

RESEARCH ARTICLE

Changing to remote psychological therapy during COVID-19: Psychological therapists' experience of the working alliance, therapeutic boundaries and work involvement

Georgina James  | Thomas Schröder | Danielle De Boos 

University of Nottingham, Nottingham, UK

Correspondence

Georgina James, Mental Health Services for Older People, Nottinghamshire Healthcare NHS Foundation Trust, Bassetlaw Hospital, Kilton Hill, Worksop S81 0BD, UK.
Email: georgina.bainbridge@nottshc.nhs.uk

Abstract

Research aims: This study aimed to investigate psychological therapists' perceived ability to form a working alliance and maintain therapeutic boundaries, and their work involvement patterns whilst working remotely via telephone or videoconferencing. Furthermore, the study aimed to explore therapists' experience of therapeutic boundaries when working remotely and how they managed these.

Method: A mixed-method sequential explanatory design was adopted. Descriptive and inferential statistics were used to analyse quantitative data, with thematic analysis used to analyse qualitative data.

Results: In total, 161 psychological therapists completed an online survey, and 12 participants were selected using maximum variation sampling to engage in a semi-structured interview. Although results between therapists varied, some perceived abilities regarding the working alliance and therapeutic boundaries differed when working remotely compared to face-to-face therapy. Therapists' work involvement patterns also differed compared to existing data for face-to-face therapy, indicated by increased rates of stressful involvement. Considering therapists' experience of therapeutic

This is an open access article under the terms of the [Creative Commons Attribution-NonCommercial-NoDerivs](https://creativecommons.org/licenses/by-nc-nd/4.0/) License, which permits use and distribution in any medium, provided the original work is properly cited, the use is non-commercial and no modifications or adaptations are made.

© 2022 The Authors. *Psychology and Psychotherapy: Theory, Research and Practice* published by John Wiley & Sons Ltd on behalf of The British Psychological Society.

boundaries, four overarching themes were identified: 'different boundaries in remote therapy', 'work home boundary', 'changes in the therapeutic safe space' and 'impact of boundaries when working remotely'.

Conclusions: Aspects of the working alliance and therapeutic boundaries are experienced differently by therapists working remotely, which relates to how they experience their work. The findings have clinical implications for increasing therapists' awareness of potential changes in their perceived abilities regarding the working alliance and therapeutic boundaries when working remotely, therefore, enabling them to address these changes where required. Future research possibilities are considered.

KEYWORDS

remote therapy, therapeutic boundaries, therapist, therapist work involvement, working alliance

Practitioner points

- Therapists' perceived abilities regarding the working alliance and therapeutic boundaries differed when working remotely during the COVID-19 restrictions.
- Remote therapy presents novel experiences of therapeutic boundaries and poses challenges for therapists' ability to manage boundaries.
- Therapists experience higher rates of stressful involvement when working remotely, which may be characterised by unpleasant emotional experiences and self-doubt.
- Therapists can attend to their own well-being when working remotely by finding ways of strengthening the boundary between work and home life.

BACKGROUND

Psychological therapy usually takes place face to face. The COVID-19 pandemic had major effects on the provision of therapy with organisations recommending therapy be provided via remote platforms, such as telephone or videoconferencing (British Psychological Society, 2020). Considering arguments for increasingly providing services remotely, such as them being more accessible and flexible with timings (Fleuty & Almond, 2020; Simpson & Reid, 2014), COVID-19 could catalyse a change in the way therapy is provided in the future. Whilst guidelines and recommendations are available for conducting therapy remotely (British Psychological Society, 2020), empirical support appears limited.

Interventions without a direct interpersonal encounter, such as internet-based therapy and guided self-help, are proposed to have benefits (Abbott et al., 2008) and can be an effective alternative to face-to-face therapy (Andersson, 2018). These interventions are arguably distinguishable from therapy where there is a direct, synchronous interaction with a therapist (Berger, 2016). In this study, remote therapy is defined as therapy that would usually be provided in person, that is instead via telephone or videoconferencing.

Weinberg and Rolnick (2020) question whether remote therapy 'is the same therapy or a different one?' (p. 5), whilst others suggest that the interaction and intimacies experienced in remote therapy are real, although operating with new dynamics (Essig & Russell, 2017). This raises questions about psychological therapists' experience of remote therapy and its impact on their management of therapeutic processes, such as the working alliance (WA) and therapeutic boundaries (TB).

A pan-theoretical concept, Bordin (1979) defined the WA as comprising three aspects: (1) goal(s), (2) task(s) and (3) bond. Considered a common factor in therapy, the WA accounts for a significant proportion of therapeutic change (Horvath et al., 2011; Wampold, 2015). A positive association between WA and treatment outcome when using remote modes of therapy has been reported, although this was based on 'minimal therapist' interaction (Anderson et al., 2012) or text-based interventions (Cook & Doyle, 2002), whereas others have failed to establish this link (Knaevelsrud & Maercker, 2006). In their systematic review of videoconferencing psychotherapy, Norwood et al. (2018) concluded that the WA was inferior in videoconferencing compared with face-to-face contact but acknowledged that this may have been affected by therapists rating it lower than their clients. Furthermore, one study where therapists rated the WA lower in videoconferencing therapy involved them watching recorded sessions (Rees & Stone, 2005), thus lacking ecological validity. Nevertheless, these findings do not explain which aspects of the WA therapists experienced differently when working remotely.

The WA is governed by the boundaries of therapy, which differentiate it from a social or business relationship (Knapp & Slattery, 2004). Boundaries guide the therapeutic relationship by regulating the therapist's and client's behaviour which, in turn, should maximise outcome and minimise harm. Drum and Littleton (2014) propose that despite the increasing use of technology in mental health provision, little to no attention has been paid to TB in telepsychology relationships, arguing that therapists are likely to be presented with novel boundary issues when working remotely. Despite Drum and Littleton's (2014) recommendations for managing TB when working remotely, these are not empirically supported, and therapists' experience of boundaries remains unknown.

Finally, how therapists experience their work when working remotely has not previously been considered. Therapist work involvement patterns were first described by Orlinsky and Rønnestad (2005) who, through factor analysis, identified two independent second-level scales to describe therapists' work experience: Stressful Involvement (SI) and Healing Involvement (HI). Stressful involvement reflects a therapist's experience of 'frequent difficulties' during sessions, unconstructive 'avoidant coping', and in-session feelings of 'boredom' and 'anxiety'. Alternatively, therapists with high levels of HI are said to be 'accommodating', 'invested' and 'affirming', have deeply attentive interest or 'flow' during sessions, and 'constructive coping' when difficulties arise. Work involvement patterns have been related to therapists' ongoing professional development and satisfaction (Orlinsky & Rønnestad, 2005), engagement in intersession experiences (Zeeck et al., 2012), and the likelihood that clients will benefit from treatment (Orlinsky & Rønnestad, 2005). However, such research has been based on conventional face-to-face therapy, raising the question whether therapists' work involvement patterns and experiences differ when working remotely.

Rationale for current study

Considering that therapy via telephone or videoconferencing may change the way therapy is provided permanently, raises the question whether therapists perceive their abilities and experiences differently when working remotely. COVID-19 has provided a natural opportunity to begin investigating this. This research aimed to investigate the following questions:

- What impact has changing to remote psychological therapy during the COVID-19 restrictions had on psychological therapists' perceived ability to form a working alliance and maintain therapeutic boundaries, and on their work involvement?

- How do therapists' perceived abilities regarding the working alliance and therapeutic boundaries relate to experiences of Healing Involvement and Stressful Involvement?
- How do psychological therapists experience and manage therapeutic boundaries when working remotely?

METHOD

A sequential explanatory mixed-method design was adopted. An online survey collected quantitative self-report data about therapists' perceived abilities regarding the WA and TB, and their work involvement patterns when working remotely (Phase One). Subsequently, semi-structured interviews explored therapists' experience of TB in remote therapy (Phase Two). Ethical approval was granted by the appropriate Research Ethics Committee, United Kingdom.

Critical realism was the adopted epistemological position, assuming that although data can tell us something about reality, it is not a direct reflection of what occurs in the real world (Willig, 2013). Critical realism provides a compatible and productive stance for mixed-method research (Maxwell & Mittapalli, 2010; Shannon-Baker, 2016).

Phase one

Survey

The research team created the online survey, basing new items on existing definitions and theory, and including questions to capture therapists' characteristics, such as level of training and theoretical orientation. Furthermore, an item exploring participant's general well-being was included considering the potential impact that COVID-19 could have on an individual's well-being. Items relating to the WA were based on Bordin's (1979) conceptualisation and addressed therapist's felt competencies in maintaining a WA (Table 5 indicates which aspect of Bordin's definition each item theoretically aligns with). Items relating to TB (see Table 5) were developed based on previous definitions of boundaries (Johnston & Farber, 1996; Smith & Fitzpatrick, 1995). For the WA and TB items, participants were asked: 'Compared to face-to-face therapy, providing remote therapy during the Covid-19 restrictions has affected...'. Changes in perceived abilities were captured by a bipolar response scale, indicating if changes were positive or negative (+5 to -5), including a neutral option to indicate no change. The WA and TB items demonstrated high internal consistency (see Results).

The Therapist Work Involvement Scale (TWIS; Orlinsky & Ronnestad, 2005) explored therapists' work involvement patterns. Therapists' HI and SI scores were calculated using the equation by Orlinsky and Ronnestad (2005). Based on HI and SI scores, therapists could further be grouped into one of four work involvement patterns: Effective Practice, Challenging Practice, Disengaged Practice and Distressing Practice. This scale has good internal consistency ($\alpha = .74$ for HI; $\alpha = .66$ for SI; Nissen-Lie et al., 2010) and was compared to existing data in face-to-face therapy.

The survey was piloted with two Trainee Clinical Psychologists. Amendments were made to information provided at the end of the survey where clients consented to being contacted for phase two to make this clearer for participants.

Sample and recruitment

Therapists had to be practising in a professional therapy role (e.g. psychotherapists, counsellors, psychologists, CBT therapist, specified 'other') and predominantly provided therapy in a face-to-face setting prior to COVID-19, changing to phone or videoconferencing with individual clients during COVID-19.

Therapists could be qualified or in training as further analyses were completed on therapists characteristics which are reported in an extended paper.

The survey was advertised on social networking sites, aiming to recruit therapists from different professional backgrounds and theoretical orientations. To enable snowball sampling, permissions were set for the advert to be shared. The survey was also advertised in the British Psychological Society Division of Counselling Psychology e-letter. The advert provided a link that took participants directly to the survey, where consent and eligibility questions preceded the main survey items. The survey was open from 23 June 2020 to 14 September 2020. Considering the analysis described below, a power calculation was completed to establish what sample size was needed, indicating 112 participants were required ($\alpha = .05$; $\beta = .9$; Effect size = 0.3).

Analysis

IBM SPSS statistics (version 27) software was used for statistical analysis. Descriptive statistics were used for therapists' responses to the WA and TB items and work involvement patterns. As this was a new survey, principal component analysis (PCA) was completed on the WA and TB items to see if the two construct scales were statistically supported and to establish the internal consistency of the survey. Compared with factor analysis looking for latent variables, PCA was chosen as a method to establish if linear components existed within the data and how each variable contributed to each component.

Pearson's product moment correlations were used to analyse the association between therapists' abilities (WA and TB) and their work involvement (HI and SI). Statistical assumptions of normality and linearity are considered the most important for bivariate correlations (Field, 2018). The WA and TB scales violated the normality assumption. Thus, bootstrapped confidence intervals at 95% were applied to address the issue of non-normality.

Phase two

Interview schedule

Consistent with the design, the focus for phase two was decided following analysis of phase one, with reference to existing literature. Whilst TB and the WA are related, they are discrete constructs, and it was thought that exploring both qualitatively would limit the depth and scope of the findings. Considering claims that remote working may present novel TB (Drum & Littleton, 2014), phase one findings indicated that some TB were experienced differently in remote therapy. Thus, we decided that phase two would explore therapists' experience of TB whilst working remotely. Interview questions were developed, reviewed, and refined by all three authors. Two authors reviewed the first interview to ensure the interview schedule enabled sufficient data to be collected to answer the research question (Braun & Clarke, 2013).

Participants and recruitment

Participants consented in phase one to being contacted for interview. Potential participants were selected using maximum variation purposive sampling (Palinkas et al., 2013), based on the therapist's TB scale score (positive, negative or neutral), age, and current state of well-being. Participants were then contacted and consented to partaking in phase two.

Analysis

Thematic analysis was used following Braun and Clarke's (2006) six phase approach. The first author transcribed all interviews and subsequently read each transcript twice to increase familiarity with the data before coding. Data were then coded using a hybrid inductive–deductive approach, firstly coding inductively and then deductively using a framework developed from existing literature on TB and data collected from phase one. This approach was designed to generate a comprehensive thematic description of the data (Willig, 2013). The third author reviewed the initial coding to ensure the approach was working as intended. Codes were subsequently organised into themes, with initial themes reviewed and refined by the first and third author. Analysis was completed manually without the use of analysis software.

Researchers' own experiences, beliefs, and values influence and shape the research process and findings. Clarke and Braun's (2019) checklist was used to consider the quality of this research. For example, the primary researcher regularly recorded thoughts and experiences in a reflexive diary, which was referred to throughout the research to maintain an awareness of their own potential biases. Furthermore, the quality of identified themes was explored in discussion between the researchers to ensure that identified themes were not a reflection of the interview questions, whilst also checking for overlap between themes; a recognised means of establishing trustworthiness in thematic analysis (Nowell et al., 2017).

Alternative qualitative methods were considered for analysis. Adopting a purely inductive approach, such as that required by Interpretative Phenomenological Analysis, was considered difficult to adopt recognising that the researcher had completed phase one analysis. Furthermore, phase two aimed to further explain findings from phase one and not necessarily develop a theory, thus grounded theory was not considered an appropriate methodology for the study.

RESULTS

Sample characteristics

Table 1 presents the personal characteristics of the 161 participants that completed the survey, whilst Table 2 reports the mean and standard deviation for theoretical orientations endorsed. Characteristics for the 12 participants who engaged in phase two is presented in Table 3.

Phase one results

Remote therapy and therapist work involvement patterns

Involvement patterns found in this study were compared to findings from traditional face-to-face therapy (Orlinsky & Rønnestad, 2005), as seen in Table 4; percentages in a larger sample ($n = 12,590$) are near identical (D. Orlinsky, personal communication, October 21, 2020). In this sample, the TWIS demonstrated good internal consistency ($\alpha = .78$).

Experiences of the working alliance and therapeutic boundaries

Responses to the WA and TB survey items are presented in Table 5.

TABLE 1 Phase one sample characteristics

Characteristic	Frequency (%)
Gender	
Female	86.9
Male	11.8
Non-binary	1.3
Age	
20–29	15.5
30–39	40.4
40–49	27.3
50–59	11.8
60+	5.0
Qualified/training	
Qualified	81.9
In training	18.2
Professional background	
Psychotherapist	17.4
Psychologist	57.8
Counsellor	14.3
CBT therapist	8.1
Other	2.5
Number of years practising psychological therapy	
Less than 5 years	32.9
Between 5 and 15 years	46.6
More than 15 years	20.5
Present state of well-being	
1 Quite poor; I am barely managing to deal with things	1.2
2 Fairly poor; life is pretty tough for me at times	6.8
3 So-so; I manage to keep going with some effort	24.8
4 Fairly good; I have my ups and downs	35.4
5 Quite good; I have no major complaints	23.0
6 Very good; I get along much the way I would like to	8.7

Note. ‘Other’ professional backgrounds included: suicide prevention worker; psychological well-being practitioner; mentalization based treatment practitioner; and social worker. ‘Present state of wellbeing’ was scored on a six-point scale.

Principal component analysis

The Kaiser–Meyer–Olkin (KMO) measure of sampling adequacy statistic (Kaiser, 1970) indicates the proportion of variance amongst variables that could be caused by an underlying component, with values close to ‘1’ indicating relatively compact components. The KMO statistic for this study was .931 which is considered ‘superb’ (Hutcheson & Sofroniou, 1999) and, therefore, could be expected to produce reliable factors.

Oblique rotation was used as the components were found to correlate at .616, exceeding the criteria for using oblique rotation proposed by Tabachnick and Fidell (2019). It has previously been argued that the significance of a component loading depends on the sample size, proposing that for a sample size of 100 the loading should be $>.512$, and for a sample of 200 the factor loading should be $>.364$ to be

TABLE 2 Mean and standard deviation for each theoretical orientation

Theoretical orientation	Mean	Standard deviation
Systemic	6.30	3.79
Cognitive	6.24	3.12
Behavioural	5.68	3.46
Humanistic	4.03	3.62
Integrative	3.99	3.32
Interpersonal	3.87	3.29
Psychodynamic	2.81	2.87
Other	2.40	3.75

Note: Therapists reported how much their work was guided by each theoretical orientation on a 10-point scale (0 = 'not at all'; 10 = 'very greatly'). 'Other' theoretical orientations included: Acceptance and Commitment Therapy, Compassion Focused Therapy, Dialectical Behaviour Therapy and Mindfulness Based Therapy.

significant (Field, 2018). Thus, considering our sample size, .512 was used as a more conservative criterion to determine which variables contributed to each component. Items that did not reach this criterion and/or loaded equally onto both factors were excluded.

Principal component analysis supported two separate components: (1) a 'working alliance' component scale including all eleven WA survey items ('WA scale'), and (2) a 'therapeutic boundary' scale with eight items ('TB scale'; see Table 5 for TB items included). Both the WA and TB scales demonstrated excellent internal consistencies at .96 and .90, respectively.

Associations between therapists' perceived abilities and work involvement

Considering therapist work involvement patterns, HI was positively correlated with therapists' perceived abilities regarding the WA, $r(159) = .478$; $p < .01$; 95% CI [0.327, 0.595], whereas SI was negatively correlated, $r(159) = -.356$; $p < .01$; 95% CI [-0.493, -0.218].

Similarly, HI was positively correlated with therapists' perceived abilities regarding TB, $r(159) = .369$; $p < .01$; 95% CI [0.215, 0.498], whilst SI was negatively correlated, $r(159) = -.370$; $p < .01$; 95% CI [-0.493, -0.218].

Phase two findings

Four overarching themes were identified: (1) different boundaries in remote therapy, (2) work home boundary, (3) changes in the therapeutic safe space, and (4) impact of boundaries when working remotely. Subthemes were created where there were clear distinctions between them. Table 6 indicates which interviewees were included in each theme and subtheme.

Different boundaries in remote therapy

Therapists described changes to TB regarding the type of boundaries experienced in remote therapy and their ability to engage with boundaries; hence, two subthemes were created: 'different boundaries' and 'ability to maintain boundaries'.

TABLE 3 Phase two sample characteristics

Pseudonym	Profession	Gender	Age range	TB scale score	Well-being score
Derek	Psychotherapist, qualified	Male	60+	4.17	6
Victoria	Psychologist, qualified	Female	30–39	1.33	5
Susan	Psychotherapist, qualified	Female	30–39	0.33	5
Jayne	Psychotherapist, in training	Female	50–59	0.17	4
John	CBT Therapist, qualified	Male	60+	−0.33	4
Kimberley	Counsellor, qualified	Female	30–39	−0.33	5
Emily	Psychologist, in training	Female	20–29	−0.50	1
Danielle	Psychologist, qualified	Female	30–39	−1.33	4
Amy	Psychologist, in training	Female	20–29	−1.83	3
Katie	Psychologist, in training	Female	20–29	−1.83	5
Mandy	Psychotherapist, qualified	Female	40–49	−2.00	3
Julie	Psychologist, qualified	Female	40–49	−2.17	5

Note. See Table 1 for the Well-being score criteria.

Different boundaries

Whilst some boundaries remained unchanged from face-to-face therapy, others were experienced differently, such as what topics could be explored in therapy:

It's really really shrank the therapy to more of a check in... therapy in terms of how you would normally experience it or imagine it... So, like I said it's mostly checking in, how is she doing you know, we might do some mindfulness, short meditation, or something like that to support her.

(Jayne).

As Jayne indicated, therapy was described by many therapists as being restricted to a 'check-in', 'stopgap', or a 'chat' rather than what would usually be explored, limiting the boundaries of what could be discussed and the content of therapy sessions. For some, the change was acknowledged at a service level, appearing to legitimise and perhaps relinquish therapist's individual responsibility for the changes in therapy: 'the service I worked in, it was quite normalised that therapy felt like it was no longer therapy' (Katie).

Changes in the formality of the therapeutic encounter were also described: 'it felt like I was being treated a bit like a FaceTime call, like if you were just chatting with your mate' (Danielle). Danielle described these changes in relation to the nature of the therapist–client relationship, with it feeling less like a formal, professional discussion as would typically happen between a therapist and client. Again, these changes appeared to reflect the content of sessions rather than what are typically considered structural (Smith & Fitzpatrick, 1995) or logistical (Johnston & Farber, 1996) boundaries, such as time or location. This change in formality included how clients appeared to push the boundaries of therapy:

A client who is complaining that she's had a very hard day and, therefore, she's going to conduct the session sitting on the bed with a glass of wine...that for me is about remembering what it is that we are doing, that this is a formal psychotherapy session and not chatting.

(John).

TABLE 4 Frequency of work involvement patterns found in this study compared with Orlinsky and Rønnestad's (2005) sample in face-to-face therapy

Healing involvement	Stressful involvement			
	Little (≤ 4.75)		More than a little (> 4.75)	
Much (> 9.55)	Effective Practice		Challenging Practice	
	Face-to-face	Remote	Face-to-face	Remote
	50%	37%	23%	62%
Not much (≤ 9.55)	Disengaged Practice		Distressing Practice	
	Face-to-face	Remote	Face-to-face	Remote
	17%	0%	10%	1%

TABLE 5 Mean and standard deviation for the working Alliance and therapeutic boundary survey items

Survey item	Item topic	PCA loading	Mean	Standard deviation
My ability to effectively communicate nonverbally with my clients (task)	WA ^a	.824	-2.04	2.62
My ability to gauge my client's implicit communications (bond)	WA ^a	.762	-1.47	2.40
My ability to gauge my client's emotions (task)	WA ^a	.788	-0.92	2.29
My ability to only work during my working hours	TB ^b	.866	-0.86	2.51
My ability to stop thinking about my client's problems in the time between therapy sessions	TB ^b	.747	-0.78	2.36
The therapeutic boundary issues I experience as a therapist	TB ^b	.685	-0.46	1.95
My ability to attune with my clients (bond)	WA ^a	.894	-0.41	2.17
My ability to effectively manage my client's risk	TB		-0.30	1.90
My ability to effectively manage ruptures in the therapeutic relationship (bond)	WA ^a	.731	-0.21	2.06
My ability to maintain concentration on the client and/or task (task)	WA ^a	.643	-0.19	2.47
My ability to build a sense of trust with my clients (bond)	WA ^a	.879	-0.11	2.18
My ability to effectively communicate verbally with my clients (task)	WA ^a	.824	-0.01	2.26
My ability to maintain therapeutic boundaries with my clients	TB ^b	.586	0.02	1.94
My ability to create risk management plans	TB		0.04	1.67
My ability to maintain a consistent space where I engage in therapy	TB ^b	.668	0.12	2.37
The amount that I self-disclose to clients	TB ^b	.612	0.18	1.64
My ability to establish a therapy contract with the client	TB ^b	.531	0.20	1.81
The way I contract with clients	TB ^b	.575	0.20	1.84
My ability to be empathic towards my clients (bond)	WA ^a	.972	0.27	2.03
My ability to work in collaboration with my clients to achieve their goals (goal)	WA ^a	.774	0.40	2.08
The length of agreed therapy sessions	TB		0.53	2.10
The way I explain the limits of confidentiality	TB		0.54	1.75
My ability to be compassionate towards my clients (bond)	WA ^a	.973	0.60	2.04
My ability to attend appointments on time	TB		1.32	2.15

^aItems included in the 'WA scale' following PCA.

^bItems included in the 'TB scale' following PCA.

John described how changes in boundaries resulted in the opportunity for clients to present with novel behaviours that would not typically occur in the formal context of therapy. Changes also indicated a loss of boundaries, such as the use of resources as well as access to colleagues to help with managing boundaries. The most common reflection was about the loss of access to client's body language:

Not being able to monitor like people's body language and their reactions and responses to things... we get a sense in the room if you are pushing someone too far and how they are responding to it which is so much harder to gauge over the phone.

(Katie).

As suggested by Katie, therapists appeared to use clients' body language to guide their boundaries, with the loss of this resource presenting a potential barrier to establishing boundaries. Contrastingly, remote therapy provided new opportunities and was perceived as broadening the boundaries of therapy, specifically regarding location and physically accessing therapy. Remote therapy was considered more accessible for clients whom there may be physical or language barriers. For example, Kimberley reported being 'Russian speaking... and more people could reach me online from my country of origin'. Alternatively, some therapists described how remote therapy provided 'insight into how people live' (Danielle) or 'a whole new avenue of exploration' (Susan), which would not typically be available in face to face.

Ability to maintain boundaries

Therapist's ability to maintain boundaries varied with some finding 'boundaries a lot harder to maintain' (Katie), whereas others noticed being 'able to do that with ease' (Mandy). Whilst the type of boundaries varied in relation to therapists' ability to maintain them, half of participants acknowledged an increased difficulty managing self-disclosure:

So, I'm having to work harder at that again because the natural tendency is to kind of start telling everyone much more about my life because I feel like they can see it and know a lot of it anyway.

(Victoria).

Victoria acknowledges how the increased difficulty with self-disclosure may relate to the environment in which she provided therapy from. Contrastingly, the variability in being able to maintain boundaries was attributed to the mode of therapy used:

I feel more easily able to do that face-to-face on video, I feel like video is still not as good as face-to-face...when someone opts for just telephone, I have that sinking feeling of arghh... almost in my head I have this hierarchy of what's better and what's worse.

(Amy).

Amy's proposed hierarchy might relate to the amount of access to clients' body language, with access gradually reducing from face to face to videoconferencing and then telephone.

Different strategies for managing boundaries were proposed, the most common being contracting boundaries more explicitly with clients from the beginning of therapy and returning to this if needed. When boundaries could not be maintained, this resulted in the suspension or rescheduling of the therapy session or, on occasion when they were enforced, or in premature termination of therapy: 'I think she was so offended that I cut her off mid-stream that she refused to come back again' (Derek).

When considering how they managed or maintained boundaries, several therapists described a period of adjustment to the different experiences. For example:

I think a lot of the initial transition things are now done. I am in this room, and this is how it's going to be, it's not going to change unless, until we can go back to face-to-face.
(Jayne).

Nevertheless, most therapists reported using supervision and reflection with others. These strategies provided a normalising experience for them but also opportunities for learning how to manage therapeutic boundaries: 'having a discussion about what it's like working remotely, maybe share ideas about how to make things a bit easier, even if it's just different things like practical things' (Susan).

Work home boundary

Therapists observed a blurring of the boundary between home and work, describing difficulty separating their home and work lives: 'I think there's been a lot more leakage for the want of a better word. It's very hard to be professional Emily in home Emily's setting' (Emily). This blurring was attributed to not having a commute or physical distance between home and work and resulted in therapists struggling to switch off from work: 'and then you're just appearing back into family life...I can't quite deal with that yet because I've still got this stuff just, I'm still mulling over this in my head' (Julie).

Aspects of therapist's personal lives, such as having to consider their family, were now also part of their work experience, adding to this blurring of work home boundaries. Contrastingly, Derek who usually provided face-to-face therapy from home, described remote therapy as feeling more 'neutral' because clients were 'not having to come into my space and be aware of my wife or see the kids'.

To cope with this blurring, several therapists described strategies to separate their experiences. Some replicated behaviours that they would do when working face to face, such as 'I put my badge on when I'm at work even though I don't technically need it' (Emily), or having to organise their personal lives so that there were fewer personal experiences in their work. Alternatively, several therapists created a physical space that they could work from to maintain a work home transition:

I have got a loft, so I go up through, there's like two doors closed when I go up into the loft...that's something that I've had to really consider actually, where to do the therapy from... I think it's just a decompression chamber I suppose, or a decompression space, you know, just to let that go and come back into me.

(Jayne).

Jayne describes how, as well as deciding where to do therapy from, having a physical separation and distance between her home and workspace enabled her to maintain this boundary.

Changes in the therapeutic safe space

Changes to the therapeutic space were observed regarding the physical space in which the therapy would take place as well as external disruptions and distractions that the therapist-client dyad encountered. Therefore, two subthemes were created: 'therapeutic safe space' and 'disruptions and distractions'.

Therapeutic safe space

Therapists acknowledged the need for a safe space in therapy and considered it a 'boundary issue' (Derek) when this was not possible. In face-to-face therapy, this was considered the therapist's responsibility whereas remote therapy required a shift in responsibility from the therapist to the client, as Mandy described how 'zoom invites there to be a request that the client be in control of that and for some clients that's very easy but for other clients that's not'. Mandy described how clients varied in their ability to manage this responsibility, potentially posing challenges for therapists in ensuring a safe

space. Although not a view embraced by all, Katie proposed that this difficulty may have arisen from the therapist and client having different perceptions of what a safe space might be:

I guess you would ask at the beginning of the session like are you somewhere private and where you are able to talk but I guess they have no frame of reference of what it is that we might be talking about...as a therapist we have some kind of frame of reference that what sort of questions we might ask or what sort of things we might ask the client to be sharing.

Without being aware of what may be explored in therapy, Katie suggests that clients may not have that shared value in having a safe space in which to do therapy from.

Disruptions and distractions

Therapists experienced the therapeutic safe space as also being affected by external distractions and disruptions that, whilst they happen in face-to-face therapy, are less predictable and controllable: 'there's a bit of being surprised by time to time by how the outside world bleeds into the therapeutic environment'. John described how such distractions may unexpectedly permeate therapy. Other disruptions related to technology issues:

If we know that the broadband is likely to be an issue the worst thing is if you are mid-EMDR session, someone could be really quite uncontained, really quite distressed and you cannot then shut it down, you cannot contain it...if I do not think that I can do that safely, I will not start.

(Danielle).

Danielle described how such technology disruptions may affect the safety of the therapeutic space and impact on what therapy can be provided when technology stability cannot be assured. Some suggestions to manage this were proposed in terms of services being set up to safely address these challenges, as highlighted by Amy stating, 'our team specifically has a certain bundle of money that is coming in to help people that don't have access to technology or consistent technology'.

Impact of boundaries when working remotely

This theme highlights the noticeable effects that therapeutic boundaries had on the therapists themselves, the clients, and the therapeutic process when working remotely, as captured in the following three subthemes: 'impact on therapists', 'impact on clients' and 'therapy process'.

Impact on therapists

Most therapists noticed an increased awareness and effort in managing therapeutic boundaries. Nevertheless, despite an increased effort, most therapists spoke about being less present in the therapy because of all the additional considerations when working remotely:

I suppose it was that boundary for me as a therapist, you know, and as someone that is there fully, kind of investing fully kind of, you know, fully within the session... Whereas I was well aware that I'm saying to them, there might be noises in the background and there might be distractions and telling someone almost my attention at times is going to be pulled elsewhere.

(Julie).

All therapists described the unpleasant emotional impact on themselves and on their well-being because of the different boundary experiences when working remotely, feeling 'embarrassed', 'frustrated', 'uncomfortable', 'angry' and 'awkward'. The intensity of this emotional impact varied depending on the boundary

experience. John described being 'slightly embarrassed' when there was a 'friendly gardener outside whistling loudly'. Whereas Danielle described a more intense experience because of the space in which she was providing therapy stating:

I felt like I needed to sort of almost say this is not my bedroom, you are not looking a place where I go to sleep every night... it's a very intimate, personal space and it, to be able to look at somebody's bed... I just felt really uncomfortable.

Furthermore, several therapists described a feeling of self-doubt in their ability to do therapy, as indicated by Susan saying, 'it leaves me questioning myself as well, it leaves me questioning if there's anything I could have done differently'. To cope with the impact on themselves as therapists, most described an increased awareness to look after their own well-being. For some, this involved a period of rebalancing, particularly following a difficult therapy session:

If I'm face-to-face and driving, I have got so many minutes before I get home to kind of debrief and err re-group... so, getting back into my own body, feeling like in my own skin, if it's been particular difficult session what might I have that is still lingering... I have learned that I need to do that, it's got to be part of a routine, I've got to spend time to decompress.

(Jayne).

Impact on clients

Changes to boundaries impacted clients' engagement: 'I would say it's a huge impact because first they're distracted and, second, they're either silent or saying something not relevant at all' (Kimberley). The main inhibitory mechanism appeared to be clients' awareness of others being present in their therapeutic space, as Susan reported 'the impact of other people being around is that they become more cautious about what they say, how they word it, and whether it's safe'. However, Derek noticed that this varied between clients depending on how comfortable clients felt:

They look more comfortable and less self-conscious... it means that things can go deeper quicker... in this more informal atmosphere perhaps it speeds that process up. There's a trust involved. I guess in contrast to that, I think some people have remarked that, you know, it can be more difficult to work at depth.

Therapy process

Altered boundary experiences had varying impacts on the therapy relationship and the perceived quality of work:

It felt very much like she was showing me that she understands what we have been working towards and she gets it... Silly example but a good one actually of I think a moment in the therapeutic relationship that probably would never have happened if we were not doing video calls.

(Danielle).

Danielle described an opportunity arising from the changed boundary, enabling a novel communication between her and her client. Alternatively, potential negative impacts are best demonstrated by Jayne:

I think it's reduced it, there's less, there's just that presence of having somebody in the room which is lost. I think it can be done virtually, and we are doing it virtually, it can be beneficial, can be therapeutic, it is working but I think we have lost something.

(Jayne).

Her experience indicates a loss of intimacy by being bereft of her clients' physical presence, whilst still perceiving remote therapy as 'working'. Finally, therapists described changes in the focus and quality of the therapeutic process:

It makes your sessions, all the therapeutic process longer and longer and maybe has less results... It's about quality probably and about processes, about the progress of the process because if you are distracted with the child or a dog or I do not know.

(Kimberley).

Kimberley attributed such changes to the quality of work to the altered boundaries experienced in remote therapy, indicating a loss of intensity to the therapeutic process because of being less focused.

Synthesis of phase one and phase two findings

Phase one highlighted that therapists experience aspects the WA and TB differently when working remotely. Therapists' experience of their work also differed from face-to-face therapy, as indicated by the increased rates of SI, which was supported by the interview findings where therapists described unpleasant emotional experiences and self-doubt as an effect of the different TB experienced. Phase two findings further explained and supported phase one TB findings, whilst also providing possible explanations for the work involvement patterns.

The varied TB experiences reported in the survey were supported by the interview inasmuch that whilst therapists experienced changes in what could be explored in therapy and the loss of some boundaries, remote therapy offered new opportunities and boundaries. Considering previous definitions of TB (Johnston & Farber, 1996; Smith & Fitzpatrick, 1995), changes described appeared to reflect content and conceptual changes rather than structural or logistical. Furthermore, whether the differences in phase one were experienced as positive or negative may also be explained by therapist's perceived ability to maintain boundaries, which varied depending on boundary type and mode of remote therapy used, as described in phase two.

The survey indicated that therapists experienced their ability 'to only work during my working hours' and 'to stop thinking about my client's problems in the time between therapy sessions' as being negatively impacted by working remotely. This was supported by the interviews where therapists described a blurring between their work and home boundary and their ability to 'switch off' from work.

DISCUSSION

Prior to the COVID-19, health care services were moving towards the use of digital technologies (NHS, 2019; Roland et al., 2020; Topol Review, 2019). These findings provide insight into aspects of remote therapy that therapists experience differently to conventional face-to-face settings and may, therefore, need consideration within service design and delivery.

Whilst pooled alliance ratings between client, therapist, and observer have been found to be lower in videoconferencing compared with face-to-face therapy, outcome was comparable (Norwood et al., 2018). Recent findings indicate that client WA ratings in videoconferencing relate to and predict outcome (Norwood et al., 2021). However, these findings still do not provide insight into what aspects of the WA therapists' experience differently. Whilst supporting the finding that therapists experience some facets of the WA differently compared with face-to-face therapy (Norwood et al., 2018; Rees & Stone, 2005), it goes some way to identifying what the perceived differences might be. Whilst therapists have difficulty using nonverbal communication and gauging client's implicit communications, their perceived ability to work with clients on their goals was not negatively affected. Considering Bordin's (1979) three aspects of the WA, this finding may indicate that in remote therapy the WA is more focused on 'task' and 'goals' to counteract for possible changes in 'bond' due to the impact on nonverbal communication. This was

previously considered internet-delivered therapies (Berger, 2016), although this is arguably different to remote therapy where there is a direct, synchronous interaction between therapist and client and, consequently, direct access to body language. Nevertheless, differences may occur between modes of remote therapy depending on level of access to body language, which is not yet fully understood. However, this study considers therapists' perception of the WA in accordance with Bordin's conceptualisation, whereas recent qualitative findings from clients' perspective of the WA related more to 'bond' as opposed to 'task' or 'goals' (Norwood et al., 2021). Whilst the findings presented here and recent findings from client's perceptions indicate that therapists and clients may experience aspects of the WA differently in remote therapy, this was neither the focus of this study nor was comparing the relationship between therapists' WA ratings and therapeutic outcome. Further exploration of the differences between therapists and clients would help us to further understand the importance of WA in remote therapy and potential mediators and moderators of outcome.

As previously argued by Drum and Littleton (2014), remote therapy presents novel boundaries. Despite therapists indicating that they were able to focus on the therapeutic goal, qualitative findings highlighted that therapists felt constrained in what they could work with in remote therapy due to difficulty gauging what was safe to explore and changes to the therapeutic safe space. Similarly, people receiving mental health support remotely have reported fearing being overheard by others, inhibiting what they would share with the therapist (Mind, 2021). Despite a loss of boundaries when working remotely, the findings supported previous claims that remote therapy provides new opportunities, particularly making therapy more accessible for clients (Simpson & Reid, 2014).

Furthermore, therapists described an increased awareness of their self-disclosure. Zur et al. (2009) conceptualised 'unavoidable self-disclosure', referring to disclosures that are not deliberate or avoidable and how they may relate to the therapy setting. Qualitative findings in this study indicated that therapists who typically worked from a clinic noticed an increased awareness of and effort in managing self-disclosure, whereas therapists who usually worked from home may have experienced a reduction in unavoidable self-disclosures.

A key finding related to the blurring of therapist's work home boundary, a concern previously raised by therapists using an interactive platform (Richards et al., 2018). Therapists reported thinking more about work during their non-working, 'home' time and an increased opportunity to work outside of their hours, which has previously been considered a potential boundary crossing (Lustgarten & Elhai, 2018). Therapists described difficulty 'switching off' from their work by continuing to think about therapy or their clients in the time between therapy, a process previously conceptualised as 'intersession experiences'. Therapists' intersession experiences have been related to experiencing difficulties in practice (James et al., 2022) which may result in a blurring of the work home boundary for therapists. Nevertheless, intersession experiences can lead to a process of discovery for therapists to overcome such difficulties, such as in supervision (James et al., 2022).

Therapists described the unpleasant emotional impact and self-doubt they experienced when working remotely in relation to TB. Feeling 'discouraged' in the time between therapy sessions positively associates with and predicts levels of SI (Zeeck et al., 2012), potentially explaining the higher SI rates in this study compared to face-to-face therapy. Recognising the association between work involvement patterns and therapists' burnout (Steel et al., 2015; Zeeck et al., 2012) and the likelihood that clients will benefit from treatment (Orlinsky & Rønnestad, 2005), has implications for clinical practice when therapists work remotely.

Clinical implications

Despite the COVID-19, therapists will inevitably be able to return to face-to-face settings. Whilst clients' ratings have been considered most important in relation to therapeutic outcome in videoconferencing psychotherapy (Norwood et al., 2021), therapists in face-to-face therapy who generally form better WAs irrespective of client factors achieve better outcomes. Gaining client feedback has repeatedly been shown to effect outcome (Duncan, 2010). Recognising the perceived changes in the WA when working

remotely, systematically gaining client feedback may be a helpful means to monitoring the relationship and potential outcome.

Whilst the extent of the impact on therapists or therapeutic process and outcome is unknown, therapists should be aware of the potential impact of working remotely, including therapist burnout and to client outcomes. Supporting therapists with skill development in remote therapy and with their currently experienced growth increases HI (Duncan, 2010). The TWIS could be used as self-reflection tool, supporting therapists' development in the realm of remote therapy. Therapists in this study also reported using supervision and peer discussions to normalise and validate their experiences, a proposed strategy to also process emotionally unpleasant intersession experiences and aid the therapeutic process (James et al., 2022).

Whilst the necessity for formality in therapy may be debated, boundaries are currently understood to differentiate the therapeutic relationship from that of a business or social relationship (Knapp & Slattery, 2004). Therapists in this study considered establishing a clear therapeutic contract from the outset to manage changes in the formality of therapy.

Limitations

Although the phase one sample size reached statistical power, more psychologists participated, constraining the generalisability of phase one findings. Nevertheless, steps were taken to overcome this as far as possible by sharing the advertisement on varied sites to attract therapists from different professional backgrounds. Furthermore, the cross-sectional nature of phase one does not enable conclusions to be drawn regarding the potentially dynamic nature of therapists' experiences and work involvement when working remotely.

Finally, COVID-19 has been considered to have a psychological impact on peoples' well-being which could be a contributory factor in the observed changes in therapists' work involvement patterns. Nevertheless, whilst the psychological impact of COVID-19 was not the focus of this study, therapists' were asked about their present state of well-being in phase one. The results indicated a skewed distribution towards a higher rating of well-being, with more than half the sample rating their well-being as 'fairly good' or better.

CONCLUSION AND FUTURE RESEARCH

This study provides novel, empirical insights into therapists' experience of the working alliance, therapeutic boundaries and their work involvement when working remotely. The findings presented support previous claims that therapists experience remote therapy differently compared with face to face, raising the following questions for further inquiry:

- How do therapists and clients perceive the WA in remote therapy and what are the mediators and moderators in relation to therapeutic outcome?
- What impact do the observed therapeutic boundary and working alliance differences have on therapeutic outcomes when working remotely?
- Do therapists work involvement patterns change over time when working remotely?

AUTHOR CONTRIBUTIONS

Georgina James: Conceptualization; data curation; formal analysis; investigation; methodology; project administration; writing – original draft. **Thomas Schröder:** Conceptualization; formal analysis; investigation; methodology; supervision; writing – review and editing. **Danielle DeBoos:** Conceptualization; formal analysis; methodology; supervision; writing – review and editing.

ACKNOWLEDGEMENTS

The study was completed in partial fulfilment of the requirements for the degree of Doctorate in Clinical Psychology to the University of Nottingham.

CONFLICTS OF INTEREST

No conflicts of interest.

DATA AVAILABILITY STATEMENT

Data are stored securely at the University of Nottingham, for which the authors have access.

ORCID

Georgina James  <https://orcid.org/0000-0002-7073-8620>

Danielle De Boos  <https://orcid.org/0000-0001-7117-2991>

REFERENCES

- Abbott, J. A. M., Klein, B., & Ciechowski, L. (2008). Best practices in online therapy. *Journal of Technology in Human Services, 26*(2–4), 360–375. <https://doi.org/10.1080/15228830802097257>
- Anderson, R. E. E., Spence, S. H., Donovan, C. L., March, S., Prosser, S., & Kenardy, J. (2012). Working alliance in online cognitive behavior therapy for anxiety disorders in youth: Comparison with clinic delivery and its role in predicting outcome. *Journal of Medical Internet Research, 14*(3), 1–16. <https://doi.org/10.2196/jmir.1848>
- Andersson, G. (2018). Internet interventions: Past, present and future. *Internet Interventions, 12*, 181–188. <https://doi.org/10.1016/j.invent.2018.03.008>
- Berger, T. (2016). The therapeutic alliance in internet interventions: A narrative review and suggestions for future research. *Psychotherapy Research, 27*(5), 511–524. <https://doi.org/10.1080/10503307.2015.1119908>
- Bordin, E. S. (1979). The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy: Theory, Research & Practice, 16*(3), 252–260. <https://doi.org/10.1037/h0085885>
- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77–101. <https://doi.org/10.1191/1478088706qp063oa>
- Braun, V., & Clarke, V. (2013). *Successful qualitative research: A practical guide for beginners*. Sage.
- British Psychological Society. (2020). *Guidance for psychological professionals during the COVID-19 pandemic*. Retrieved from <https://www.bps.org.uk/news-and-policy/new-guidance-psychological-professionals-during-covid-19-pandemic>
- Clarke, V., & Braun, V. (2019). Guidelines for reviewers and editors evaluating thematic analysis manuscripts. Retrieved from <https://cdn.auckland.ac.nz/assets/psych/about/our-research/documents/Checklist%20for%20reviewers%20and%20editors%20evaluating%20thematic%20analysis%20manuscripts.pdf>
- Cook, J., & Doyle, C. (2002). Working alliance in online therapy as compared to face-to-face therapy: Preliminary results. *Cyber Psychology and Behavior, 5*(2), 95–105. <https://doi.org/10.1089/109493102753770480>
- Drum, K. B., & Littleton, H. L. (2014). Therapeutic boundaries in telepsychology: Unique issues and best practice recommendations. *Professional Psychology: Research and Practice, 45*(5), 309–315. <https://doi.org/10.1037/a0036127>
- Duncan, B. L. (2010). On becoming a better therapist. *Psychotherapy in Australia, 16*(4), 42–71. <https://doi.org/10.1037/12080-000>
- Essig, T., & Russell, G. I. (2017). A note from the guest editors. *Psychoanalytic Perspectives, 14*(2), 31–137. <https://doi.org/10.1080/1551806X.2017.1304111>
- Field, A. (2018). *Discovering statistics using IBM SPSS statistics* (5th ed.). SAGE.
- Fleuty, K., & Almond, M. K. (2020). Remote access therapy for veterans with psychological problems: Current state of the art. *Military Medicine, 185*(7–8), 1046–1050. <https://doi.org/10.1093/milmed/usaa020>
- Horvath, A. O., Del Re, A. C., Flückiger, C., & Symonds, D. (2011). Alliance in individual psychotherapy. *Psychotherapy, 48*(1), 9–16. <https://doi.org/10.1037/a0022186>
- Hutcheson, G., & Sofroniou, N. (1999). *The multivariate social scientist: Introductory statistics using generalized linear models*. Sage.
- James, G., Schröder, T., & De Boos, D. (2022). Therapists' discovery: A systematic review of therapists' intersession experiences. *Journal of Psychotherapy Integration, 32*(2), 190–209.
- Johnston, S. H., & Farber, B. A. (1996). The maintenance of boundaries in psychotherapeutic practice. *Psychotherapy, 33*(3), 391–402. <https://doi.org/10.1037/0033-3204.33.3.391>
- Kaiser, H. F. (1970). A second generation little jiffy. *Psychometrika, 35*(4), 401–415.
- Knaevelsrud, C., & Maercker, A. (2006). Does the quality of the working alliance predict treatment outcome in online psychotherapy for traumatized patients? *Journal of Medical Internet Research, 8*(4), e31. <https://doi.org/10.2196/jmir.8.4.e31>
- Knapp, S., & Slattery, J. M. (2004). Professional boundaries in nontraditional settings. *Professional Psychology: Research and Practice, 35*(5), 553–558. <https://doi.org/10.1037/0735-7028.35.5.553>
- Lustgarten, S. D., & Elhai, J. D. (2018). Technology use in mental health practice and research: Legal and ethical risks. *Clinical Psychology, 25*(2), 1–10. <https://doi.org/10.1111/cpsp.12234>

- Maxwell, J. A., & Mittapalli, K. (2010). Realism as a stance for mixed methods research. In A. Tashakkori & C. Teddlie (Eds.), *Sage handbook of mixed methods in social and behavioral research* (pp. 145–168). Sage Publications.
- Mind. (2021). *Trying to connect: The importance of choice and remote mental health services*. Retrieved from <https://www.mind.org.uk/media/7592/mind-20582-trying-to-connect-report-low-res.pdf>
- NHS. (2019). *NHS long term plan*. Retrieved from <https://www.longtermplan.nhs.uk/>
- Nissen-Lie, H., Monsen, J. T., & Rønnestad, M. H. (2010). (2010). Therapist predictors of early patient-rated working alliance: A multilevel approach. *Psychotherapy Research*, 20(6), 627–646. <https://doi.org/10.1080/10503307.2010.497633>
- Norwood, C., Moghaddam, N. G., Malins, S., & Sabin-Farrell, R. (2018). Working alliance and outcome effectiveness in videoconferencing psychotherapy: A systematic review and noninferiority meta-analysis. *Clinical Psychology & Psychotherapy*, 25(6), 797–808. <https://doi.org/10.1002/cpp.2315>
- Norwood, C., Sabin-Farrell, R., Malins, S., & Moghaddam, N. (2021). An explanatory sequential investigation of the working alliance as a change process in videoconferencing psychotherapy. *Journal of Clinical Psychology*, 77(6), 1330–1353. <https://doi.org/10.1002/jclp.23112>
- Nowell, L. S., Norris, J. M., White, D. E., & Moules, N. J. (2017). Thematic analysis: Striving to meet the trustworthiness criteria. *International Journal of Qualitative Methods*, 16(1), 1–13. <https://doi.org/10.1177/1609406917733847>
- Orlinsky, D. E., & Rønnestad, M. H. (2005). *How psychotherapists develop: A study of therapeutic work and professional growth*. American Psychological Association.
- Palinkas, L. A., Horwitz, S. M., Green, C. A., Wisdom, J. P., Duan, N., & Hoagwood, K. (2013). Purposeful sampling for qualitative data collection and analysis in mixed method implementation research. *Administration and Policy in Mental Health and Mental Health Services Research*, 42(5), 533–544. <https://doi.org/10.1007/s10488-013-0528-y>
- Rees, C. S., & Stone, S. (2005). Therapeutic alliance in face-to-face versus videoconferenced psychotherapy. *Professional Psychology: Research and Practice*, 36(6), 649–653. <https://doi.org/10.1037/0735-7028.36.6.649>
- Richards, P., Simpson, S., Bastiampillai, T., Pietrabissa, G., & Castelnuovo, G. (2018). The impact of technology on therapeutic alliance and engagement in psychotherapy: The therapist's perspective. *Clinical Psychologist*, 22(2), 171–181. <https://doi.org/10.1111/cp.12102>
- Roland, J., Lawrance, E., Insel, T., & Christensen, H. (2020). *The digital mental health revolution: Transforming care through innovation and scale-up*. Retrieved from <https://2020.wish.org.qa/app/uploads/2020/09/IMPJ7849-03-Digital-Mental-Health-WISH2020-201103-WEB.pdf>
- Shannon-Baker, P. (2016). Making paradigms meaningful in mixed methods research. *Journal of Mixed Methods Research*, 10(4), 319–334. <https://doi.org/10.1177/1558689815575861>
- Simpson, S. G., & Reid, C. L. (2014). Therapeutic alliance in videoconferencing psychotherapy: A review. *The Australian Journal of Rural Health*, 22(6), 280–299. <https://doi.org/10.1111/ajr.12149>
- Smith, D., & Fitzpatrick, M. (1995). Patient-therapist boundary issues: An integrative review of theory and research. *Professional Psychology: Research and Practice*, 26(5), 499–506. <https://doi.org/10.1037/0735-7028.26.5.499>
- Steel, C., Macdonald, J., Schröder, T., & Mellor-Clark, J. (2015). Exhausted but not cynical: Burnout in therapists working within improving access to psychological therapy services. *Journal of Mental Health*, 24(1), 33–37. <https://doi.org/10.3109/09638237.2014.971145>
- Tabachnick, B. G., & Fidell, L. S. (2019). *Using multivariate statistics* (7th ed.). Pearson.
- Topol Review. (2019). *Preparing the healthcare workforce to deliver the digital future: An independent report on behalf of the Secretary of State for health and social care February 2019*. Retrieved from <https://topol.hee.nhs.uk/the-topol-review/>
- Wampold, B. E. (2015). How important are the common factors in psychotherapy? An update. *World Psychiatry*, 14(3), 270–277. <https://doi.org/10.1002/wps.20238>
- Weinberg, H., & Rolnick, A. (2020). *Theory and practice of online therapy: Internet-delivered interventions for individuals, groups, families, and organizations*. Routledge.
- Willig, C. (2013). *Introducing qualitative research in psychology* (3rd ed.). Open University Press.
- Zeeck, A., Orlinsky, D. E., Hermann, S., Joos, A., Wirsching, M., Weidmann, W., & Hartmann, A. (2012). Stressful involvement in psychotherapeutic work: Therapist, client and process correlates. *Psychotherapy Research*, 22(5), 543–555. <https://doi.org/10.1080/10503307.2012.683345>
- Zur, O., Williams, M. H., Lehavot, K., & Knapp, S. (2009). Psychotherapist self-disclosure and transparency in the internet age. *Professional Psychology: Research and Practice*, 40(1), 22–30.

How to cite this article: James, G., Schröder, T., & De Boos, D. (2022). Changing to remote psychological therapy during COVID-19: Psychological therapists' experience of the working alliance, therapeutic boundaries and work involvement. *Psychology and Psychotherapy: Theory, Research and Practice*, 00, 1–20. <https://doi.org/10.1111/papt.12413>