

MEDICAL PSYCHOTHERAPY TRAINING AND THE COVID-19 PANDEMIC

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The COVID-19 pandemic has seen a move away from face-to-face interactions and core psychiatry training has not been immune to this. The Royal College of Psychiatrists introduced online examinations (<https://www.rcpsych.ac.uk/training/exams>), Health Education England utilized virtual annual reviews of competencies (<https://www.hee.nhs.uk/coronavirus-information-trainees>), and locally, trusts adopted virtual academic and clinical work. This article seeks to highlight the impact of the pandemic on acquiring psychotherapy experience in the context of core psychiatry training. Trainees delivering psychodynamic psychotherapy via telephone in Surrey and Borders NHS Foundation Trust were included in the study and data were gathered using a phenomenological approach via reports provided by two core trainees in addition to a questionnaire distributed to all core trainees delivering telephone therapy. The results indicated that whilst telephone therapy may not be a full replacement for face-to-face contact, it has been an adequate substitute during the COVID-19 period, enabling trainees to achieve the required competencies, receive supervision and provide care where it may otherwise have been impossible.

KEYWORDS: COVID-19, CORONAVIRUS PANDEMIC, TRAINING, CORE PSYCHIATRY, PSYCHOTHERAPY, TELEPHONE, THERAPY, VIRTUAL THERAPY, REMOTE, PSYCHODYNAMIC

INTRODUCTION

The ability to think in psychotherapeutic terms is a key feature of the delivery of all psychiatric care; developing psychotherapeutic competencies is thus an essential component of core psychiatry training (Awal, 2016).

According to the publication, ‘A competency based curriculum for specialist training in psychiatry’ (Royal College of Psychiatrists, 2020), psychotherapy training is mandatory for all core trainees in psychiatry. Appropriate workplace-based assessments need to be completed, trainees ‘must ensure that they make it a priority to obtain and profit from relevant experience in psychotherapy’ and by the end of core training the trainee must have competently completed at least two cases of different durations (Royal College of Psychiatrists, 2020). This will then lead to

achieving satisfactory progress in the annual review of competency progression process and enable the transition to higher specialist training.

In February 2020, we (IS and CJ), both core psychiatry trainees in the Kent, Surrey and Sussex deanery, started our psychotherapy 'long case', aiming to deliver approximately 40 sessions of psychodynamic psychotherapy. However, this occurred in parallel to the global pandemic of COVID-19. The Royal College of Psychiatrists (2020) states that 'the aim of psychotherapy training is to contribute to the training of future consultant psychiatrists in all branches of psychiatry who are psychotherapeutically informed, display advanced emotional literacy and can deliver some psychological treatments and interventions', however it is not specified that this training needs to be face to face.

The impact of COVID-19 has threatened the status quo of therapy delivery in the UK as national policy to reduce virus transmission discouraged the traditional face-to-face format (Payne *et al.*, 2020). Our trust issued guidelines that all non-essential face-to-face contact should cease on 23 March 2020, the day on which the UK national 'lockdown' commenced. Not being allowed to have face-to-face contact with our patients meant that we needed to rethink the way we intended to complete the psychotherapy component of our core training.

This article seeks to explore the impact of the COVID-19 pandemic on psychotherapy delivery as part of core psychiatry training.

BACKGROUND

As the COVID-19 pandemic presented such a novel scenario, with the resultant need for us to accommodate changes to our training, supervision and therapy, we sought previously published information to support the adaptation of therapy we were providing. A literature search was completed on 24 April 2021 via PubMed looking at the past 5 years, 2016 – 21. The search terms 'psychotherapy OR psychodynamic OR psychoanalysis OR psychiatry AND telephone AND training AND remote' were used. Sixty-four articles were screened, 54 were initially excluded. Ten full text articles were assessed for eligibility (one was in German but was viewed in English by Google translate). Three were excluded on further analysis for the following reasons: (1) related to private general psychiatry; (2) looked at children with epilepsy; (3) unrelated topic. Of these articles, none specifically looked at psychotherapy performed over the telephone alone.

Humer *et al.* (2020), investigated remote psychotherapy in the first few weeks of the COVID-19 lockdown in Austria. This study demonstrated that psychotherapy performed remotely via the internet or telephone was not comparable to face-to-face sessions. However, psychodynamic and humanistic therapists reported more favourably on remote therapy compared with behavioural therapists. Moreover, remote therapy was widely considered a more positive experience than the therapists had predicted. This was also supported by Korecka *et al.* (2020), who, although their research was looking at cognitive behavioural therapy (CBT), demonstrated

both improved perceptions of remote therapy and increased comparability to face-to-face sessions in line with increased numbers of remote cases undertaken.

Boldrini *et al.* (2020) focused on two outcomes: the incidence of treatment interruption and the satisfaction of therapists with remote therapy. The results demonstrated a statistically significant increase in treatment interruption in the cohort of therapists with no or little prior exposure to remote therapy. Boldrini *et al.* made the assumption that a lack of experience with remote therapy may have threatened clinicians' professional self-confidence; from this, our interpretation is that they avoided it. The study also identified a further barrier to therapy in some patients' reluctance to engage given a perceived lack of a safe space in the home. It may therefore be of use to have a pragmatic discussion about this issue with patients prior to commencing treatment in order to avoid engagement difficulties.

Everitt *et al.* (2019) designed a three-arm randomized controlled trial assessing telephone-delivered CBT, web-based CBT with minimal therapist support and treatment as usual. They identified that both telephone-delivered and web-delivered CBT for irritable bowel syndrome showed large clinical and statistically significant improvements in symptoms and impact on life and mood, which were maintained at 12 months.

In the face of COVID-19, Payne *et al.* (2020) performed a review of the e-therapies literature. This included looking at the effectiveness and challenges that need to be addressed to support the safe use and growth of e-therapies in psychology services. They found that further research is needed to better understand the full impact of what might be lost and gained in comparison to face-to-face therapy, and to assess the patient groups and settings in where it might be most effective.

Liberati *et al.* (2021) interviewed patients, psychiatrists, mental health nurses and clinical psychologists about their experiences of remote psychiatry. Patients on the whole preferred face-to-face consultations, with remote experiences leaving them with feelings of uncertainty due to concerns that their appointments would be changed or cancelled. Patients showed a preference for having remote consultations with staff members they had already met before the termination of face-to-face treatment, and expressed the difficulties when trying to build relationships with people they had not met. These observations directly relate to our own decisions to conduct a session face-to-face before commencing remote therapy. Some patients in this study chose not to receive remote care or vocalized that it was not a choice they would otherwise have made. Interestingly, therapists in the study identified that patients who had not previously received in-person therapy were more likely to be accepting of remote consultations, potentially because they did not suffer the 'shock' of a change of delivery.

Hawton *et al.* (2016) completed a Cochrane review looking at psychosocial interventions for self-harm in adults. This included 55 trials with over 17,000 patients, but only included one looking at therapy via the telephone, namely 'Effect of mobile phone-based psychotherapy in suicide prevention: a randomized control trial in Sri Lanka' (Marasinghe *et al.*, 2012). This article looked at providing support via the telephone, improving problem solving and social support, and reducing drug

and alcohol intake, so was not looking at psychodynamic psychotherapy provision via this mode. The fact that such a large review only uncovered one study related to telephone therapy demonstrates the paucity of data in the field.

To further bolster the evidence from our literature review we engaged in wider reading around the topic of remote therapy. As a starting point, we utilized the recently published question and answer session in the *British Journal of Psychotherapy* with a leading voice in remote psychotherapy, Gillian Isaacs Russell (2020). She remarks on the potential exhaustion as a result of remote therapy delivery, primarily due to the increased concentration required to attempt to counteract the sensory losses inherent to the modalities. This observation is supported by Bailenson (2020), who further explores the potential role of remote therapy in excess fatigue, attributing it principally to a lack of control over personal space, discomfort with perceived 'staring' and unpleasant reactions to a 'huge face' on the screen. This exhaustion is likely to have been compounded by the widely accepted negative mental impact of the pandemic across populations, including both therapists and patients. White (2020), although accepting remote therapy as 'better than nothing', cautioned against its acceptance as an adequate replacement for an in-person approach. She compared virtual therapy to the potential perception of acts of virtual warfare as 'meaningless' in comparison to 'direct contact', stating 'the soldier who sits at a screen directing the drone or the missile must feel that he is playing some sort of video game'. Despite this, she recognized that to stop therapy during the pandemic rather than continuing remotely would be 'maltreatment' and 'immoral'. We strongly support that position.

METHOD

At the time of the trust's decision to stop face-to-face contact, there was not a secure video conferencing facility available for us to use with our patients (although video supervision was possible as the sharing of individual email addresses was not seen as problematic when initiated with our supervisor). This led to both of us (IS and CJ) having to have frank discussions with patients about how best to proceed with their therapy. Each patient was offered choices of:

1. Waiting to start therapy face to face when the trust allowed this.
2. Having monthly 'check-in' sessions and then resuming face to face when allowed.
3. Having therapy over the telephone.

Both of our patients chose the telephone route. Interestingly, during the first 10 sessions the trust did release a secure video conferencing facility, which IS and CJ offered to their patients, however both turned this down, choosing to remain using the telephone only.

There was also the question of how we would receive psychotherapy supervision for our cases and engage with our peer group. It was decided that supervision was

to be carried out over Microsoft Teams, using the audio and video function of this app.

Other core trainees within the trust also chose to move to telephone-delivered psychodynamic psychotherapy. It was decided that their experience could be gauged through a questionnaire, which was completed by all trainees ($N = 5$).¹ The questionnaire was sent and returned as a Word document via email, therefore responses were not anonymized, potentially affecting the candidness of the responses. The questions were as follows, and could be answered on a Likert scale as ‘not at all’, ‘limited extent’, ‘unsure’, ‘some extent’ or ‘significant extent’:

1. To what extent do you believe telephone therapy was the most appropriate method for delivering therapy during the COVID-19 pandemic?
2. To what extent do you believe the lack of a constant physical setting impaired the quality of therapy?
3. To what extent do you believe the inability to view the patient impacted the quality of therapy?
4. To what extent did issues with technology (for example, the telephone or the connection) impact therapy?
5. To what extent has this method of therapy enabled you to achieve your required psychotherapy competencies during the COVID-19 pandemic?
6. To what extent was the quality of supervision sessions impacted by the use of remote supervision?
7. To what extent was the frequency of supervision sessions negatively impacted by the use of remote supervision?

Responses were scored for each question, with scores of -2 to 2 being assigned consecutively to the five possible responses on the Likert scale in order to convert responses to numerical data (i.e. ‘not at all’ would score -2 and ‘significant extent’ would score 2). This allowed the calculation of mean scores for each question to determine an overall picture of the effect of moving to telephone therapy in the opinion of the core trainees surveyed.

Questions 6 and 7 regarding supervision were included as it was acknowledged that this part of training would also be impacted by remote working. It is a core curriculum requirement that psychotherapy is appropriately supervised (*Royal College of Psychiatrists*, 2020). There was a concern that remote supervision may have resulted in less engagement from all parties, affecting the quality of the process. The frequency may also have been affected by the disruption of the pandemic, so this was also explored.

VIEWES FROM THE THERAPISTS

The following accounts detail our personal reflections on the use of remote therapy and supervision in our training. A summary of key themes is presented in Table 1.

Table 1: *A Summary of Key Themes from the Reflective Accounts*

Positive aspects of remote psychotherapy	Negative aspects of remote psychotherapy
One therapist's patient expressed a preference for it due to lack of money for travelling, parking etc.	No constant analytical setting
Convenience for patient and therapist	Patient may be responding to sensory features in their analytical setting
Can perform/participate in therapy from any location	Potential lack of privacy if patient is participating in therapy in a location with others around
Reduced number of missed appointments due to ease of access for patient	Difficult to feel engaged with the patient at times
Removal of any travel time, reducing the interruption to the patient's day	No ability to read patients non-verbal communication
Removal of treatment barriers, such as stigma around accessing psychological support	Reliant on patient having a reasonable mobile telephone signal
Some patients feel more able to talk freely	Use of therapeutic silences may be impaired as it can seem that the line has been 'cut off'
	Possibility that remote therapy would be more time-consuming if technical difficulties
	Patients' pre-existing prejudices and preconceptions about telephone treatment that they are not getting 'proper therapy'
	Lack of travel time removes 'processing and preparation time' for each session (for both the therapist and patient)

Dr Jones

I had only met my patient twice when I had to inform them that we were no longer going to be able to continue having regular face-to-face psychotherapy sessions. It became clear that we would need to consider arranging alternative options from when our trust issued guidelines that all face-to-face non-essential contact should cease due to the COVID-19 pandemic. This was a difficult discussion to have with my patient and initially they were very angry about the changing context of their sessions; however, it soon became apparent to them that this was the safest thing to do regarding COVID-19. At the time of the initial discussions the only option was to continue therapy via the telephone. Once this had started it became evident that it suited my patient's lifestyle, working pattern and finances better than physically travelling to see me face to face on a weekly basis. An alternative would have potentially been to have postponed their psychotherapy sessions until the end of the COVID-19 pandemic, but as we are now acutely aware, unfortunately this could have led to a delay of over a year before the start of their treatment.

While in the literature much has been made of difficulties surrounding performing psychotherapy with no constant analytical setting, for example via telephone or video conferencing facility, I have not found this a negative experience with my patient. We have been able to maintain a variety of constants, such as time, frequency of sessions and the role of the therapist. Despite not being able to provide a

constant 'background' that contributes to containment and the patient's transference, (Lemma, 2016), I feel that in such difficult times with the global pandemic ongoing they have been provided with considerable containment and a suitable alternative that suits their needs. Scharff (2013) raised the importance of discussing the loss of the physical setting as being sensitive to one's own losses should better enable the patient to be sensitive to their own. This is something I sought to address with my patient early in the therapeutic process and I sensed this removed an unconscious barrier. My patient has been offered video sessions instead of speaking to me over the telephone but has turned these down. Even when we have discussed a return to face-to-face sessions, they have said that they would prefer to continue over the telephone due to how well they feel this method is suiting them, the progress they feel they are making and the fit with their lifestyle.

It has been said that non-verbal communication is 'pervasive in any human interaction and accompanies every utterance' (Lemma, 2016), and I have found the lack of non-verbal cues the area I have struggled with most during this experience. My patient also has no access to my non-verbal cues, and for this reason I find myself making more positive reinforcement sounds when they are talking so that they know I am still present on the end of the telephone and listening to what they are telling me. As a result, I feel at times there have been possible misunderstandings that would have been addressed more quickly if I had been able to actually see my patient rather than guessing their body language.

While we continued therapy over the telephone we also had to plan an alternative option for supervision with our supervising psychotherapy tutor Dr Reddi. It was decided that we could safely and securely continue this to a high level via Microsoft Teams. I felt constantly contained participating in supervision this way and felt myself and my colleagues were able to have considerable discussions about the treatment that was ongoing for the patient, alongside support for ourselves during this process. To me, there did not appear to be any negative aspects of supervision occurring like this. I was working on a busy working age adult ward at the start of the COVID-19 pandemic and being able to quickly and easily access supervision this way enabled me to be supported for my psychotherapy cases and caused minimal disruption to my time away from the ward. Participating in supervision via a video link was a novel concept when we initially started in March 2020, but it has now become common place. Due to the way it has worked so well, I hope that this aspect of the changes that have occurred secondary to the COVID-19 pandemic will continue going forward.

Dr Shanley

My patient and I only had the opportunity to meet on one occasion prior to the move to remote working, so I do not believe this was particularly disruptive to the process. I do feel, however, that this may have been more jarring at a later stage, as supported by the reviewed literature (Liberati *et al.*, 2021). The change did of course mean an alteration to the analytic frame; the core features of the frame being

consistency, reliability, neutrality, anonymity and abstinence (Lemma, 2003). The consistency of the consultation room was lost and replaced with uncertainty for both parties – I could not be sure of the patient's location and nor they of mine. Those altered locations would also provide different stimuli for both parties, with other distractions, particularly visual, now a possibility given our only connection was through our voices. This enabled a new anxiety to develop, an anxiety which was likely felt by both parties that they were not capturing the full attention of the other. This was amplified by the impossibility of the reassuring nod of the head or empathetic facial expression.

The new physical distance did undoubtedly create an emotional gap initially; certainly from my perspective in the role as therapist. I found it harder to connect to the sessions and found the distractions of a home setting, even as minor as a clock on the wall or an open window, to be far more powerful when having a telephone discussion. It was then that I moved to replicate the consistency I previously found in the consultation room – ensuring I undertook the sessions in an unstimulating environment and did so in the same place each week. This had a transformational effect on my experience and I believe coincided with a change in the patient's emotional availability, suggesting that perhaps they too had noticed the alteration. Given the nature of remote therapy the duty of maintaining suitable surroundings is shared between both therapist and patient, unlike if seen in a clinic room (Isaacs Russell, 2020). This new responsibility now sitting with the patient was likely to generate a sense of pressure on them if not addressed. A clear example occurred midway through therapy when the early parts of a session were significantly disrupted by the patient's distress at being unable to locate the key to the room in which they would usually conduct the session.

The flexibility offered by the change in practice did however confer some benefit. My patient was employed full time and worked quite long hours. This, combined with their initial scepticism regarding the role of therapy in their recovery, made them a candidate for premature discontinuation of treatment. The time lost to driving to and from the clinic each week was returned to them, and they were able to engage in therapy in their home just a short distance from their work. I strongly believe that the minimization of disruption caused by the therapy has strongly supported the success of, and adherence to, the process, thereby enabling treatment goals to be reached. Even outside of this pandemic, remote technology may be a useful tool for the therapist to engage similar individuals.

In terms of psychotherapy training within the core psychiatry curriculum, I have found remote working particularly advantageous. Clinical supervision has continued uninterrupted by the pandemic, and the time previously lost to travelling between sites has been regained. This has allowed ample time for cases to be discussed thoroughly with the supervising consultant, as well as providing the opportunity to hear multiple colleagues discuss their cases. Overall, I believe that the flexibility afforded by remote working has allowed a level of consistency and accessibility to supervision and treatment which would not have otherwise been achieved.

I strongly believe that the COVID-19 pandemic has presented clinicians with a unique opportunity to modernize methods of communication, both for treating patients and communicating within multidisciplinary teams. Technology plays an ever-increasing role in day-to-day life, and it would seem unwise to assume that healthcare would not be impacted to some degree. The flexibility, accessibility and efficiency which communication technology can offer will likely become the expectation of patients when considering their preferred treatment plan, and I feel it is important that as clinicians we match that expectation as far as possible. I sincerely hope that when the pandemic passes, we do not automatically revert to our previous systems, but instead harness the many positive steps we have taken over the past year with a forward-facing approach. The changes have indeed been rapid compared with the usual ways of adopting technology in healthcare settings (the only very recent move away from NHS fax machines being a case-in-point), but this demonstrates our ability as professionals to adapt. The pandemic has been a time for finding solutions to problems and making dynamic changes, and long may that spirit continue.

A View from the Supervising Consultant Dr Reddi

The following account details the reflections of our supervising consultant psychiatrist in psychotherapy.

The unexpected lockdown caused by COVID-19 resulted in having to adapt to these circumstances to continue offering patients a service as well as a training experience for psychiatry trainees. The change caused anxiety within the psychotherapy departments as this was a move from the traditional setting in the NHS and took some time to think through. We agreed on some guidelines that would be helpful to discuss with patients with regards to establishing a safe therapeutic framework: setting, privacy, the boundaries of the sessions, food consumption, not taping sessions, dress, and sent these guidelines to our patients prior to starting assessments/therapy. Patients were offered a choice of psychotherapy by telephone or via video conferencing using Attend Anywhere (once the latter had been made available by the trust).

Trainee psychiatrists generally do not have much experience/teaching of psychotherapy, nor do they undertake personal psychotherapy, so their experience of a having a long case is a novel one.

What was helpful was that both trainees had one or two face-to-face contacts with their patients and both patients turned down virtual sessions in preference for using the telephone, though this was revisited several times. I was impressed that both patients engaged well with the trainees and continued with their sessions. The lack of bodily cues meant that the trainees had to listen more carefully to tone and the cadence of the conversations – the hesitations, the pauses. Both trainees managed to establish a therapeutic, secure space with regular weekly sessions and without interruptions, ensuring confidentiality, and patients were informed of breaks. Patients challenged these boundaries, wanting access outside sessions, but these

were withstood. We found that patients could be more emotionally available as they did not have to regulate themselves in the same way as being in a room with the therapist. However, the somatic transference and embodied experience in which to explore non-verbal cues was missing. Though this implicit communication was missing, patients nevertheless had an awareness of the trainees' presence, who were experienced as being there for them. Epistemic trust developed within the therapeutic space so that patients could take on board other perspectives and felt that their experiences, concerns and difficulties could be made sense of, as evidenced by the material discussed in supervision.

Virtual supervision had its challenges, with occasional WiFi problems leading to using the telephone; however, it allowed trainees to attend despite on-call duties which might not have been possible face to face. I will be using a blended approach with some virtual and some face-to-face supervision sessions. Both trainees have had a high level of attendance and use supervision effectively. Transference was alive and could be talked about. Other trainees have taken on patients without first meeting them, but the sessions were virtual and visual contact helped establish a therapeutic relationship. To summarize, my department will offer the choice of virtual sessions for patients to improve access to psychotherapy as many patients have engaged well with better attendance. Virtual therapy is not a substitute for the whole-body experience of being in the room with a patient but the work that can be done with this medium is helpful and life changing.

QUESTIONNAIRE RESULTS

Five questionnaire responses were received, which represented all core trainees in the trust delivering psychodynamic psychotherapy via telephone. The mean score for each question was lower than 2 (or higher than -2 for questions 2, 3 and 4, as the questions were regarding a negative impact), therefore suggesting that overall therapy delivery was affected by moving to telephone consultations. However, as demonstrated in Figure 1, the impact was felt to be limited, particularly regarding the impact on the attainment of psychotherapy competencies and the receipt of supervision (questions 5, 6 and 7). There was also a broad agreement that telephone psychotherapy was the most appropriate choice of modality given the circumstances (question 1, mean score 1.5).

DISCUSSION

We shall now place our results in the context of the published literature and seek to highlight the relevant similarities and differences. This is of particular importance given our relatively small dataset and the largely impressionistic nature of our study necessitated by the small data pool within the trust.

Liberati *et al.* (2021) reported that some patients felt the use of remote methods made it more likely that appointment times would be altered or not followed through, which often led to a sense of uncertainty and frustration for them. This was something that the authors did not have a problem with, and indeed the remote

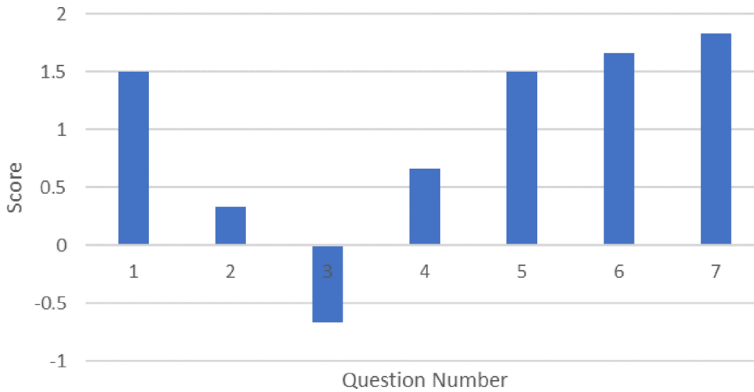


Fig. 1: Mean Response Scores from Core Trainees [Colour figure can be viewed at wileyonlinelibrary.com]

nature of the consultation enabled them to stick to agreed appointments more easily than if they had been on a face-to-face basis.

Boldrini *et al.* (2020) raised the important point that remote psychotherapy allows for the continuity of psychotherapy during a pandemic. This also highlights the need to increase the general acceptance of remote psychotherapy among the public and professional populations. A recent adult survey suggested that 72% of adults would be happy to try therapy via video conferencing, but when given the choice, the largest subset (44.5%) preferred individual face-to-face sessions (Renn *et al.* 2019). This supports our findings that, whilst not a like-for-like replacement for face-to-face contact, alternative contact methods are certainly of use to provide therapy when it would otherwise be inconvenient or unsafe. However, as we experienced, patients may require some reassurance that remote therapy can meet their needs.

Korecka *et al.* (2020) informed us that psychotherapists' previous experience in using digital media positively correlated with further use and a positive attitude towards the medium. Contrary to this, we found that our inexperience with psychotherapy enabled us to be more open and flexible with the approach of performing psychotherapy over the telephone in a non-traditional way.

In this article we have discussed our opinions of a psychotherapy long case using the telephone. As stated above, when we started this case remotely there was no option for secure video conferencing within our trust between ourselves and our patients. It would have been interesting to have seen how we would have changed our psychotherapy practice if we had been able to use a video function with our patients, and this is something we hope to explore in the future. 'Telemedicine' is an area of practice that will continue to grow within psychotherapy and psychiatry practice. Telephone therapy is a subset of remote therapy that is further removed from the 'real world' experience given visual stimulation is entirely removed (although this arguably better replicates the analytic situation). It may, in addition, provide a level of consistency beyond other remote methods due to the inherent reliability of telephone

connections compared with WiFi or other data exchange. This was evidenced anecdotally within our trust when other trainees later attempted to move to video therapy and had significant technical issues, resulting in therapy oscillating between telephone and video modalities, or even sessions being aborted entirely.

Eichenberg (2021) concluded that the 'experiences of psychotherapists with online psychotherapy in times of the COVID-19 pandemic are largely positive', which is a statement that we ourselves found to be true. They did speak about the need for further training for clinicians to enable psychotherapists to feel more confident when providing online psychotherapy. While we see the value in additional training for remote psychotherapy, our personal experience was that with adequate clinical supervision from the supervising consultant psychiatrist in psychotherapy we were sufficiently prepared to deliver therapy in this way. This opinion was supported by the results of our survey, specifically question five, which demonstrated strong agreement that psychotherapy competencies were able to be met. This was in the absence of formal remote psychotherapy training.

If the role of the supervisor is to take the place of formal training in remote psychotherapy, that relationship must be strong, as stated by Cameron, Ray and Sabesan (2015). Although psychotherapy supervision face to face had been something that we had attended prior to the COVID-19 pandemic, we were able to continue positive engagement between supervisors and supervisees, an attribute essential for effective collaboration and cohesion within a videoconference-based supervision model. Concern was raised by Cameron, Ray and Sabesan (2015) over the possibility of this relationship being hampered by technology issues, but this is not something which we or our colleagues experienced. By continued regular contact via video with our supervisor, as predicted by Cameron, Ray and Sabesan, we were able to decrease our feelings of isolation, improve our knowledge of delivering psychotherapy, and confirm or discuss ongoing patient management. Participants in the study by Cameron, Ray and Sabesan (2015) indicated that the working relationship was best established with consistent weekly sessions, which is something that we established from the start of our videoconferencing supervision.

Our experience and the published bodies of work analysed support the conclusion that competency in using digital and other remote communication tools will be essential in the future development of psychiatry training. Although we did not feel specific training for remote psychotherapy was required, more broad competencies in communication/digital technologies were seen to be imperative. As stated by Dave *et al.* (2021) 'embedding digital literacy in the training and assessment framework will require a significant shift in culture and practice'. This will require full engagement from the Royal College of Psychiatrists and the trainer–trainee body.

CONCLUSIONS

It is likely that there is no right or wrong way to have completed therapy during the COVID-19 pandemic and it may be that the therapy received via this method is a poorer relation of that performed in a more traditional way. However, there have certainly been advantages, including improved accessibility, convenience, and

potentially for some patients, a greater willingness to explore uncomfortable feelings in their own environment.

We did not seek to replicate the physical environment, but instead acknowledged the limitations of the modality and sought to compensate as necessary. We can certainly say that we believe the process was beneficial to our patients at a time when alternatives were unavailable, and benefitted ourselves by being able to continue our training. This flexibility in the delivery of therapy may well increase accessibility far beyond the end of this pandemic.

For us, this was a necessary part of our core training that had to be completed to achieve our competencies, and so we had to adapt from the traditional face-to-face approach to using the telephone and received our supervision via a videoconference link. However, it is clear that there are far wider benefits to the use of remote therapy, from the reduction in our carbon footprint (Cameron, Ray & Sabesan, 2015) to improved engagement as in our own experiences. Further research would no doubt be of benefit, with core areas for exploration including comparisons of alternative remote modalities, investigation of differing training experiences between professions, plus the identification of particular patient and therapist cohorts most suited to remote therapy. We would also encourage the publication of further case-based material to bolster the current body of literature.

NOTE

1. Ethical approval was discussed with our supervisor/head of department and it was decided that we need not seek formal approval given the nature of our study.

REFERENCES

- Awal, M. (2016) CT1-3 Psychotherapy Training Guide for Trainees. *Surrey and Borders Partnership*.
- Bailenson, J. (2020) Why zoom meetings can exhaust us. <https://www.wsj.com/articles/why-zoom-meetings-can-exhaust-us-11585953336>
- Boldrini, T., Schiano Lomoriello, A., Del Corno, F., Lingiardi, V. & Salcuni, S. (2020) Psychotherapy during COVID-19: How the clinical practice of Italian psychotherapists changed during the pandemic. *Frontiers in Psychology* **11**: 591170.
- Cameron, M., Ray, R. & Sabesan, S. (2015) Remote supervision of medical training via videoconference in northern Australia: A qualitative study of the perspectives of supervisors and trainees. *BMJ Open* **5**(3): e006444.
- Dave, S., Abraham, S., Ramkissoon, R., Matheiken, S., Pillai, A.S., Reza, H. et al. (2021) Digital psychiatry and COVID-19: The Big Bang effect for the NHS? *BJPsych Bulletin* **45**(5): 259–63.
- Eichenberg, C. (2021) Online psychotherapy in times of the corona pandemic. *Psychotherapeutics (Berlin)*. <https://doi.org/10.1007/s00278-020-00484-0>
- Everitt, H., Landau, S., O'Reilly, G., Sibelli, A., Holland, R., Hughes, S. et al. (2019) Assessing telephone-delivered cognitive-behavioural therapy (CBT) and web-delivered CBT versus treatment as usual in irritable bowel syndrome (ACTIB): A multicentre randomised trial. *Gut* **68**(9): 1613–23.

- Hawton, K., Witt, K., Salisbury, T., Arensman, E., Gunnell, D., Hazell, P. *et al.* (2016) Psychosocial interventions for self-harm in adults. *Cochrane Database Review* **12**(5): CD012189.
- Humer, E., Stipl, P., Pieh, C., Pryss, R. & Probst, T. (2020) Experiences of psychotherapists with remote psychotherapy during the COVID-19 pandemic: Cross-sectional web-based survey study. *Journal of Medical Internet Research* **22**(11):e20246.
- Isaacs Russell, G. (2020) Remote working during the pandemic: A Q&A with Gillian Isaacs Russell, questions from the Editor and Editorial Board of the BJP. *British Journal of Psychotherapy* **36**(3): 364–74.
- Korecka, N., Rabenstein, R., Pieh, C., Stipl, P., Barke, A., Doering, B. *et al.* (2020) Psychotherapy by telephone or internet in Austria and Germany which CBT psychotherapists rate it more comparable to face-to-face psychotherapy in personal contact and have more positive actual experiences compared to previous expectations? *International Journal of Environmental Research and Public Health* **17**(21):7756.
- Lemma, A. (2003) *Introduction to the Practice of Psychoanalytic Psychotherapy*. New York: John Wiley and Sons.
- Lemma, A. (2016) *The Digital Age on the Couch, Psychoanalytic Practice and New Media*. London: Routledge.
- Liberati, E., Richards, N., Parker, J., Willars, J., Scott, D., Boydell, N. *et al.* (2021). Remote care for mental health: Qualitative study with service users, carers and staff during the COVID-19 pandemic. *BMJ Open* **11**(4): e049210.
- Marasinghe, R., Edirippulige, S., Kavanagh, D., Smith, A., Jiffry, M. (2012) Effect of mobile phone-based psychotherapy in suicide prevention: A randomized control trial in Sri Lanka. *Journal of Telemedicine and Telecare* **18**(3).
- Payne, L., Flannery, H., Gedara, C.K., Daniilidi, X., Hitchcock, M., Lambert, D. *et al.* (2020) Business as usual? Psychological support at a distance. *Clinical Child Psychology and Psychiatry* **25**(3): 672–86.
- Renn, B.N., Hoefl, T.J., Lee, H.S., Bauer, A.M. & Areán, P.A. (2019) Preference for in-person psychotherapy versus digital psychotherapy options for depression: Survey of adults in the US. *NPJ Digital Medicine* **2**(1): 1–7.
- Royal College of Psychiatrists. (2020) A competency based curriculum for specialist core training in psychiatry, July 2013 (updated March 2016, May and June 2017, April 2020). https://www.rcpsych.ac.uk/docs/default-source/training/curricula-and-guidance/core_psychiatry_curriculum_may_2019.pdf?sfvrsn=f8594b3e_6
- Scharff, J.S. (2013) Clinical issues in analysis over the telephone and the Internet. In: Scharff, J.S. (ed.), *Psychoanalysis Online: Mental Health, Teletherapy, and Training*, pp. 61–74. London: Karnac.
- White, K. (2020) Practising as an analyst in Berlin in times of the coronavirus: The core components of psychoanalytic work and the problem of virtual reality. *International Journal of Psychoanalysis* **101**(3): 580–4. <https://doi.org/10.1080/00207578.2020.1761816>

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