromises – at the early stages of therapy – the possibility that they feel involved in a shared process of co-construction of their pathway and of the space in which this will take place. What is more, according to our sample, the urgency of the patient's initial request is reinforced by the immediacy of the nature of online access. Whereas an in-office appointment has to be agreed upon well in advance and requires physical movement of the patient and therapist to a meeting place, using an online setting feeds the belief that psychotherapy can be experienced as emotional first

aid, quickly bought and achieved.

Furthermore, the patient's request to be "taken care of" seems mostly vague, and the patient's awareness of the real need that motivates the request for help often appears poor. Regarding fantasies and expectations about VP, the therapists reported patients imagining that VP is shorter than in-person therapy—in line with the difficulty of perceiving the temporal dimension as foundational to the therapeutic process described earlier—or that it is less effective. Therefore, as also shown by Van Daele et al. (2020), taking into account the patient's beliefs and fantasies about VP is crucial for effective treatment management by the therapist. The idea of lower effectiveness may also be because, in the absence or lack of digital skills, it is more complex for both therapist and patient to feel engaged and able to imagine the beneficial effects of psychotherapy; this condition seems to decrease as the skills required to activate and manage the virtual connection increase.

Patient and therapist involvement in the online relationship **(Core Category 3).** This thematic core category concerns what happens in the early moments when the patient and therapist begin to collaborate in identifying shared goals. The topic is sensitive since, as James et al. (2022) have also shown, there is evidence of higher rates of stressful involvement in VP than in face-to-face therapy. Our results showed that, from the clinicians' point of view, patients show relatively greater and faster levels of openness in VP, thus facilitating the creation of a climate of intimacy. This aligns with a consideration proposed by Marouda-Chatjoulis and Ntali (2022), claiming that VP opens a window into the patient's places, dilating the physical spaces of therapy and taking the therapist to places that, in face-to-face settings, can only be experienced through a narrated representation of the patient and a mental reconstruction of the therapist. These data, however, partially contradict the recent results obtained by Ahlström et al. (2022), who highlighted in therapists' interviews a reference to much more superficial levels of conversation in PV than in face-to-face therapy. Békés et al. (2023) also found a change in engagement in the therapeutic process by both patient and therapist and a reduction in levels of intimacy in VP. Based on this, future studies should better explore this issue.

New elements of the therapeutic relationship introduced by VP **(Core Category 4).** This fourth thematic category is central because it indicates a time of profound change in clinical practice, grappling with new forms of uncertainty that affect therapeutic work. A relevant element concerns reducing the session to the time between when the video call starts and when it actually ends. On the one hand, some clinicians argued that this clear definition of "beginning and end" prevents one from grasping aspects of the patient's behavior in a social/work-life context that the therapist can otherwise use to identify the session's role in the patient's daily routine. On the other hand, some therapists' reports were consistent with Marouda-Chatjoulis and Ntali (2022), according to whom the introduction of the online modality has instead allowed clinicians to become better accommodated to the patient's home or work context, in a sense offering a magnifying glass on fragments of "real" life. Another important issue concerns the picture-in-picture function, which was a source of distraction for some therapists, while for others, it was a tool for clinical self-monitoring. Finally, consistent with the difficulties highlighted by Cataldo et al. (2019), the clinicians shared some challenges linked with the onset of technical problems, aspects that may affect the maintenance of communicative coordination and, therefore, the attunement between patient and therapist (see Podolan & Gelo, 2023; Schiepek et al., 2020). The fact that therapists observed a reduction in the negative impact of these issues as the quality of the therapeutic relationship consolidates over time is in line with findings regarding its relevance to the therapeutic process (e.g., Flückiger et al., 2018).

Nonverbal aspects and corporeality in VP **(Core Category 5).** The results showed a fairly common feeling among therapists that the computer screen misses important elements (e.g., posture) for regulating nonverbal therapeutic exchanges. Ahlström et al. (2022) and Cataldo et al. (2019) recently highlighted the difficulties associated with the reduced ability to detect small gestures and changes in facial expressions in VP. Similarly, Thomas et al. (2021) showed how, according to a large body of literature, difficulties may also be associated with judging nonverbal behavior. In the present study, the olfactory dimension assumed a prominent role during descriptions of not seeing the patient's body in VP. Although there are empirical findings on the role of olfaction in therapy with specific types of patients (Begum & McKenna, 2011; Brown, 2015), the literature has only marginally addressed what happens when the olfactory dimension is suddenly excluded from the therapeutic setting. Consistent with the studies of García et al. (2022), this and other limitations in verbal and nonverbal communication can be framed as an opportunity for psychotherapists to cultivate the pre-reflexive and reflexive skills that may be needed in VP.

Furthermore, discussions around proxemics in therapy were enriched by statements in this study concerning the use of tone of voice and silence. Using and managing silence in VP was associated with a wide range of responses. On the one hand, the therapists agreed on the greater difficulty in managing silence in VP, also because they did not know whether to attribute it to the patient or to the connection. On the other hand, the therapists appeared to disagree concerning the patients' tolerance of silence; some thought it was greater than in face-to-face therapies, while others found it to be reduced. The literature on this topic has already made several contributions, especially in face-to-face psychotherapy—treating silence as a new regulatory element of transference and countertransference (Sayers, 2021).

Differences in the quality of the emotional and relational level of VP **(Core Category 6).** It was striking how the clinicians immediately agreed on a lack of recognition of the clinician's professional status per patients' behaviors. This happened, for example, when patients in VP tried to normalize behaviors usually not allowed in face-to-face therapy (e.g., drinking or smoking). This behavior during VP arguably strips the treatment itself of "sacredness." Just as McBeath et al. (2020) found in therapists involved in VP negative feelings of fatigue and a sense of isolation, the clinicians in the present study dwelled heavily on their own negative feelings and the sense of discomfort associated with both feeling professionally devalued and helpless in the face of patients' suffering. Thus, it seems that the virtual context not only frequently depletes the halo of solemnity (once) peculiar to the therapy room (e.g., Békés et al. [2023] identified greater levels of informality in VP) but also reduces the concrete possibilities of containment.

Treatment satisfaction and drop-out **(Core Category 7).** This thematic core category pertains to an attitude of patient "permanence" versus abandonment in therapy. Murphy et al. (2009) found no obvious

differences between the satisfaction of patients who received psychological treatment in person compared to VP. Cataldo et al. (2021) also produced ample evidence of the impact of patient satisfaction on the relationship quality with the therapist and the establishment of a working alliance. However, in our study, the therapists seemed to have experienced a sense of precariousness linked to the fact that the session could be interrupted at any moment, partly making the therapist fear a reduction in patient satisfaction. When the patient begins to feel comfortable, on the other hand, there is greater engagement and greater motivation to remain in the therapeutic process. In addition to noting an initial difficulty in engaging in VP work, clinicians also articulated a difficulty on the closure side of therapy. The flexibility of the setting was, in fact, portrayed as a quality that postpones termination.

Personal characteristics of patient and therapist that influence VP **(Core Category 8).** Clinicians' comments in this category seemed to focus on whether or not they could use protocols and tools in VP that they usually use in person. From this point of view, less manualized approaches appeared to suffer less from the limitations of VP. Békés & Aafjes-van Doorn (2020) highlighted that psychotherapists' attitudes toward VP are influenced by their past experiences, including psychotherapy modality, clinical expertise, previous experience with VP, and their transitional experience during the COVID-19 pandemic and geographical location. Possible difficulties may be handled differently by the patients themselves, especially younger patients who, unlike older ones (Juthavantana et al., 2021), are more comfortable with virtual connections and appear to be better suited to VP. At the same time, certain intersubjective characteristics and the presence of particular disorders (e.g., social anxiety; cf. Feijt et al., 2020; Thomas et al., 2021) might make it more difficult for patients to be involved in VP.

Comparison between groups. Although our research question did not concern the comparison between the groups (which were instead created to maximize their internal homogeneity), some observations can be made in this regard. Overall, all three groups contributed to the emergence of all thematic core categories. However, some differences were observed in a few thematic subcategories. Regarding the quality of the emotional and relational levels of VP, therapists with less experience reported greater difficulties in emotional attunement in VP. In contrast, more experienced therapists seemed better at governing the emotional aspects underlying nascent therapeutic alliances. Moreover, therapists with lower and medium experience reported the need for greater flexibility in dealing with the blurred boundaries of the VP setting.

On the contrary, some therapists with medium and higher experience acknowledged that, regarding patient and therapist involvement in the online relationship, it may be harder to reach a given depth in the therapeutic work in VP and to go beyond a focus on symptom reduction. They also acknowledged a higher speed in the VP process regarding the patient's presentation and discussion of issues. In addition, concerning the nonverbal aspects and corporeality in VP, they reported manipulating intonation to enhance the richness of nonverbal communication. Moreover, regarding the personal characteristics of the patients and therapists that influence VP, more experienced therapists focused more on the patient's characteristics. In contrast, less experienced therapists tended to focus more on their own training and clinical experience. These results, which suggest that therapists with more experience may have greater competency in adapting their skills to VP and in being aware of the difficulties encountered in it, are consistent with findings that younger and less experienced therapists may report greater concerns and poorer skills in delivering VP (e.g., Lin et al., 2022).

Finally, therapists with lower and higher levels of experience reported that regarding patient and therapist involvement, they were more likely to be distracted in an online relationship than in face-to-face settings. These results could be explained by the fact that these two groups were predominantly composed of cognitive-behavioral therapists, who may typically be accustomed to being guided by more stringent protocols in managing the therapeutic relationship. As a result, the fact that these protocols are still lacking with respect to VP, along with the fact that VP presents higher levels of variability than in-person psychotherapy, may have made these therapists more sensitive to distractions. Similarly, the fact that therapists with a medium level of experience reported difficulties in terminating therapy could also be explained by their theoretical orientation. In fact, most of the therapists in this group adhered to theoretical approaches (systemic-relational therapy, family therapy, Gestalt therapy with an existential-phenomenological orientation) that tend to be more open-ended in their duration compared to more time-limited approaches such as cognitive-behavioral therapy (which was most prevalent in the other two groups) (e.g., Lowry & Ross, 1997). This fact, combined with the increased variability of VP, may have led to more difficulties for therapists in this group in determining and managing treatment termination. Future research should better explore whether these findings are due to differences in theoretical orientations, levels of experience, or a combination of both.

Limitations

First, although there is no evidence yet concerning the impact of therapists' gender on their perception of the therapeutic relationship in VP, the prevalence of female participants in our sample might represent a bias in our study. The same could be said for the relatively young age of the participants. Future studies should explore the therapeutic relationship in VP through more heterogeneous and balanced samples with regard to gender and age. This should also be done regarding the participants' clinical experience, whose influence on therapists' perception of the therapeutic relationship in VP should be explored in a more explicit and articulated way. For example, it would be interesting to explore how this might be consistent with evidence from previous studies showing that the stress and traumatic reality of the pandemic affected younger and less experienced therapists' experiences with teletherapy the most (Aafjes-van Doorn et al., 2020; Békés & Aafjes-van Doorn, 2020).

Second, our sample was characterized mainly by cognitive-behavioral therapists. Since previous findings suggested that these latter may report more positive attitudes toward online psychotherapy (e.g., Békés & Aafjes-van Doorn, 2020), future research should better assess to what extent the present study's findings may or may not actually overlap among therapists of different theoretical orientations.

Third, readers should be mindful that this study focused on therapists' experiences. Future studies might also explore patients' experiences to build more comprehensive theoretical models of the therapeutic relationship in VP and related clinical processes.

Furthermore, it would be interesting to focus on the social representations of therapists and patients of the therapeutic relationship in VP (see, e.g., Gelo et al., 2016).

Fourth, our findings may suffer from self-selection bias due to the sampling procedure. Future studies should address this issue by building more heterogeneous samples, for example, regarding attitudes, preferences, and motivations toward VP.

Fifth, the therapists involved in the present study were recruited from a psychotherapeutic service agency in southern Italy. Future studies should extend to other parts of the country.

Sixth, our findings are limited to psychotherapists' perspectives, which may not reflect patients' perspectives. Future studies should also explore patients' in-depth experience of the therapeutic relationship in VP and compare it with therapists' experience. Future studies could also better assess both patients' and therapists' satisfaction with VP with a specific focus on the therapeutic relationship (Murphy et al., 2009; see also Ciavolino et al., 2020).

Seventh, this research was conducted three years after the onset of COVID-19, when restrictions and overall level of anxiety had begun to decrease (see Di Blasi et al., 2021, 2022; Lo Coco et al., 2023). Thus, it can be assumed that therapists have had time to adjust to new ways of providing therapy. Future studies could monitor how therapists' experience of the therapeutic relationship in VP might change from when they had to conduct VP to when it became a choice.

Finally, although the researchers' theoretical background and perspectives were made explicit, and methodological integrity and credibility were enhanced in line with international standards (Levitt et al., 2018), the qualitative nature of the present study entails that its findings cannot be considered independently of the authors' theoretical background and perspectives.

Implications for research, theory, practice, training, and advocacy

The present findings may stimulate the implementation of both additional qualitative research on the subject and quantitative studies on the development of instruments to measure the therapeutic relationship in VP and the different constructs underlying it (for a general methodological overview, see Gelo et al., 2020a, 2020b; Gelo & Manzo, 2015; Gennaro et al., 2019). This could meaningfully contribute to further empirically informed theory development on the therapeutic relationship and the related clinical processes in VP and the possibility of generating and testing hypotheses about them in an increasingly articulated and sophisticated way (Gelo et al., 2008, 2009; Gelo et al., 2015a, 2015b).

Regarding clinical practice, our findings may provide clinicians with insight into relevant issues to be considered when designing or delivering VP. Overall, we encourage clinicians not to consider VP as an impoverished surrogate for face-to-face therapy but to try to recognize and ethically exploit the new forms of interaction it offers (see García et al., 2022). To this end, therapists should be aware of the greater complexity of VP regarding its setting (e.g., role and responsibility of both patient and therapist), the meaning of the patient's request for help (e.g., patient awareness, urgency, expectations, motivations), different degrees of involvement and relational quality (e.g., intimacy, work depth, emotional attunement), and nonverbal communication (e.g., mimic, gestures, prosody). By not taking these aspects for granted, they may be able to enhance their critical reflective thinking about therapy issues (e.g., through peer supervision) and use them to benefit the treatment.

Our findings also suggest that psychotherapy trainees might benefit from specific training on building and managing the therapeutic relationship in VP. To this end, training programs could include self-reflection and experiential practice exercises as well as supervision aiming, for example, to enhance trainees' facilitative interpersonal skills in the specific context of VP. Moreover, training programs should increasingly draw on the empirical findings addressing the therapeutic relationship in VP. Similar to what has been done in the context of face-to-face settings (e.g., Messina et al., 2018; Messina et al., 2018; Tilkidzhieva et al., 2019), future research could, for example, examine the different factors that influence the training of psychotherapists with a specific focus on the therapeutic relationship in VP and assess the extent to which this could improve their efficacy in delivering VP. Such empirically informed psychotherapy training could greatly benefit the delivery of VP.

Finally, we believe these efforts would significantly contribute to VP's public advocacy and community outreach. This, in turn, could make VP more accessible to underserved populations.

Conclusion

Contrasting quantitative research findings on the role of the therapeutic relationship in VP have led scholars to suggest that psychotherapists' in-depth experience in this regard should be better explored through qualitative methods. Existing qualitative studies have either focused on specific aspects of the therapeutic relationship in VP (e.g., Fletcher-Tomenius & Vossler, 2009; García et al., 2022; Shoullis et al., 2023) or referred to it only indirectly (e.g., Aafjes-van Doorn et al., 2023; Ahlström et al., 2022; Bambling et al., 2008; Békés et al., 2023; Burbach et al., 2022; Glasheen et al., 2015; Ivey & Denmeade, 2023). This is the first qualitative study explicitly addressing therapists' in-depth experiences of the therapeutic relationship in VP in its own right.

Our results showed that a qualitative approach can be useful in grasping various factors that determine therapists' complex experiences of the therapeutic relationship in VP. Overall, our findings were consistent with the emerging literature on the topic, suggesting that psychotherapists experience the therapeutic relationship in VP as having some specific characteristics compared to face-to-face setting, which on the one hand may hinder the therapeutic work (see Ahlström et al., 2022; Békés et al., 2023; Burbach et al., 2022; Fletcher-Tomenius & Vossler, 2009; García et al., 2022; Ivey & Denmeade, 2023), but can also be seen as opportunities for productive therapeutic work (see Békés et al., 2023; Burbach et al., 2022; Fletcher-Tomenius & Vossler, 2009). In addition, our study provided an overall more specific view of the therapeutic relationship in VP, particularly regarding the co-construction and management of the psychotherapeutic setting, the relational modalities that characterize the dyad, the types of requests for help, and the patient's beliefs and expectations. It also emerged that having practiced psychotherapy for more or less time may influence which aspects of the therapeutic relationship in VP are experienced as most relevant or problematic.

The present study represents a first step in expanding our knowledge about the therapeutic relationship in VP. Considering the uptake of VP even at the end of the pandemic emergency, it makes sense to believe that all the changes and challenges discussed here can and should provide food for thought for clinicians who want to try VP, for those who now practice it routinely, and for researchers in the field.

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Appendix A.
Interview Guide

We would like to discuss with you what you consider, based on your clinical experience, to be specific features of the therapeutic relationship in videoconferencing psychotherapy (VP) and what elements are involved in its construction. We will ask you some questions related to some specific themes that we would like to explore; however, feel free to space out your answers and share your thoughts regarding any element of the therapeutic process that, based on your experience, you feel may be related to the therapeutic relationship in VP.

1. **Content and quality of the psychotherapeutic relationship in VP:** What characterizes therapeutic relationship in VP? Have you found any new aspects compared to traditional clinical practice? What are the relational processes that you feel both yourself and the patient enter into? How do you feel within this relationship and how do you think patients feel about this?

2. **Personal and professional background and the therapeutic relationship in VP:** Do you believe there are any factors, related to the patient's personal history and your own personal and/or professional background as therapists, that may affect the therapeutic relationship in VP?

3. N**onverbal communication in the therapeutic relationship in VP:** How does communication, both verbal and nonverbal, work in VP therapeutic relationship? Especially regarding nonverbal communication, do you experience it differently than in face-to-face setting? If yes, to what extent do you believe it affects the therapeutic relationship?

4. **Setting and the therapeutic relationship in VP:** Are there any particular features of the environment in VP that you think have a spillover and impact the therapeutic relationship? What are they and how do you think they influence it?