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Client Experiences of Videocall-Delivered Therapy During COVID-19 Restrictions in Aotearoa New Zealand: A Qualitative Study

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ABSTRACT

Aim: Intermittent restrictions on personal movement were introduced in Aotearoa New Zealand in March 2020 in response to the COVID-19 pandemic. As in-person therapeutic appointments became unavailable, psychotherapy, psychology and counselling services were increasingly delivered by phone or online, often via videocall. While there is a growing literature on therapists' experiences of videocall therapy, fewer studies have examined clients' experiences.

Method: This study used semi-structured interviews to explore the experiences of six clients who engaged in videocall therapy during COVID-19 restrictions in Aotearoa New Zealand. A Qualitative Description approach with reflexive thematic analysis was used to provide a low-inference account of participants' experiences in language close to their own.

Findings: Participants described videocall therapy as fundamentally different from in-person therapy. Therapeutic space was created through practices by both therapists and clients, including modifications to the client's physical environment and thoughtful communication that supported continuity and responsiveness. Participants valued the flexibility of videocall therapy and its capacity to support continuity of care, but also noted the limitations of reduced access to body language and non-verbal cues. Practices before, during and after sessions shaped how videocall therapy was experienced, including transition practices that helped participants move between the therapeutic space and everyday life.

Conclusion: Although limited by a small sample size, these findings add an Aotearoa New Zealand client perspective on videocall therapy during COVID-19 restrictions. They suggest that perceived therapeutic efficacy may be influenced by practices before, during and after sessions, as well as by the creation and maintenance of a therapeutic space in the videocall environment.

1 | Introduction

Therapists' beliefs that in-person therapy was the 'gold standard' (Agosta 2019) were challenged when restrictions were imposed to reduce the spread of COVID-19. Effectively overnight, telepsychology became the primary mode of therapy engagement in many parts of the world, including Aotearoa New Zealand. To maintain therapeutic relationships and delivery of therapy during movement restrictions, the use of distance communication technologies for psychological service delivery exploded, including videocall technology (henceforth called videocall therapy).

Limited pre-pandemic research documenting clients' experiences of telepsychology indicated that clients reported similar levels of satisfaction compared with in-person therapy (Norwood et al. 2018; Simpson et al. 2005). Often, these studies were of specific client populations that experienced challenges attending in-person therapy, such as clients living remotely or with problems accessing appropriately qualified therapists (Babbage

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> **Implications for Practice**
>
> - Videocall therapy requires a different set of skills to develop the therapeutic space.
> - Clinicians engaging in videocall therapy are encouraged to be aware of behaviours they can engage in to approximate the physical therapy setting.
> - Clients may benefit from the use of behavioural patterns that help to define the therapeutic space.

et al. 2020; Scogin et al. 2018; Zheng and Gray 2014), and clients with social anxiety (Yuen et al. 2013) and medical conditions limiting contact (Lleras de Frutos et al. 2020), therefore posing issues with generalisability.

In Aotearoa New Zealand, the 2020 Alert Level system introduced periods of stay-at-home orders that constrained non-essential, in-person clinical contact, including psychotherapy (Cumming 2022; Werkmeister et al. 2023). As such, these restrictions entailed cancellation of gatherings and closure of public venues and non-essential workplaces; in health care, this produced a rapid shift to remote modes to maintain continuity of care (Werkmeister et al. 2023). These restrictions, and later region-specific measures, normalised the remote delivery of care during the pandemic. In mental health services, telehealth use increased sharply and then varied as restrictions eased, influenced by clinician preparedness, client comfort, service capability, and digital inclusion (Werkmeister et al. 2023; Officer et al. 2023). At the same time, longstanding inequities in access to culturally safe mental health care, particularly for Māori (Elers et al. 2022; Donkin et al. 2024), Pacific peoples (Grimes and White 2019; Matenga-Ikihele et al. 2023), and those living rurally (Babbage et al. 2020), were thrown into sharper relief, and digital inclusion emerged as a critical consideration in the delivery and sustainability of telehealth. As such, equity impacts and digital inclusion emerged as system-level considerations for telehealth in Aotearoa New Zealand, with services and clinicians emphasising the need to support client choice and access (Officer et al. 2023; Reay et al. 2020).

Although there is increasing evidence of the effectiveness of videocall therapy (Zamiri-Miandoab et al. 2022; Uysal et al. 2022; Wignall 2006; Sclare et al. 2015; Olsson et al. 2021), there is only a limited body of research examining experiences of clients engaging in videocall therapy during the COVID-19 pandemic. Emerging research on client experiences indicates that the removal of time and cost considerations due to travel was viewed as beneficial for engaging in videocall therapy. Jenkins-Guarnieri et al.'s review of 15 studies examining client perceptions of telepsychology found generally little difference in perceptions of working alliance or satisfaction with therapy (Jenkins-Guarnieri et al. 2015). While working alliance was found to be lower on average in a meta-analysis of randomised controlled trials comparing remote and in-person cognitive behavioural therapy, this was not shown to result in any difference in therapeutic outcomes (Norwood et al. 2018).

Client perspectives on experiences and efficacy of telepsychology are under-represented in global literature, both pre- and post-COVID-19 pandemic. Recent qualitative work in other health contexts has begun to examine how patients understand and evaluate telehealth, highlighting ambivalence around relational closeness, convenience, and the meanings of remote care, but in-depth accounts focused specifically on psychotherapy remain limited (Loriot et al. 2024; Ärlebrant et al. 2026). There is a significant gap in the literature for client experiences of videocall therapy during the COVID-19 global pandemic, in particular with respect to personal movement restrictions that impacted therapist and client abilities to choose in-person therapy if it were a preference. This study complements emerging Aotearoa New Zealand (Officer et al. 2023) and international (Reay et al. 2020; Liberati et al. 2021) evidence on client experiences of mental health telehealth during the pandemic by examining in depth how clients experienced videocall-delivered therapy and the practices that shaped a perceived therapeutic 'space'.

2 | Method

A qualitative approach using semi-structured interviews was selected for its potential to elicit rich accounts of participants' experiences.

2.1 | Procedure

Braun and Clarke's (2021) 'rule of thumb' sample size of six to 10 participants for a small-scale exploratory study was used as a basis for recruitment. Consistent with reflexive thematic analysis, we did not use 'saturation' as a stopping rule. Instead, we targeted a small, information-rich sample suitable for an exploratory study and judged data adequacy by whether we had sufficient depth and diversity of meaning to address the research question (Braun and Clarke 2021).

We recruited via Facebook and Instagram through unpaid advertisements over a four-week period in June–July 2022. Advertisements linked to a Qualtrics information sheet and an eligibility screener. Interested individuals entered an email address and received an invitation and consent form. Once the researcher received the completed consent form, the interview was scheduled via email at a mutually convenient date and time. Participants also completed an oral interview consent in a separate voice recording before commencing the interview. Interviews were conducted via a video-calling platform of the participant's choice and were recorded with their consent. Interviews followed a semi-structured nature using 13 key questions.

2.2 | Ethics Statement

Ethical approval for this project was granted by the Auckland University of Technology Ethics Committee (AUTEC), reference number 22/127.

2.3 | Participants

Inclusion criteria for participation were: not being a client of a member of the research team, having experience of videocall

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therapy from March 2020 through to July 2022, and not presently engaged in therapy. Participants also needed to be over 18 years of age, residents of New Zealand while receiving videocall therapy, and able to read and speak English to provide informed consent and to participate in an interview.

We did not impose a minimum number of videocall therapy sessions. This choice reflects an exploratory, experience-focused design in which the diversity of experiences, including those with limited exposure, would enhance information power and allow us to capture barriers and facilitators at different stages of engagement.

2.4 | Data Collection and Analysis

Interview recordings were transcribed verbatim and were analysed by A.J. in discussion with L.D and K.V.K. Analysis followed Braun & Clarke's reflexive thematic analysis (RTA) as a flexible, iterative and researcher-active approach (Clarke and Braun 2013). A.J. (primary analyst) immersed herself in the transcripts, generated initial codes inductively and deductively, and wrote analytic memos throughout. Codes were then collated into candidate themes, capturing shared meaning, refined through discussions with L.D. and K.V.K. that examined internal coherence and distinctions between themes. We treated themes as interpretative patterns underpinned by central organising concepts, not topic summaries, and iteratively returned to the data to test coherence, review negative cases, and sharpen definitions and names. Inter-rater reliability or codebooks were not used, consistent with RTA's emphasis on reflexivity and subjectivity.

We used a Qualitative Description (QD; Sandelowski 2010; Sandelowski 2000) design to provide a pragmatic, low-inference account of clients' experiences of videocall therapy during COVID-19 restrictions. QD prioritises clear, practice-relevant summaries in language close to participants' own, and in this study, our analytic aim was descriptive rather than explanatory (Sandelowski 2010; Sandelowski 2000; Neergaard et al. 2009). We applied reflexive thematic analysis as a flexible method for identifying recurring patterns across interviews, deliberately avoiding theory-heavy interpretation or inferences about unobservable causal processes in favour of clarity, credibility, and usefulness for practitioners, consistent with recent guidance on using qualitative methods to explore participants' experiences of digital health interventions (Harrison Ginsberg et al. 2024).

To minimise deductive disclosure risk in this small sample, we report demographics in aggregated form (e.g., age range, broad ethnic categories, gender identities) and avoid potentially identifying combinations, consistent with qualitative reporting guidance (COREQ) (Tong et al. 2007).

3 | Results

Seven potential participants contacted the researcher, but one was excluded due to not meeting the study inclusion criteria. All participants were women (three identified as cisgender), ranging in age from 27 to 50 years. Three out of five participants who disclosed their ages were in their 30s. One participant identified as a disabled person living with multiple chronic illnesses and neurodivergence. Four participants described themselves as New Zealand Europeans. One participant described herself as a migrant to New Zealand, and another as a child of a refugee parent. Five participants described having a husband or a partner, with one of these participants identifying as bisexual in a heterosexual relationship. Participants were located throughout Aotearoa, with five in metropolitan centres and one in a rural area.

From March 2020 to July 2022, half of the participant group exclusively used videocall technology for therapy. Conversely, half of the participants also attended in-person sessions, generally at the therapist's workplace. One participant attended some in-person sessions held outdoors. Many participants worked with more than one therapist over the two-year period, which was the focus of this study. Of the four participants who engaged with more than one therapist, three saw two therapists in total, and one saw four. Three of these participants elected to end services with one therapist and to start with another during this period. One participant was referred to another therapist for four sessions by videocall therapy while their primary therapist took a leave of absence.

Five themes were identified. The first theme concerned participants' therapy experience by videocall as a conceptual therapeutic ‘space’. This theme was supported by two subthemes: participants' ownership of their physical environment and the incorporation of material comforts into videocall therapy. The next themes were participant appreciation for therapists demonstrating thought and care about the client experience, the inability to observe and respond to body language, and the need for transitory practices to emerge from the therapeutic ‘space’. The final theme was videocall technology facilitating a more flexible approach to incorporating therapy into participants' lives. Findings are presented as descriptive themes that summarise what participants reported about videocall therapy; illustrative quotes show typical and contrasting accounts.

3.1 | Theme 1. Space to Just ‘Be’

Participants had a range of prior in-person therapy experiences, from one-off sessions to longstanding or ongoing relationships. As such, they all brought pre-existing ideas about the elements needed for a therapeutic ‘space’ to their experiences of videocall therapy. Like face-to-face appointments, participants considered videocall therapy sessions a conceptual ‘space’. Elements of both the physical and digital environments helped participants create a therapeutic ‘space’ contained in everyday life.

> I still think physically going somewhere and doing a thing, then leaving – it's that mental space where you've got that clear boundary. When I'm pottering around and doing a Zoom call, and you go back to whatever you're doing, it's not the same as actually physically being in a different space and physically doing the work that you need to do.
>
> (Participant 06)

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The experience of engaging in therapy from home, with videocall therapy as the mode of delivery, was considered fundamentally different from the in-person therapy experience. Participants considered the transition into and out of the therapeutic 'space' as part of 'the work' of therapy, and experiencing therapy in a separate physical environment communicated the 'clear boundary' necessary to evoke the 'mental space'. The distinction suggested that the tangible actions of (a) travelling to a location, (b) being physically, intellectually and emotionally present while engaging with a therapist, and (c) physically and mentally transitioning out of the therapeutic 'space' were fundamental elements of the therapy experience.

> Not being able to remove myself from my environment, because I like the experience of going somewhere. It's somewhere safe, and it's somewhere that I'm also not distracted and worried about everything else that's going on around me.
>
> (Participant 01)

Several participants described discomfort and frustration when they were unable to access an affective atmosphere cued by 'the experience of going somewhere' that was not associated with everyday stressors. Across the interviews, the value of a physical environment that supported the client to be fully present was recognised—a therapeutic 'space' defined by feeling safe and contained away from everyday life.

> There were a few challenges when you've got all the kids home and you've got to find a space that you can just kind of 'be'…There were no interruptions and nobody who was likely to walk in and go 'Hey, mum?'. I think being in a space that's out of the ordinary, the kids were less likely to come and go 'Oh, mum where are the biscuits?' or something.
>
> (Participant 06)

> I haven't thought about it much, but just in reflection, I think it was also nice that [doxy.me] was a separate tool. It wasn't my usual tool, it was her tool. I didn't use it for any other purpose except for that. So, there was something nice in that—almost like there won't be a blurring of accounts.
>
> (Participant 04)

It was important for participants to 'contain' therapy away from the roles and responsibilities in their everyday lives to create the conditions for the therapeutic 'space'. This illustrates that digital and physical environments are interdependent elements of a person's identity, the therapy process, and everyday experience.

3.1.1 | Theme 1.1 Creating Space for Therapy at Home

Participants engaged in minimal but targeted preparatory practices to facilitate the therapeutic 'space' within their physical environment. For some, this manifested as taking a walk before the videocall therapy session to emulate travelling to a destination. Mostly, participants were intentional when selecting the location at their residence to videocall from, taking actions to ensure acoustic and visual privacy.

> The odd occasion where I had to find a small room in the house to Zoom when I knew there was other people here, that was a little bit uncomfortable. It just made home feel less like a therapy environment, probably.
>
> (Participant 02)

The importance of privacy in a therapeutic 'space' was emphasised as the participants' physical environment felt 'less like a therapy environment' when privacy was compromised. Out of necessity, many participants selected a room in their residence with a different primary function to videocall from. This included their bedroom, children's bedrooms, a home office, and the dining area. On occasion, a participant engaged in sessions from a car parked in the driveway as there was no other appropriate space that would allow them to engage therapeutically.

> But other times, it was because there were people in the house and, I was like, as much as I love them there, this is my time and I don't want to cry in front of them. They can have me afterwards. This is my space, and my time, and so sometimes that's why I did that.
>
> (Participant 02)

> One thing I did do to prepare was make sure that my dog had something to entertain herself so she wouldn't be too distracting.
>
> (Participant 01)

Participants described ownership over the experience of videocall therapy, where interactions with others in the immediate vicinity would be considered 'interruptions' or 'distractions' from the therapeutic process. Actions to facilitate a therapeutic 'space' were placing a 'Zoom meeting in progress' sign outside the door, telling other people they needed privacy, and dedicating a room for work, study and videocall therapy purposes only. These actions illustrated the clients' willingness to create the conditions in their physical environment to support a 'space' in which they can be better attuned to their experience.

3.1.2 | Theme 1.2 Feeling Comforted

Material items in the home environment that were not usually available in the therapeutic space provided haptic comfort during videocall therapy. Comfort was important for getting the best benefits from therapy. For example, participants reported videocalling from bed, wearing their pyjamas, and bringing a blanket, something to hold, and a cup of tea to therapy sessions.

> I did some of my sessions from bed, which from a therapist perspective, was very interesting for her. She's like, 'You're in bed, you're not doing well'. It meant I could be really vulnerable and I felt very

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> safe here. Being in a therapist office and crying your eyes out in an unfamiliar place where you then have to get yourself together and go out to reception and drive home, it's unfamiliar and it's uncomfortable. Whereas being at home, I just cried and cried and then my partner was here afterwards straight away.

(Participant 02)

The association between feeling comfortable and the ability to achieve therapeutic goals was a sentiment shared across the interview data. However, client and therapist interpretations could vary. As illustrated above, the primary meaning the participant ascribed to her decision to videocall from her bed was a sense of safety, which allowed her to 'be really vulnerable'. For this participant, the ability to incorporate supports available in the surrounding environment that provided comfort stood in contrast to 'unfamiliar' and 'uncomfortable' experiences of vulnerability during in-person therapy sessions. Participants described a need for comfort and soothing in their therapeutic 'space'. Material items that signified and provided comfort were important for helping participants access and 'stay with' their emotions during the videocall.

3.2 | Theme 2. Feeling Cared for and Attended to Through Continuity

A common theme was an appreciation for continuity in the quality of the working alliance during the videocall. Participants expressed this when describing demonstrations from therapists that showed consideration for the client's experience of videocall therapy.

> I mean, it ended up being not so different from when I did it in person. Even with the one I was seeing for the first time via videocall, it was fine. I've noticed in my experience, it's either a good relationship or it's not.

(Participant 03)

Participants largely felt that the quality of the working alliance was not influenced by the circumstances under which therapy occurred. Many participants who had existing relationships with therapists prior to engaging in videocall therapy indicated that they did not perceive a change in the quality or nature of the working alliance. Despite this, some participants lamented having the final session by videocall, as it did not provide adequate closure for the relationship.

> If the therapist had a high level of creativity online, like bringing up some kind of interactive whiteboard or something that could replicate the creative elements of the action-based methods, that possibly would have maintained some continuity. Whereas the more talking, psychoanalytic, profound navel-gazing methods work fine online. They work really well.

(Participant 04)

Many participants characterised the content of their therapy sessions as conversations or indicated that they were working with a therapist using talk-based modalities (therefore not requiring the addition or radical adaptation of processes), such as cognitive behavioural therapy (CBT), psychoanalysis, relational psychotherapy, and metacognitive therapy. In the above extract, the participant described actions a therapist practising psychodrama (an action-based modality) could have taken to create a beneficial experience for the client. She acknowledged that adapting this modality to videocall therapy required specific personal attributes and technical ability—a 'high level of creativity online'—that the therapist did not possess. This participant subsequently sought a therapist who practised talk-based modalities with whom she experienced a successful working alliance.

> She did little things like checking I could always hear her okay, and if we did have a slightly dodgy connection, she would check in and check she'd caught what I'd said and repeat things if needed. Which is I suppose is just good practice, but I guess not everyone would naturally do that either…I think it probably boils down to the therapy was always for me, and everything she did was to make sure that I was comfortable, and I understood, and I got the most out of it, even though it wasn't face-to-face. It always felt like she cared most for me and that was the key.

(Participant 04)

Therapists' demonstration that they were actively expanding or integrating new ways of communicating with clients was appreciated for the continuity it achieved within videocall therapy and the therapeutic process. The extract above illustrates a sentiment present across interview data regarding appreciation for the therapist's focus on clear verbal communication, deliberately asking for repetition or checking that they had correctly heard before moving on. As this participant noted, this behaviour facilitated the client feeling cared for and likely helped the therapeutic alliance. Participants also expressed appreciation for emails sent before the first session outlining the process of working together by videocall and the option to use messaging functions between sessions. Intention made the difference in how the session was utilised and the space was created.

> It didn't feel like someone sitting at their desk on Zoom with headphones on. It was actually like a real therapeutic room. It was a really lovely little couch and plant, that I could see she had clearly thought about her presentation on Zoom…It wasn't like Zoom was an add-on to her practice, she's thought about this, and this is a nice environment. As much as you can make an online environment feel safe, and nice, and personalised, and all of that.

(Participant 02)

> I found that people would start the Zoom meeting and then start getting ready. It makes me straight away

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> pull back and start to shut down and be less open...I do find that those first few minutes are really important. If I have the tendency to shut down, then the clinician is all unorganised, and I've already shut down, then it's not going to be good for the rest of the time.
>
> (Participant 01)

The first extract describes actions the therapist took that contributed to a successful work alliance. The participant expressed appreciation for the therapist's composition of what could be seen on screen because it communicated care and attentiveness towards the client's experience. It gave the participant confidence that videocall therapy was a legitimate and worthy way of engaging in therapy. By contrast, the second extract illustrates how the immediacy of the therapeutic 'space', created in part by 'up-close' audio-visual connection, meant that 'those first few minutes' became crucial for a successful working alliance. Participants expected that the therapist would reciprocate their level of engagement and were looking for demonstrations of this. Instead, the immediacy of the transmissions meant that therapists could appear underprepared when moving from one space to the next.

3.3 | Theme 3. The Limitations of Screen-Based Communication

Across the interview data, participants described their awareness that body language and nonverbal cues helped a therapist's practice during a therapy session and contributed to the therapy process. Similarly, the lessened ability to observe and respond to nonverbal cues posed difficulties for engaging in videocall therapy.

> I can only see what's on a tiny screen and they can only see me on a tiny screen.
>
> (Participant 01)

> But I do know it is a lot harder to gauge where I'm at or what I'm thinking if you can't see and observe some of the other more subtle cues that you would be picking up on in-person, more so than over a screen.
>
> (Participant 06)

Despite actions taken to create a therapeutic 'space', the artificiality of the 'tiny screen' and restrictions on what can 'only' be seen was clearly articulated across the interview data. By reducing sources of information that create intimacy and authenticity, videocall therapy introduced distance into the client-therapist relationship. In the second extract, the participant remained ambivalent about returning to in-person therapy despite recognising that they could 'mask really easily' and that in-person therapy would have more therapeutic value for them. Generally, discussions about the preference for mode of therapy delivery indicated ambivalence, but participants indicated that avoidant tendencies had some influence in this.

> It's like, 'Wow! Good luck to you' because I'm pre-wired not to actually do that thing because culturally [cultural group] people don't talk about feelings. Trauma is like, 'stuff it down and get on with it'—even looking at intergenerational trauma—because my dad came over as a refugee with the Japanese invasion and how parenting and stuff has happened.
>
> (Participant 06)

> That capacity to be with yourself more and not feel the other people's stuff, which I think you become quite attuned to as a trauma survivor. You're feeling a lot of what's going on, then actually you're not quite sure is this mine or is this yours? There's something quite useful being with another person, but because they're online, you're not feeling them. Like you're not getting all of that sensory information...Actually, how could it be used usefully and purposefully for those who really struggle in that interpersonal space and it's too intense and too much? This could actually be a really useful tool.
>
> (Participant 04)

Videocall therapy provided a less intimate sensory experience in which some participants felt 'protected' from the relational aspect of therapy. The potential for videocall therapy to amplify or reinforce existing avoidant tendencies was noticed, generating some experiences of being more self-referential than relational. Cultural considerations around the use of videocall therapy were highlighted. In the second extract, the therapeutic utility of videocall therapy for this client's therapeutic goals is floated, by helping the participant become better attuned to her own emotions when 'not getting all of that sensory information'.

3.4 | Theme 4. The Transition to Life After (Online) Therapy

Participants expressed a need to engage in solo, sensory practices to transition out of the therapeutic 'space' and into their everyday lives.

> I did notice that I couldn't go straight back to work after a session. Whereas when I was going in person, I would have the bus ride home to decompress. I noticed that I needed to go on social media or exercise or something like that, because my brain wasn't ready to be on work right afterwards. Even if I wasn't upset after a session, it's just because you're doing so much with your brain during a session.
>
> (Participant 03)

Discussions of practices immediately after videocall therapy sessions were commonly accompanied by recognition of therapy as a draining experience, cognitively as well as emotionally. The phrases 'tiring' and 'draining' were used across the interviews to describe how participants felt following videocall therapy. As shown in the extract above, participants were aware that when therapy occurred at a separate physical

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location, it allowed for organic processing of the therapy session. The need to select new ways to 'decompress' post-session to represent the new ways of engaging was shared across the interview data. There was general agreement that it was necessary to engage in some kind of practice before attempting other activities.

> Because [in-person therapy] was when the kids were at school, I could go home, sit down, have a cup of tea or something and not have to worry about 'Where's the biscuits, where's my socks?' Having to just jump straight back into brain stuff was probably more the challenge—going from quite a mental drain anyway to quick, back into parent mode. Whereas being at the office, you get that downtime.
>
> (Participant 06)

Participants often engaged in solitary and sensory transition practices, including taking a walk, washing clothes, sleeping, social media use, exercise, tea-drinking and doing an activity that did not involve a screen. For participants who were parents, this was sometimes not possible. The difficulty of having to 'jump straight back into brain stuff' was illustrated by the participants and highlights a difference between videocall therapy and office-based therapy.

3.5 | Theme 5. A More Flexible Approach

Videocall therapy was considered more flexible, making it easier to 'fit in' or continue therapy despite competing priorities for time and energy. Many participants already possessed some familiarity with videoconferencing technology, but COVID-19 restrictions accelerated and expanded participant use, especially for work, education and socialising.

> I changed jobs five weeks before the first lockdown… to a job where they were like…here's your laptop and your headphones. I mean five weeks before I was moving into that space of 'Oh, you can do things online, and it is valuable'. So, I think I probably had that bias towards like, 'I'm playing someone $150 an hour, I don't feel like a video chat is good value'. But then it's funny because that's completely flipped on its head for me because it's like 'Of course it's good value!'—I don't have to leave the house. It saves me rushing somewhere.
>
> (Participant 05)

A sentiment expressed across the interview data was that participants had come to accept and expect that digital technologies would play an increased functional role in their everyday lives. The sustained exposure to a variety of activities facilitated by videocalls helped open participants up to the potential value of videocall therapy, where value was expressed through financial, time and energy commitments, thus making videocall therapy a preferred option for some.

> Some of it is just logistics. Especially because I have to drop the small boy at school and then backwards and forwards, because for some reason the office is on the exact opposite end of town to where we are and it's like a good 20 min/half an hour depending on the traffic. So, some of that is a mental barrier.
>
> (Participant 06)

Some participants described reluctance to attend in-person therapy sessions when this became an option again. Not having to travel to attend an in-person therapy session was considered a strength of engaging in videocall therapy. Consideration of timing travel by public and private transport to attend in-person therapy sessions featured in all discussions on the merits of engaging in videocall therapy. Some participants appreciated that they could schedule a therapy session for the optimal time within their planned day, around work and other commitments. This circumvented the 'mental barrier' that incorporating therapy into a daily routine can create.

> We were doing online and offline according to lockdowns, but then if I needed to travel for work, I could carry on my therapy. There was just this more acceptance of we've done online so much before, we can we see it works. So, if you're away for work, we don't have to cancel your appointment, which was really nice, actually, in terms of continuity. And similar, my therapist had just gone away on holiday. She was travelling overseas, so the week and a half before travelling, she put herself in self-isolation and was seeing all her clients online. It's given a more flexible approach to the work in many ways.
>
> (Participant 04)

The forced trial of videocall therapy and subsequent satisfaction experienced gave many participants the confidence to engage in videocall therapy after COVID-19 restrictions had eased. The 'flexible approach to the work' illustrated above facilitated continuity and strengthened the client-therapist commitment to a shared therapeutic project of videocall therapy.

4 | Discussion

The aim of this study was to describe a contextualised analysis of clients' experiences of videocall therapy during COVID-19 restrictions, with the potential for findings to inform future research. The reflexive thematic analysis of interview data has indicated that participants' experiences of videocall therapy comprise interactions with physical, digital, and affective environments. Themes were generated describing participants' experiences of videocall therapy as a conceptual therapeutic 'space' defined by safety and containment from everyday life, with actions to enter this 'space' by changing or adapting the physical environment and actions to transition out of it that were solitary and sensory. Other themes described participants' appreciation for continuity maintained by therapist demonstrations that they were attending to the clients' experiences of videocall therapy,

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and observations of diminished access to body language and nonverbal cues.

These findings are consistent with the literature that posits that an alternative working alliance is created when interpersonal connection fundamental to the therapeutic process is mediated by digital communication technologies. Typically, with in-person therapy, the therapist is in a privileged position—maintaining control and ownership of the environment. During videocall therapy, when the therapist and client need to cooperate due to unreliable audio synchronisation and technical challenges, this can place them in symmetrical roles. (Kocsis and Yellowlees 2018; Lingley-Pottie and McGrath 2007; Irvine et al. 2020; Turner et al. 2018). Further, the roles of client and therapist within the shared therapeutic project of videocall therapy are equally valuable, yet distinct. These shifts may partially equalise power dynamics between therapist and client and can be understood as creating a somewhat different way of relating.

Participant expressions of appreciation for continuity in the therapeutic relationship and the therapy process establish consistency with the literature that indicates clients generally do not perceive a negative impact on working alliance from videocall therapy compared to in-person therapy (Simpson et al. 2005; Jenkins-Guarnieri et al. 2015). Participants' awareness of diminished ability to communicate through body language and nonverbal cues may provide some context for studies in which therapists consistently indicate a decline in working alliances or therapeutic relationships (Norwood et al. 2018; Berger 2017; Rees and Stone 2005) and this has been supported by a meta-analysis indicating that online therapeutic alliance may be less than in person (Norwood et al. 2018). This also supports Geller's (2020) thesis that a lack of training and experience with using digital communication technology shapes negative views of videocall therapy. The generation of this theme tentatively endorses the view that adaptation within practices and processes is more likely to result in positive client experiences of videocall therapy.

This study has the potential to provide beneficial insight for therapists engaging in videocall therapy practices and processes. In-person therapy may no longer be considered the ‘gold standard’ as participants appreciated the flexibility that videocall therapy allows. Like other research on client experiences of videocall therapy, participants appreciated not having to engage in travel to a location and associated planning. Thus, it would be pertinent for therapists to consider ways to adapt their current therapeutic practice or adopt new communication and engagement processes to meet client expectations for videocall therapy.

Participants described the kind of therapeutic work they were engaging in for videocall therapy as ‘having conversations’ or involving talk-based modalities, which aligns with most research pre- and post-pandemic, primarily examining CBT (Zamiri-Miandoab et al. 2022; Uysal et al. 2022; Wignall 2006; Sclare et al. 2015; Olsson et al. 2021). While this study did not seek to measure therapeutic efficacy, many participants evaluated little change within the therapeutic relationship. A strong working alliance within the therapeutic relationship is widely regarded to be fundamental for therapeutic satisfaction and success (Flückiger et al. 2018). Therefore, participants' evaluation that videocall therapy had little to no impact on the quality or nature of the therapeutic relationship indicates support for research that consistently shows the therapeutic efficacy of videocall therapy was equivalent to in-person therapy (Rees and Stone 2005; Jerome and Zaylor 2000; Simpson and Reid 2014) This is particularly significant for Aotearoa New Zealand, where videocall therapy remains a popular mode of delivery due to intermittent restrictions on in-person healthcare and the geographical distribution of the population. Further, some populations face greater barriers to accessing adequate in-person therapy in Aotearoa New Zealand than others. Populations that may benefit from videocall therapy as a first-order approach due to access barriers include people living rurally and Māori (who are consistently overrepresented in mental health statistics; Babbage et al. 2020).

Equity considerations are salient in Aotearoa New Zealand. Research pre- and post-pandemic shows that telehealth uptake and persistence are shaped by clinician readiness, service capability, and population factors, with concerns about digital exclusion and culturally safe engagement. Client perspective work in Aotearoa New Zealand underscores the importance of relationship foundations and creating safe spaces in telehealth. Clinician accounts highlight impacts on connection and well-being, including specific challenges reported by Māori clinicians. These findings suggest that culturally grounded approaches, whānau-centred engagement, and proactive mitigation of access barriers (e.g., device/data support, flexible modality choice) are important when offering videocall therapy to Māori and other groups experiencing inequities.

4.1 | Limitations

The sample was relatively homogeneous, being predominantly women aged 27–50 years with no youth or older adults; the study may have excluded those whose relational engagement with videocall technologies may differ. International evidence also suggests that older adults and some other groups may engage differently with telehealth modalities, underscoring the need for more inclusive sampling in future work (Mao et al. 2022; Zhang et al. 2023; Barwise et al. 2023).

It is important to note that the digital recruitment approach may have resulted in a selection of people with higher digital literacy. Further, the study captured experiences of videocall therapy in environmental conditions specific to Aotearoa New Zealand. The social and cultural specificities of predominantly New Zealand European woman clients, with secure accommodation during the period of COVID-19 restrictions in Aotearoa New Zealand, are noted. Future research with more diverse and larger samples is encouraged to advance knowledge in this area. Even with these constraints, the themes developed in this research offer useful insights into clients' experiences of videocall therapy and are likely to be relevant to a range of health professionals, as well as to therapists and clients.

Future research using a mixed-methods design that combines offline and online recruitment methods may be valuable for building a broader picture of videocall therapy experiences in Aotearoa New Zealand. The themes generated in this study can provide the basis for future in-depth exploration of this research area. Thematic findings from the broad research question in this

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study led to further research questions. These include: what was the experience of men/Māori who engaged in therapy by videocall? How did the experience of videocall therapy influence attitudes towards therapy in general? What effect did engaging in videocall therapy have on clients' experiences of lockdown and/or the COVID-19 pandemic?

5 | Conclusions

Themes generated from accounts of clients' experiences of videocall therapy in Aotearoa New Zealand during COVID-19 restrictions indicate that the experience of videocall therapy involves interactions among the conditions of the client's physical environment, the audiovisual connection provided by the videocall medium, and the quality of the relationship between the therapist and client.

5.1 | Reflexivity and Positionality

We provide brief positionality statements to enhance transparency about the researchers' backgrounds and experiences that may shape attention and language choices in descriptive analyses. L.D. is a practising clinical and health psychologist with an interest in the use of technology in therapeutic interventions. She regularly uses videocalling in her work with clients and was an early adopter of technology to facilitate clinical practice. A.J. is a Master of Health Science student, training to be a counselling psychologist. A.J. has an interest in psychological growth, telepsychology, and the interplay between spatial environments and psychological well-being. A.J. has an occupational background in spatial design research and has some experience delivering therapeutic interventions via videocall. K.V.K. is a practising clinical psychologist and is interested in the development and evaluation of eHealth interventions and the integration of technology into clinical practice.

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Conflicts of Interest

The authors declare no conflicts of interest.

Data Availability Statement

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

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