sible again in later phases. From April 27, 2020, Argentina was able to adapt the restriction measures to the respective epidemiological situation in the provinces. On November 29, 2020, the last isolation measures were lifted and replaced by pure distancing measures [*Distanciamiento social, preventivo y obligatorio* (DiSPO)]. A total of 9,060,923 COVID-19 cases have been confirmed in Argentina to date, and 128,344 deaths have been recorded (Ministerio de Salud Argentina, 2022).

Psychological stress during COVID-19

Globally, the pandemic and its associated constraints had a major impact on mental health. In their systematic review, Vindegaard and Benros (2020) consider the results of 43 international studies that addressed mental health effects of the COVID-19 pandemic. Patients with preexisting psychiatric symptoms subsequently reported worsening of their symptoms (k=2). An increase in depressive and anxiety symptoms, among others, could be seen in both individuals working in health care (k=20) and the general population (k=19). Actual infection with coronavirus also appeared to be associated with posttraumatic and depressive symptoms (k=2) (Vindegaard & Benros, 2020). The review by Wang *et al*. (2020) considered 68 cross-sectional studies from 19 different countries. The authors reported a prevalence of 33% for symptoms of anxiety and a prevalence of 30% for symptoms of depression in the general population. The following factors were associated with higher odds: female sex, younger age, rural residence (only for symptoms of anxiety), and low socioeconomic status (Wang *et al*., 2020). In an Argentine study (N=10,053), 33.7% of the participants exceeded the cut-off for depression and 23.2% exceeded the cut-off for anxiety in the first week of quarantine. Associated distress factors were identified as feelings of loneliness, daily worry, and repetitive negative thoughts. The highest symptom prevalence was shown in the youngest group of 18 to 25-year-olds (Torrente *et al*., 2021).

Telepsychotherapy during COVID-19

The pandemic led to changes in the practice of psychotherapy and, in particular, to a rapid shift from face-to-face therapy to telepsychotherapy (Appleton *et al*., 2021). The study by McBeath *et al*. (2020) surveyed 335 therapists who switched to telepsychotherapy during the COVID-19 pandemic. They used primarily videoconferencing (46%) or telephone (36%); the transition to telepsychotherapy was described as challenging or somewhat challenging by 77% of respondents and experienced as effective by 51% of respondents. Benefits included access to therapy for specific patient populations, more choice of therapists, and time efficient (McBeath *et al*., 2020). In a similar study, Olwill *et al*. (2020) examined psychiatrists' experiences with telephone consultations during the COVID-19 pandemic (N=26). Participants felt less confident in making a diagnosis (92%) and were impaired in their judgment by the lack of visual cues (96%). Risk assessment over the telephone was also considered more difficult. Regarding the therapeutic alliance, most respondents (88%) agreed with the statement, "More difficult to establish atmosphere of openness and trust with new patients" (Olwill *et al*., 2020, p. 4). The studies by Aafjes-van Doorn *et al*. (2020a) and Békés and Aafjes-van Doorn (2020) examined therapists' experience with videotherapy during the pandemic. To prepare for the transition, therapists talked with colleagues, followed posts on forums or mail distribution lists, read regulatory guidelines, or created consent forms, among other activities. Challenges associated with the transition were reported to be technical issues, patients' difficulty in finding an appropriate location for therapy, or possible distraction of patients or therapists during the session. Regarding the relational level, therapists reported feeling less connected, difficulty reading patients' emotions, or expressing empathy. In addition, the study used standardized scales to assess the therapeutic relationship, self-doubt and anxiety in the professional context, and attitudes regarding acceptance and use of videotherapy. The therapeutic alliance was rated as sufficiently good and the actual relationship as strong. Participants were positive about videotherapy but experienced it as somewhat less effective (Aafjes-van Doorn *et al*., 2020a). A large proportion of respondents reported feeling more tired but authentic and confident as a result of the video sessions (Békés & Aafjes-van Doorn, 2020).

Aafjes-van Doorn *et al*. (2020b) examined the construct of vicarious traumatization (VT) among 339 therapists during the COVID-19 pandemic. Most therapists showed moderate levels of VT (62.7%) and 14.9% high levels of VT. Younger therapists, with less clinical experience, who had worse previous experiences with telepsychotherapy, showed higher levels of VT. Kramer *et al*. (2020) investigated the subjective burden of healthcare workers during the COVID-19 pandemic (N=3669). High agreement was found for items related to psychological distress, worries about the future, worries regarding family, or their own COVID-19 contamination. Nurses showed higher subjective stress than physicians or other hospital staff. Individuals who worked in a COVID-19 area showed higher distress than all other participants (Kramer *et al*., 2020).

Relevance of the study and research questions

This study is part of the research project *Psychotherapy in times of quarantine during the COVID-19 pandemic. Perspective of mental health professionals* (PsiCO-19), which aims to investigate the psychotherapeutic practice during the COVID-19 pandemic in Argentina. Between July and August 2020, we conducted an online survey among psychotherapists (N=978) on telepsychotherapy use during the first wave of the COVID-19 pandemic. While 77.7% of the respondents reported using telepsychotherapy for the first time since the beginning of the pandemic, 62.6% of them conducted telepsychotherapy with at least 50% of their patients (Fontao *et al*., 2022). The aim of this study was to add to these findings by exploring the psychotherapists' subjective views about the transition between in-person and telepsychotherapy.

Based on the described international studies and the results of the online survey of Argentine psychotherapists, three main topics were selected for the interviews in the present study: General conditions of therapeutic work, therapeutic relationship, and therapist and stress factors. These main topics are highly relevant for clinical practice and address important topics in psychotherapy research beyond the pandemic, *e.g.*, the therapeutic alliance (Flückiger *et al*., 2018), procedural adherence, or therapy dropouts. In the cited international studies, the first main topic (general conditions of therapeutic work) is only partially addressed. Olwill *et al*. (2020) report shorter telephone consultations in their study, and in Aafjes-van Doorn *et al*. (2020a) therapists report the same external framework conditions (fees and cancellation) in videotherapy. However, there is evidence that the context of therapy played an important role during the pandemic. For example, changes in the content of therapy (everyday problems or practical problems, existential concerns)

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and adjustments in interventions were reported in other surveys (Bundespsychotherapeutenkammer, 2020). The majority of studies on psychotherapy during the COVID-19 pandemic are from North America and Europe. Since the cultural context also affects the therapy situation (Benish *et al*., 2011), it cannot be assumed that the results can be fully transferred to the Latin American context. By conducting in-depth interviews with Argentinian psychotherapists, we aimed to capture the local particularities of the transition to online psychotherapy. On the other hand, by using a structured qualitative approach we expected to provide a detailed picture of the psychotherapists' experiences and to contribute to the understanding of telepsychotherapy in a wider context (*e.g.,* international and post-pandemic context).

The following questions were investigated:

i. Does the switch to telepsychotherapy have an impact on the general conditions of therapeutic work, *e.g*., in terms of setting, therapeutic method, or therapy content?
ii. Does the switch to telepsychotherapy have an impact on the therapeutic relationship, *e.g*., in terms of the way in which the relationship is formed, of therapy discontinuations, or of new admissions?
iii. Do the switch to telepsychotherapy or the contact restrictions have an impact on therapist and stress factors, *e.g.,* with regard to in-session experience, non-verbal information, critical situations, or therapist (subjective) stress?

Materials and Methods

Participants

Nine psychotherapists out of a pool of participants of a previous online survey (Fontao *et al*., 2022) were invited to take part in the study. Eight participants were already known to members of the research team in a professional context. All interviewed psychotherapists were female and had a degree in Psychology. Different age ranges were represented [20-29 years (1), 30-39 years (1), 40-49 years (2), 50-59 years (3), 60-69 years (2)], as well as Argentine provinces [Chubut (1), Córdoba (1), Mendoza (2) and the city of Buenos Aires (5)]. Moreover, different areas of practice [working in private practice (4), in institution (1), in private practice and institution (4)], theoretical orientation [psychoanalytic/psychodynamic (7), eclectic/integrative (1), systemic (1)] and patients' age groups [adults (3), adults + children and adolescents (6)] were also represented in the sample. All participants reported having worked therapeutically during the pandemic, and all of them switched to telepsychotherapy during the pandemic. Of these, one therapist used only video therapy, and the remaining therapists used a combination of video and telephone therapy (as well as chat).

Materials

An interview guide for telepsychotherapy during the pandemic was created for the semi-structured interviews. This guide contains three main topics based on the results of the literature review: General conditions of the therapeutic work, therapeutic relationship, therapist factors and burden. For each topic, the therapists were asked i) if a phenomenon of interest (*e.g*., difficulties/problems in switching to telepsychotherapy) did happen to them, and ii) to provide more details and to describe their personal experience, which is the main focus of our research question. In addition, the interview guide includes a section with general, introductory questions and an outlook (*Supplementary Material*, A). Questions about the therapists' personal situation (therapist and stress factors) were asked at the end. Semi-structured interviews are the method of choice to exploratively investigate a complex phenomenon that has not yet been sufficiently described. On the one hand, they offer enough flexibility to capture a detailed, subjective perspective from the point of view of those involved. On the other hand, since all participants are asked the same questions, different perspectives and aspects of the phenomena under investigation can be captured (Döring & Bortz, 2016, pp. 357-358; p. 365).

Procedure

The semi-structured interviews were conducted via video between 03.12.2020 and 18.12.2020 by a member of the project group, a female licensed psychologist with a doctoral degree and research experience in psychotherapy processes. The interviews lasted on average approximately 57 minutes (range: 40 to 88 minutes). The preparation of the transcripts involved three steps: i) the audio recordings were transcribed by native-speaking students of psychology under the supervision of a member of the project group and ii) mutually proofread. The proofread transcripts were then iii) checked again, corrected or amended, when necessary, standardized in their form, and analyzed by an independent member of the project group (female psychologist with a bachelor's degree).

Data analysis

The interview transcripts were analyzed using Qualitative Content Analysis according to Mayring (2015), which includes different techniques. In this study, the inductive category formation was chosen as the main technique: the material is selectively worked through with regard to the research questions, and categories (codes) are assigned for relevant text passages. These are either newly formed or the text passages are assigned to already existing categories (subsumption). The goal of the analysis is to develop a category system and to answer the research question. The software MAXQDA was used.

Coding rules and coding process

Basic coding rules were established prior to the analysis. During the coding process, these rules were reviewed and refined; moreover, additional, more specific rules were created. In the coding process, all text passages were considered that related to the questions of this study (effects of the switch to telepsychotherapy) or described advantages and disadvantages of telepsychotherapy (selection criterion). The smallest text component to be evaluated was defined as "clear, meaning-bearing elements in the text" (Mayring, 2015, p. 88) (coding unit), and the largest component to be evaluated was an entire response paragraph (context unit). The level of abstraction of the codes was set as concrete, *i.e*., coding was relatively precise and close to the text. In addition, relevant (person-related) variables from the interviews were recorded, and content notes were created for each interview for our own documentation. As recommended by Mayring (2015), the codes were reviewed after analyzing 10-50% of the material; thereafter, the interviews were reviewed again. Subsequently, the codes were divided into main categories, and when necessary, further subcategories were created. Codes were also classified within categories into positive (ther-

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apy-enhancing), negative (therapy-hindering), or neutral (or unclassifiable) effects following the respondents' own views. The results are presented in a codebook (*Supplementary Material, D*). Finally, the category system was interpreted with regard to the research questions. An overview of the evaluation process is provided in Figure 1 (*Supplementary Material*). In addition to the impact of the switch to telepsychotherapy (as positive, negative, or neutral effects), negative statements were coded as "- no effect -". Indirect statements (statements made by third parties, for example by colleagues), affirmative answers, and Yes/No answers were coded separately. When the therapists agreed with summary statements made by the interviewer but did not further elaborate on the aspect themselves, the text passage was coded as "Yes answer". If a question was answered by the therapists only with "Yes" or "No" or if another aspect was addressed afterwards, this was counted as a Yes/No answer. This procedure can be illustrated by the following scheme: Yes/No => Yes/No answer; Yes/No + congruent statement => code; Yes/No + incongruent statement => Yes/No answer + code. These additional rules about the coding of Yes/No answers made it possible to make maximum use of the text material. In the case of conflicting statements by the same therapist, both aspects of the statement were coded (*e.g.*, positive and negative effects on the patient's clinical problem). Conflicting statements were additionally registered in the notes for each interview. Statements that were considered as too vague (*i.e.,* the statement misses the required level of concreteness) were not coded. The qualitative analysis was carried out by the first author of this paper.

Ethical considerations

The research project received a positive vote by the Ethics Committee of the National Scientific and Technical Research Council (CONICET) Mendoza, Argentina. Prior to the interview, the participants were informed about the aim and content of the study and about the processing of their personal data. They signed a consent form for participation.

Results

An overview of the results of the nine interviews on telepsychotherapy is given in the codebook (*Supplementary Material*, *C*). It includes a description of the codes, an example, the absolute number of times a code was assigned as well as in how many interviews it was assigned is given in the codebook (*Supplementary Material*, *D*). The codes were divided into a total of six main categories: general conditions, therapeutic relationship, therapist factors, patient factors, advantages of telepsychotherapy, and disadvantages of telepsychotherapy. Some main categories included further subcategories. In addition, the codes within the categories were divided into positive (therapy-promoting), negative (therapy-hindering), and neutral (unclassifiable) effects. The six main categories are described below.

General conditions

The main category *general conditions* include the subcategories *therapeutic setting*, *therapeutic method* and *therapy content*.

Therapeutic setting

Eleven negative effects were described in this subcategory. They related to the following aspects: payment, therapy costs, therapy conditions, patients at home during sessions, working in an institution. Due to the switch to telepsychotherapy, some unfavorable therapy conditions have arisen, for example small cell phone screen, eye contact in couples therapy is lost, children leave screen during therapy, patients do not have enough privacy, are distracted or have to go to another place, *e.g.,* car, walking, as this example shows:

> *T2: "Bueno porque se sentía mas cómoda en el auto, porque siente que ahí nadie la va a escuchar, que tiene privacidad total, teme que si está en la casa por ahí alguien pase y la escuche y eso la incomoda y entonces en el auto está en un ámbito bien cerrado, medio oscuro, a veces se llevaba una manta, en invierno cuando hacía frío." [Well, because she felt more comfortable in the car, because she felt that no one would hear her there, that she had total privacy, she was afraid that if she was in the house someone would pass by and hear her and that made her uncomfortable, so in the car she was in a very closed environment, half dark, sometimes she took a blanket, in winter when it was cold].*

Further, nine neutral effects were described. These were mainly related to the setting (payment, therapy times, frequency and duration of sessions). For example, therapists reported the use of alternative payment methods (*e.g.,* bank transfer), more flexible therapy times, lower frequency, or longer therapy sessions. Looking at the - no effect - section of the codebook, it is clear that there were changes in terms of setting variables, but in general they could be maintained, for example frequency, seating arrangements, or therapy costs, as this answer shows:

> *T1: "Con respecto a los honorarios, para mí es lo mismo, porque el trabajo es el mismo." [With respect to fees, it's the same for me, because the work is the same].*

Therapeutic method

Regarding the *therapeutic method*, six hindering effects were described by the therapists. These refer to the use of different interventions or aspects of treatment technique and diagnostics (*e.g.,* loss of nonverbal cues), as well as, in general, therapy with children:

> *T7: "Sí, porque en las primeras sesiones para hacer el diagnóstico yo soy mucho de mirar el cuerpo, tanto en cómo se mueve como también en la fisonomía si es alta, si es petisa, si tiene rulos, pelo lacio, más regordita, más delgada… Pero bueno, me demoró más tiempo y lo tuve que preguntar, no preguntaba si era gorda o flaca, pero sí cómo se sentían con su cuerpo, si tenían alguna dificultad con las comidas… Antes hacía preguntas más puntuales para poder hacer el diagnóstico diferencial, y ahora ya no." [Yes, because in the first sessions to make the diagnosis I am a lot about looking at the body, both in how it moves and also in the physiognomy if it is tall, if it is petite, if it has curls, straight hair, chubbier, thinner... But well, it took me longer and I had to ask, I did not ask if it was fat or thin, but how they felt about their body, if they had any difficulty with meals... Before I asked more specific questions in order to make the differential diagnosis, and now I don't].*

Five other effects were described by the therapists regarding the therapeutic method, which cannot be classified as either positive or negative. These refer to the adaptation of interventions or treatment technique, and the handling of suicidal (or destabi-

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lized) patients. For example, online games were used with children, parents were more involved, or sessions were concluded differently. Therapists also sometimes reported more active or more restrained behavior in therapy. One therapist explained her more active behavior in therapy (talking more) as a way to replace the physical presence, also because silence is harder to endure in online therapy:

T9: "Por eso creo que hablamos más, porque intentás reemplazar el cuerpo por otras cosas, no soportás el silencio, es difícil soportarlo en esta dimensión." [That's why I think we talk more because you try to replace the body with other things, you can't stand the silence, it's hard to stand it in this dimension].

Regarding the therapeutic way of working, codes - no effect - were also assigned. This shows that some aspects of the therapeutic method could also be maintained (*e.g.*, theoretical orientation).

Therapy content

As for the *therapy content*, two negative effects on the therapy process were reported in the interviews (therapy process takes longer, therapy process interrupted). The two effects classified as neutral also refer to the therapy processes or content. Of note is the code "subject matter present in therapy", which was assigned 15 times within eight of the nine interviews. The code was used when therapists described that many topics related to the pandemic or to social restrictions were present in the sessions:

T8: "Sí, bueno, el tema central es el coronavirus. Ha pasado a tener un lugar sumamente… bueno, a nosotros, por lo menos, en el caso nuestro, no nos permite ir a trabajar." [Yes, well, the central issue is the coronavirus. It has come to have an extremely... well, to us, at least, in our case, it doesn't allow us to go to work].

This can be considered more an effect of the general situation than of the switch to telepsychotherapy. From the therapists' point of view, the therapeutic processes have not been interrupted, but topics related to the pandemic, or the contact restrictions came in addition to the other topics.

Therapeutic relationship

For the main category *therapeutic relationship,* four positive effects were described. For example, some patients were able to open up more easily or unfold more in the online therapy. The lack of physical presence, especially the possibility of looking each other in the eyes, and the fact that the therapist "goes into the patient's home" were mentioned as possible reasons for this. The insights into the patient's home were also described by some therapists as additional (diagnostic) information:

T7: "… entonces eso fue una ventaja, porque permitía también comentar cosas y como sabían que yo estaba mirando el quincho de la casa, la tele o la cocina de ellos, compartían con mayor libertad algunas cuestiones más personales, o sin tantos rodeos." [... so that was an advantage, because it also allowed them to comment on things and since they knew that I was watching the barbecue at home, the TV or their kitchen, they shared more freely some more personal questions, or without so many detours].

Another positive aspect was that the patients and therapists were in the same situation regarding the pandemic or contact restrictions. This was associated with a better understanding of the current situation and was considered as a unifying element.

Further, regarding the therapeutic relationship, six effects were described that can be classified as negative. These refer to the characteristics of the therapeutic relationship, interruptions of the therapy and therapy terminations. Analyzing the last two codes in more detail, interruptions of therapy (twelve assigned codes in seven interviews) as well as terminations of therapy (21 assigned codes in eight interviews) were reported in almost all interviews since the beginning of the contact restrictions or the switch to telepsychotherapy. According to the therapists, some therapy discontinuations can be directly linked to the switch to telepsychotherapy or the changed modality.

The three effects that can be classified as neutral refer to the discontinuation of physical presence as well as the characteristics of the therapeutic relationship in telepsychotherapy. Because there are both positive and negative aspects associated with the elimination of physical presence, this was classified as neutral. For example, telepsychotherapy is experienced as less rich or reduced compared to therapy in presence:

T1: "Para mí es valioso el consultorio, estar con el cuerpo presente es otra cosa que estar viéndonos solamente así, se pierden algunas cosas me parece. La forma presencial tiene otras riquezas que no tiene esto." [For me the office is valuable, being with the body present is something else than just seeing each other like this, I think some things are lost. The face-to-face form has other assets that this does not have].

T9: "... creo que hay algo recortado, algo que ¿no? por esto de lo humano que tiene que ver con la presencia, hay algo recortado, ..." [... I think there is something cut out, something that, well, because of this human thing that has to do with presence, there is something cut out ...].

Regarding the therapeutic relationship, codes -no effect- were also assigned. This shows that not all aspects of the relationship were (equally) affected by the change (*e.g.*, emotional depth) and that therapists had different experiences.

Therapist factors

The main category *therapist factors* includes the subcategories burden, therapist factors, and therapists' in-session experiences.

Burden

Nine stress factors were described by the therapists. These were negative effects of the switch to telepsychotherapy and the current situation (pandemic/restrictions). There was an increased workload due to a higher number of patients and the additional workload due to the switch (*e.g.*, learning the technology, transferring tests into Excel). Work and home life (without the physical separation) could no longer be clearly delineated:

T4: "Yo atiendo desde mi casa, y no estaba preparada para esto, tuve que acondicionar una parte de mi casa, lo que también afecta a mis familiares." [I work from my home, and I was not prepared for this, I had to condition part of my house, which also affects my family members].

In addition to these aspects, the therapists reported experiencing the general situation as stressful, struggling with their own fears and worries, and economic insecurities. The fears and

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worries are mainly related to the infection or transmission of the coronavirus.

Regarding burden, codes - no effect - were also assigned. This shows that there are individual differences between the therapists. For example, no financial insecurity was described by the therapists who had an additional job (*e.g.*, in a school).

Therapist factors

Two aspects can be classified as positive. The work was experienced as a drive or resource during this time. Also, the transition to telepsychotherapy was described as an interesting, positive or enriching experience:

> *T4: "Aprendí muchísimo, esto irrumpió en la vida de todos, pero también pienso en la experiencia, tan rica, tan enriquecedora." [I learned a lot, this was a breakthrough in everyone's life, but I also think of the experience, so rich, so enriching].*

The rest of the effects in this category can be classified as neutral. Almost all therapists (seven out of nine) reported that they had to get used to or adapt to the new situation. Adapting to the new circumstances seemed to require flexibility and creativity.

Therapists' in-session experience

Two positive and four negative effects were reported. Of note here was the code "telepsychotherapy exhausting." Telepsychotherapy was perceived as (more) exhausting by all therapists (at least at times). This was partly expressed physically, for example by a buzzing noise in the ear, symptoms of fatigue or headaches. Reasons given for the exertion included the new situation, technical problems, or that the physical presence had to be compensated for:

> *T9: "Me parece que está vinculado con el cansancio que genera sostener algo sin el cuerpo y por el otro lado sostener lo tecnológico." [It seems to me that it is linked to the fatigue generated by holding something without the body and on the other hand holding technology].*

In some cases, the first online sessions were associated with stress (*e.g.*, tension or despair). Altogether, taking into consideration the category - no effect - the therapists' statements vary in terms of their experience of safety and competence.

Patient factors

Three described effects can be classified as positive. These refer to a more active participation in the therapy and to the patients' clinical problems (mostly single aspects of the problem, for example: social restrictions lead to spatial separation from persons who have destabilized the patient; one patient stops substance use during strict social isolation).

Further, four negative effects were described. These refer to the behavior of the patients in therapy, the patients being at home during the session, and the clinical problems of the patients. Negative effects of the situation (pandemic/restrictions/online modality) on the patients' clinical problems were described in all the interviews. For example, patients were reported to have become destabilized, symptoms increased, or new symptoms emerged:

> *T10: "No, bueno este paciente que yo te digo, por un lado lo ayudó el encierro a dejar de consumir porque no salía a consumir, pero sí que se empezó a bajonear." [No, well this patient that I am telling you, on the one hand the confinement helped him to stop using because he did not go out to use, but he did start to become depressed].*

Four other reported effects can be classified as neutral. These refer to patients' needs in therapy (*e.g.*, children want to play more, patients need more support) and their preferred modality. Some patients are described as expressing a desire for therapy in presence, preferring it, or waiting until it is offered again. Others prefer telepsychotherapy and want to keep it, for example, for safety reasons.

Advantages of telepsychotherapy

A total of nine advantages of telepsychotherapy were described. The most commonly reported was that telepsychotherapy is not tied to a specific location and thus can treat patients who live further away. Telepsychotherapy was also considered "more convenient" by the therapists, or it was reported that some patients did so. Other advantages were the ability to continue treatment and the safety aspect (no risk of contamination) during the pandemic, cost savings, and increased flexibility in terms of setting (*e.g.*, length of sessions).

Disadvantages of telepsychotherapy

Four disadvantages of telepsychotherapy were identified. Two disadvantages relate to technical problems (technical malfunctions due to a poor Internet connection, difficulties in dealing with the technology). Also, telepsychotherapy was not considered suitable for some patients or groups of patients (*e.g.,* children with psychotic symptoms or autism). At the same time, telepsychotherapy is also a resource for other patient groups, *e.g.,* patients with physical conditions.

Discussion

The aim of this study was to investigate the psychotherapists' experiences of telepsychotherapy during the COVID-19 pandemic in Argentina. A particular relevance of the study stems from its Latin American context. Building on the results of a previous online survey, this qualitative study based on in-depth semi-structured interviews with psychotherapists provides insights into the processes underlying the transition to telepsychotherapy. The interviews were analyzed using Qualitative Content Analysis according to Mayring (2015), and the results are presented in detail in a codebook (*Supplementary Material, D*).

Summary of the results

General conditions (question 1)

Effects of switching to telepsychotherapy were reported with regard to the therapeutic setting, the therapeutic method, and the therapy content. These were exclusively negative and neutral effects. As in the international literature, patients' difficulties in finding a suitable place for therapy, not being distracted (Aafjes-van Doorn *et al*., 2020a; Békés & Aafjes-van Doorn, 2020), and maintaining their privacy (Shklarski *et al*., 2021) were described. Setting variables are rarely addressed in the international literature, and in the present study, data on session length, therapy times, or frequency of sessions diverged. For example, three therapists reported longer sessions, one therapist reported

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shorter sessions, whereas four therapists reported no impact on session length. Two therapists reported more flexible therapy times, two therapists a lower frequency, and in five interviews no impact in this regard was described. Flexibility regarding time and length of the sessions was referred to as an advantage of telepsychotherapy, but these findings might also reflect difficulties in maintaining some of the elements of the setting. As in the international literature (Aafjes-van Doorn *et al*., 2020), relatively similar therapy costs were reported. Consistent with the international studies, difficulties were described due to the loss of (nonverbal) cues and in diagnosis (McBeath *et al*., 2020; Olwill *et al*., 2020), and some interventions were not possible or had to be adapted to the online modality along with the treatment technique. The pandemic was present as a topic in the sessions. In sum, effects were described in all areas of the general conditions into consideration, although not by all therapists.

Therapeutic relationship (question 2)

Positive, negative and neutral impacts were described. These refer to the characteristics of the relationship and to therapy discontinuations, less to new admissions. With regard to the characteristics of the relationship, both positive (bonding) and negative (distancing) aspects were described by the therapists, among others with regard to the discontinuation of physical presence. In the international literature, more negative aspects were addressed (Olwill *et al*., 2020; Shklarski *et al*., 2021). In the study by Aafjes-van Doorn *et al*. (2020a), therapists reported feeling less connected to patients, but the working alliance was rated as sufficiently good and the actual relationship as strong. In the present study, therapy dropouts were reported in almost all interviews. Some aspects of the therapeutic relationship remained unchanged, and relationship building (even with new patients) was possible. In the international literature, problems are sometimes described in this regard (Olwill *et al*., 2020; Shklarski *et al*., 2021). Effects were reported for two aspects mentioned in the research question (not for new admissions). The results suggest that keeping patients in telepsychotherapy was sometimes difficult due to the switch, but that a good relationship in the online modality is possible.

Therapist factors

Regarding subjective burden, therapist factors (in general), and therapists' in-session experience, positive, negative, and neutral effects were reported. Stress factors included higher workload, additional tasks, no clear distinction between work and personal life, fears and worries, and financial insecurity. These findings are consistent with international studies (Kramer *et al*., 2020; Bohlken *et al*., 2020). Moreover, the overall situation was also experienced by some therapists as positive and enriching, but the therapists had to get used to or adapt to the new situation. In the study by McBeath *et al*. (2020), free-text comments were also rated as mostly positive. Some of the comments were categorized as "adjustment aspects" (McBeath *et al*., 2020); also, in the study by Shklarski *et al*. (2021), adjustment processes among the therapists were described. Regarding the in-session experience, the code "telepsychotherapy more exhausting" can be highlighted, which was also reported in international studies (Aafjes-van Doorn *et al*., 2020a; Békés & Aafjes-van Doorn, 2020; McBeath *et al*., 2020) and referred to as "zoom fatigue" caused by long screen time (Shklarski *et al*., 2021). Effects are reported in all subcategories. Here, there are differences between the third research question and the category system in the codebook (*Supplementary Material, D*). Two of the aspects described here were assigned to therapeutic method in the category system.

Patient factors

For patients, positive, negative, and neutral effects were reported in the interviews. In this category, the code "Negative impact on the clinical problems" (*e.g.* destabilization, new or stronger symptoms) can be highlighted, which was assigned in all interviews. This refers to the entire situation of the pandemic. In their review, Vindegaard and Benros (2020) also reported a worsening of symptoms in patients with existing psychiatric symptomatology (k=2) during the pandemic. In addition, in the interviews of the present study, it was also occasionally described that the situation had had a positive effect on individual aspects of the patients' problems (*e.g.,* substance misuse). Furthermore, according to the therapists, some patients preferred therapy in presence, others telepsychotherapy.

Advantages and disadvantages of telepsychotherapy

Advantages included the safety and convenience of telepsychotherapy, and that therapy is no longer tied to a specific location. The disadvantages were mainly technical problems. In particular, the technical glitches are also reported in international studies (Békés & Aafjes-van Doorn, 2020; Olwill *et al*., 2020; Shklarski *et al*., 2021).

Limitations of the study

Because of the qualitative study design and small sample size (N=9), the intensity and the extension of the described effects cannot be assessed. The quantitative indicators (*Supplementary Material, C*) give an indication of the relevance of each code. These are the absolute number of codes and the number of interviews in which each code was assigned. For example: when a code was assigned more than once in an interview (*e.g.*, three different patient examples), a greater relevance of this code can be assumed. The number of interviews, on the other hand, gives an overview. In addition, the interpretation should take into account that one patient example does not mean that the described aspect applies to all patients of the therapist. Thus, a risk of overestimating the significance of the codes cannot be fully ruled out. Nevertheless, the study provides a trend of how the switch to telepsychotherapy affected different aspects of therapy, thus giving hints for future quantitative research. Eight participants were already known to members of the research team. This might have biased their responses in terms of social desirability, but it is also possible that they were more open because of the preexistent relationship. All interviewed therapists were female; perhaps a more diverse sample regarding sex would have reflected different aspects of the phenomena.

The study reflects the therapist perspective, *i.e*., how the therapists experience the patients or what the patients reported to the therapists. The validity of the codes related to the patients (patient factors) is limited (indirect statements). In addition, some codes can be also understood as effects of the overall situation (pandemic/contact restrictions) or a combination of these with the switch to telepsychotherapy. Thus, not all effects can be attributed solely to the switch to telepsychotherapy, and these results should be understood in the context of the overall situation during the first wave of the pandemic. Some advantages

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and disadvantages of telepsychotherapy also result from the overall situation (*e.g.,* safety of telepsychotherapy).

An interrater reliability analysis (Mayring, 2015) could not be conducted. Instead, the following steps were taken: i) basic coding rules were established before performing the coding or during the initial coding process; ii) procedures for coding were discussed with another member of the project group; iii) after four interviews, the initial coding rules were reviewed, and additional, more specific rules were created; iv) all nine interviews were coded using these improved coding rules. These measures contribute to better reliability and objectivity of the coding. A positive aspect in terms of objectivity is that the interviews were collected, transcribed and analyzed by different members of the project group. Moreover, the procedure of the qualitative analysis was well documented in the codebook. The results, which are similar to those reported in the international literature, also speak for a generally good validity of the work.

Conclusions

Despite the limitations described above, this paper provides an initial overview of the impact of switching to telepsychotherapy during the COVID-19 pandemic in Argentina from the perspective of the therapists. The study explored relatively open-ended questions and thus provides a good basis for further quantitative research in this area. For example, the codes in the section Quantitative Evaluation could serve as the basis to conduct a survey on the investigated topics. It can also provide a basis for in-depth interview studies on the patient perspective or on experiences with the use of different technologies. For example, telephone therapy has been compared by some therapists to the couch in psychoanalysis, which helps to create a freer association (Wöller & Kruse, 2018), and similar experiences during the pandemic are also reported in the study by Shklarski *et al*. (2021). The massive changes in the practice of psychotherapy during the COVID-19 crisis highlighted the challenges of applying new technologies. Among others, differences in the therapeutic alliance in in-person or telepsychotherapy, patients' preferences and needs, psychopathology and risk assessment, the person of the therapist and therapist training, and ethical considerations have been described (Fernández-Álvarez & Fernández-Álvarez, 2021). As it can be assumed that telepsychotherapy will remain an integral part of routine practice even after the pandemic, these issues should be addressed in psychotherapy research. The present study shows that most international findings also apply to the Latin American context, and it contributes to the scientific discourse by providing insights into the subjective impact of the sudden switch to telepsychotherapy among psychotherapists.

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Online supplementary material:

Appendix A. Interview guide for telepsychotherapy.

Appendix B. Process of qualitative analysis of the text material; adapted from process model in Mayring (2015).

Appendix C. Quantitative evaluation.

Appendix D. Codebook.