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Patient experiences in receiving virtual psychotherapy: a qualitative study

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Abstract

Virtually delivered psychotherapy is a widely adopted means of providing mental health interventions. There is little research on patients' perspectives on this mode of delivering therapy, and their perspectives are important given that patient factors predict a large proportion of mental health outcomes. This study explores patients' experiences with online psychotherapy to help inform best practices. Thirty-three patients who were currently receiving synchronous, virtually delivered psychotherapy were interviewed. The interview focused on patient experiences, both positive and negative, and their recommendations for improving virtually delivered therapy. Interviews were audio-recorded and transcribed. We used an inductive approach to thematic analysis in coding the transcripts. Audit trails and reflexive and independent coding ensured the trustworthiness and fidelity of the identified themes. Themes reflecting positive patient experiences included convenience, accessibility, and connection with the therapist. Themes of negative experiences included technology-related challenges, perceived disconnection due to not being physically present with a therapist, concerns about safety, and privacy issues. Patient characteristics and personal circumstances interacted with the online modality to affect their experiences. Patients recommended enhancing privacy and safety, utilizing online tools effectively, and encouraging therapists to be more deliberate in their non-verbal communication. For clinicians and researchers, this study outlines patients' perspectives on the aspects of virtual care that work effectively and those that could benefit from further improvement.

Key words: virtual psychotherapy, patient perspectives, telehealth, thematic analysis, accessibility.

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Introduction

Public health measures related to the COVID-19 pandemic resulted in an abrupt pivot to virtually delivered mental health care. While only 3% of the pre-COVID-19 mental health care visits were virtual, in the first months of the pandemic, this number jumped to over 50% (Ahmedani *et al.*, 2024) and remains high today (Ferguson *et al.*, 2024). Thus, it appears virtual care is firmly established as a widely adopted means of delivering and receiving mental health services. There is some research on psychotherapists' experiences of virtual care (*e.g.*, Houle *et al.*, 2025), but little on patients' experiences of receiving psychotherapy virtually (Smith *et al.*, 2022).

Common factors that operate across therapeutic orientations (*e.g.*, therapist characteristics, therapeutic relationship quality, and patient factors) are associated with patient mental health outcomes (Wampold, 2015). Therapist characteristics include therapeutic presence, empathy, interpersonal skills, and cultural adaptation (Norcross & Wampold, 2019). Research on the quality of the therapeutic relationship is often in the context of the therapeutic alliance, which is a robust predictor of patient outcomes (Flückiger *et al.*, 2018). Patient factors include expectations, preferences, hope, motivation, and symptom severity (Norcross & Lambert, 2019). Patients' perspectives on therapeutic processes are important given that an estimated 30% of mental health outcomes in psychotherapy are predicted by patient characteristics (Norcross & Wampold, 2019). Patients' positive and negative experiences have been shown to predict psychotherapy processes and outcomes (Rubel *et al.*, 2017; Verkooyen *et al.*, 2024). A meta-analysis of 53 studies and over 16,000 patients showed that accommodating patient preferences was associated with fewer treatment dropouts and more positive treatment outcomes (Swift *et al.*, 2018). Hence, the goal of this study is to explore patients' experiences with virtual therapy to inform best practices when providing virtually delivered psychotherapy.

Virtual care in the context of psychotherapy can comprise many modalities, including videoconferencing, telephone calls, chats, emails, texts, and AI-delivered care. Virtual care can be delivered synchronously (*i.e.*, patients and therapists interacting in real-time) or asynchronously (*i.e.*, patients accessing virtual therapy materials at their own pace, with or without input from a therapist). In this work, we focused on synchronously delivered psychotherapy via videoconferencing or telephone. These modalities most closely resemble traditional face-to-face psychotherapy by preserving some

non-verbal communication (*e.g.*, facial expressions, tone of voice) between therapist and patient to aid in the psychotherapy process, and they are the most frequently used telehealth modalities (Khoshrounejad *et al.*, 2021).

Although the pandemic brought the topic of virtual care into public discourse and provided natural experiments with this format, researchers had already been exploring it for decades. A recent meta-analysis (Lin *et al.*, 2021) examined randomized controlled trials from 2002 onward that compared virtual care to in-person therapy. These authors found that the two modalities did not differ significantly in patient outcomes at post-treatment or follow-up, and that there was no difference in attrition rates (Lin *et al.*, 2021). In addition, quantitative research comparing data from patients and clinicians who received or provided virtual or in-person treatment over 16 months found that patients rated virtual treatment highly. Patients indicated a preference for virtual therapy, and virtual therapy demonstrated higher completion, attendance, and treatment visit rates (Waite *et al.*, 2022). Quantitative research found that patients receiving teletherapy have noninferior alliance and clinical outcomes compared to clients who have received in-person psychotherapy (Davis *et al.*, 2024). Quantitative indicators of patient outcomes demonstrate that virtual and in-person care have comparable effects, indicating virtual care's potential as an effective, low-cost, and accessible option (Lin *et al.*, 2021).

Research on patient experiences

As indicated, there is limited research on patient experiences to inform our understanding of patient factors affecting virtually delivered therapy. Regarding accessibility, virtual care can assist a wide range of patients with unique needs and accommodate their lifestyles. Patients in Hajiheydari and colleagues' qualitative study (2024) conducted in Iran reported that virtual care helped housebound or rurally located individuals access care or allowed patients to access specialized professionals located in other regions. Patients also suggested that virtual care may be more financially accessible (Hajiheydari *et al.*, 2024) and less logistically burdensome (Nogami *et al.*, 2023).

In a qualitative analysis of a structured online questionnaire, Giordano and colleagues (2022) found that patients, who mostly received group therapy, reported initial positive feelings of reassurance, trust, and curiosity regarding their emotional comfort with virtual care. While being in a home environment can bring patients a sense of ease, some studies reported initial negative feelings of precariousness, skepticism, resignation, and privacy concerns related to virtual mental health care (Cluver *et al.*, 2005; Giordano *et al.*, 2022). However, in a small case series study, Nogami and colleagues (2023) reported that as virtual care continues, patients' privacy concerns may dissipate as they become more comfortable and familiar with the modality.

Technology skills may be pivotal in patients' ability to adapt to virtual care. Patients who were more familiar with technology were less worried about the technical issues of video conferencing therapy and exhibited more enthusiasm for using this modality (Nogami *et al.*, 2023). Technical issues sometimes negatively impact patient satisfaction with virtual care (Backhaus *et al.*, 2012). Poor video quality, slow internet speed, and less efficient platforms may make virtual care less accessible for some (Hajiheydari *et al.*, 2024). Mixed evidence from these studies warrants further investigation into patients' experiences with technology features in online therapy.

Therapeutic relationship

Empirical research suggests that aspects of the therapeutic relationship, like the therapeutic alliance rated by patients, are central to psychotherapy effectiveness (Norcross & Lambert, 2019). A meta-analysis of 295 studies, including over 30,000 patients, has found that patient ratings of therapeutic alliance and treatment outcomes are positively correlated (Flückiger *et al.*, 2018). As such, it is important to understand patients' experiences of how the therapeutic relationship develops in the context of virtual care. Nogami and colleagues (2023) found that before starting therapy, some patients struggled with the notion of a virtual format because they felt that it would create a feeling of separateness or diminish their ability to express emotion with their therapist. Giordano and colleagues' survey (2022) found that 17% of patients believed the quality of virtually delivered therapy suffered because of emotional and physical detachment, and 25% found that their therapist was rushed and lacked patience.

Although some patients may perceive a negative impact of the virtual format on the therapeutic relationship, this may not always be the case. According to responses to an online questionnaire, 33% of participants found the relationship quality improved during virtual care (Giordano *et al.*, 2022). Similarly, patients in Nogami and colleagues' case series (2023) often found their pre-therapy concerns about connection with their therapist were allayed as they progressed through therapy. In a review of quantitative studies, Cataldo and colleagues (2021) reported that, on average, patients found digital communication easier and more intimate. In their systematic review of quantitative studies, Fernandez and colleagues (2021) recommended further research into the factors that drive the therapeutic alliance in virtual care.

One of the main differences between virtual care and in-person care is that the therapist and patient do not share physical space during the virtual session. This separateness may impact communication in ways that patients see as both a drawback and a benefit of this format. Therapeutic presence may be particularly important in the context of virtual care. Therapeutic presence refers to the therapist immersing themself in the therapeutic encounter with their patient by being in the moment on different levels, such as physically, emotionally, cognitively, and spiritually (Geller *et al.*, 2010). Research indicates that patients' experiences of the therapist's presence are associated with a positive therapeutic alliance and therapist empathy (Geller *et al.*, 2010). Patients receiving virtual care reported missing the shared physical space with their therapist and that this lack of *in vivo* interaction may decrease the level and quality of non-verbal communication (Giordano *et al.*, 2022). Some patients reported experiencing less freedom to express themselves when they are not in the same space as their therapist (Hajiheydari *et al.*, 2024). While there are drawbacks, other patients may have benefited from this arrangement. In an evaluation of case material of six patients who received virtual psychotherapy, Chen and colleagues (2021) reported that some experienced greater ease and a sense of safety in expressing emotions such as anger.

Rationale for the current study

Smith and colleagues (2022) concluded that virtual care research lacks input from the patient's perspective, and a meta-analysis of quantitative studies found that patients' perspectives and experiences typically are not explored (Fernandez *et al.*, 2021). Most research on virtual care focuses on symptom improvement and mental health outcomes, using quantitative methods, rather than prioritizing patients' experiences. Some qualitative studies had small sample sizes of patients receiving teletherapy (n≤6; Nogami *et al.*, 2023;

Simpson *et al.*, 2015; Trondsen *et al.*, 2018) or did not use specific or recognized qualitative methods (Chen *et al.*, 2021). The study by Hajiheydari and colleagues (2024) was situated within a specific cultural and economic context, whereas the study by Giordano and colleagues (2022), although informative, primarily focused on patients receiving group therapy and analyzed written texts, making deeper exploration through follow-up questions difficult. An in-depth investigation of patients' virtual care experiences and preferences is essential to inform virtual care practices (Smith *et al.*, 2022). Thus, a thorough qualitative examination of patients' experiences with virtual care is both timely and warranted to help inform strategies for improving virtually delivered psychotherapy.

Patients' experiences with virtual care are crucial, as patient factors are the largest predictors of psychotherapy outcomes (Norcross & Wampold, 2019). Patients are the primary beneficiaries of these services and can offer critical insights into the practical, relational, and emotional experiences of virtually delivered treatment. This is especially pertinent given that video-conferencing modalities were well-established during the COVID-19 pandemic and are likely to endure in future psychological practice (Lo *et al.*, 2022).

Based on the foregoing discussion, we explored several research questions in the current study: i) What aspects of virtual care do patients perceive to be beneficial? ii) Which aspects of virtual care do patients believe could be improved? iii) Are specific patient characteristics or circumstances related to differences in perceived virtual care advantages and disadvantages? iv) Based on patients' experiences and preferences, how can we foster common psychotherapy factors (therapeutic alliance, therapist empathy, patient-therapist collaborations, patient preferences) in virtual care?

Materials and Methods

Study design

We chose to investigate these research questions using a qualitative approach to gain a deep understanding of patients' experiences with virtually delivered psychotherapy. We used semi-structured interviews for flexible data collection and an inductive thematic analysis approach (Braun & Clark, 2006; Miles *et al.*, 2014). We relied on previous research on common factors to guide some questions, but given the limited research on patients' perspectives, we felt an exploratory, broad inductive approach was appropriate. This allowed the main themes of patients' experiences with virtual care to emerge naturally. We used this design to expand the scope of what we can learn from patients receiving virtual care and to gain a deeper understanding of patients' experiences that may inform best practices.

Participants

Psychotherapy patients

Initially, 40 psychotherapy patients consented to participate in a research interview to share details about their experiences of receiving virtual psychotherapy and complete a demographic questionnaire. Seven participants dropped out of the study prior to being interviewed due to time constraints or lack of interest. We included data from 33 psychotherapy patients who received virtually delivered individual psychotherapy and consented to and completed interviews for the analysis. Researchers recommend a range of 9 to 17 participants for qualitative analyses to achieve thematic saturation (Hennink & Kaiser, 2022). We included 33 patient participants to allow for broad variability of patient experiences, to support the exploratory nature of our study, and to ensure our data was adequate. We provide detailed patient participant characteristics in Table 1.

The research team

Two doctoral-level clinical psychology graduate students (CS, DB) conducted the interviews. The initial coder of the interviews was a doctoral-level research psychology graduate student (AS) supervised by an experienced qualitative researcher (JS). A doctoral-level clinical psychology graduate student (DB) and a research associate (SB) were involved in auditing the themes to ensure they were representative of the interview data. The team consisted of six women and two men, all White, working at a Canadian university. Most research team members had experience in providing psychotherapy, and most were affiliated with the Psychotherapy Practice Research Network (www.pprnet.ca) at the University of Ottawa. All team members had experience with psychotherapy research. The team recognizes its positive bias towards virtual care, given its potential to increase access to psychotherapy. However, the team remained keenly aware of the potential for both positive and negative effects of the virtual care format on patients' psychotherapy experiences.

Procedure

All patients were sent an email inviting them to participate in this study. Some patients (n=14) were receiving virtually delivered therapy at a community-based clinic affiliated with the School of Psychology at the University of Ottawa. Other patients (n=19) were part of a study in which they received therapy delivered virtually by private practice psychotherapists not affiliated with the university. A licensed health professional, or a trainee supervised by a licensed professional, treated the patients. Patient participants experienced a shift from in-person to virtual care during their treatment. All participants provided informed consent for the study and were assured of their privacy and confidentiality at the start of the interview. Prior to the interview, they were asked again to consent to an audio recording (see interview guide in the *Supplementary Material*). The University of Ottawa Office of Research Ethics and Integrity approved the study and its procedures.

We conducted semi-structured interviews, 20-25 minutes in length, virtually using Zoom between June 2022 and August 2023. Before the interview, patient participants completed the consent form and a demographic questionnaire. The interviewers asked participants to recount their experiences with virtual psychotherapy. Specifically, we asked participants to reflect on aspects of virtual care that benefited them and caused challenges, as well as their recommendations for improving this modality (see the interview questions in the *Supplementary Material*).

Interviews were audio recorded and transcribed using QSR International NVivo software (version 1.7.1). Research assistants simultaneously listened to the audio recordings and reviewed the transcripts, making edits where necessary to improve accuracy. All transcripts were anonymized prior to coding.

Data analysis

We entered all anonymized transcriptions into the NVivo software to facilitate data organization. We conducted qualitative thematic analysis following the approaches outlined by Braun and Clarke (2006) and Miles and colleagues (2014), coding transcripts, extracting preliminary codes, and identifying themes. Since patients' perspectives on using virtual care have been under-investigated, we used an inductive approach to thematic analysis to explore answers to our research questions (Braun & Clarke, 2006; Miles *et al.*, 2014). Throughout the process, as outlined below, we engaged in several procedures to support trustworthiness and fidelity of the coding consistent with the American Psychological Association Journal Article Reporting Standards (Levitt *et al.*, 2018).

The process began with summarizing all interviews, generating a start list of codes derived from our research questions, conducting first-cycle coding of each transcript using the start list of codes and refining the codes as necessary, constructing cross-case matrices of the data to compare codes across participants, and conducting second-cycle coding to consolidate and comprehend themes in the data as they aligned with the research questions. To ensure trustworthiness, coders maintained an audit trail to document decisions and confirm themes that represented participants' narratives. Data analysis was conducted by AS and validated through a peer audit by SB and DB, who independently reviewed a subset of transcripts and derived initial codes. There was an ongoing reflexive dialogue between the primary coder (AS) and the research team (SB, DB) on the initial themes. This involved the coders discussing potential bias influencing the emerging themes. The researchers resolved disagreements or mediated potential biases in coding or thematic development through discussion or by consulting another team member not involved in this stage of the coding. These procedures helped to support the credibility of the findings. Once the thematic structure was developed, independent members JS and GT reviewed it to support consolidation of the central thematic structure. The iterative process of data collection and analysis continued until no new themes emerged, indicating thematic saturation. The original coder, AS, verified the revised structure with transcripts to ensure accuracy. Finally, the interviewers, who were not involved in the coding, reviewed the thematic structure and themes to confirm that the findings reflected the content of the interviews, further indicating credibility.

Results

Initial expectations of virtual therapy

Patients' descriptions of their expectations for virtual therapy were categorized as positive, neutral, or negative. Notably, only a minority of patients initially expressed positive expectations about virtual therapy, citing convenience, accessibility, and flexibility as key advantages. For example, one patient said: "I don't have to come back home again after a therapy appointment to take care of my dog, to leave and go to work. So, I mean, I really just expected it to be a lot more convenient, and I was not let down" (235).

In contrast, most patients recalled having negative initial expectations about virtual therapy, related to concerns about technology, privacy, and the potential impact on their therapeutic progress. Regarding *technology*, patients expressed concerns about delays, connectivity issues, and poor-quality video or audio. Others had *privacy* concerns, with one explaining: "…I wasn't sure how I was going to create an environment in which I felt comfortable" (207). Others were concerned that the *quality of therapy might hinder ther-*

Table 1. Patient demographics (n=33).

Characteristics	N (%)		
Gender			
Woman	25 (75.76)		
Man	7 (21.2)		
Nonbinary	1 (3.0)		
Mean age, M (SD)	40.00 (12.67)		
Married or in a relationship	17 (51.52)		
Employment status			
Full-time or part-time	23 (69.70)		
No employment/etired	6 (18.18)		
Student/Other	4 (9.12)		
Median annual household income	75,001-100,000 Canadian dollars		
University education	24 (72.73)		
Racial or ethnic identity			
White	27 (81.82)		
Asian	2 (6.06)		
Jewish	1 (3.03)		
Latino/a	1 (3.03)		
No response	2 (6.06)		
Sessions in therapy modalities	In person	Phone	Virtual
0	1 (3.03)	15 (45.45)	1 (3.03)
1-10	3 (9.09)	12 (36.36)	6 (18.18)
11-20	8 (24.24)	3 (9.09)	10 (30.30)
>20	21 (63.63)	2 (6.06)	6 (18.18)
Experienced a transition from in person to virtual therapy	22 (66.66)		
Primary presenting problem for seeking therapy			
Anxiety	10 (30.30)		
Interpersonal problems	6 (18.18)		
Depression	5 (15.15)		
Trauma	3 (9.09)		
Stress	3 (9.09)		
Other	6 (18.18)		

M, mean; SD, standard deviation.

apeutic progress. Said one patient: "… I felt like I'd been making a lot of progress, and I felt like virtual therapy was going to stop that, and I'll regress…" (211). These patients identified a range of negative emotions associated with the transition to virtual therapy, including nervousness, apprehension, anger, and sadness. One specific concern was with their ability to forge an *emotional connection* with their therapist, with one patient stating: "I think one of the things that can sometimes be misinterpreted when you're doing online is all those little nuances that you don't get when you're actually face-to-face. And I was wondering if it was going to be a little bit more impersonal" (227).

Positive experiences with virtual therapy

Despite initial concerns, most patients had positive experiences with virtual psychotherapy (see Table 2 for a summary of findings). One patient shared: "It ended up being a lot better than I was thinking it would be" (208). The themes of positive aspects of virtual therapy included Accessibility and Convenience, Comfort and Therapeutic Presence, Communication and Physical Separation from the Therapist, and Connection with the Therapist.

Accessibility and convenience

Many patients considered *accessibility* to be a significant advantage of virtual therapy. Patients identified practical advantages, including flexible scheduling, increased appointment availability, shorter wait times, and access to a broad range of therapists with diverse specialties. Patients valued the ability to continue therapy while travelling or after moving to a new city. One patient said: "There are a lot more options to choose from because you don't have to find somebody where you live" (226). Accessibility was particularly important for patients with mobility issues, disabilities, or other challenges. Said one: "It's hard for people with anxiety, and virtual just gets rid of that barrier to access of having to leave my house" (235).

Patients appreciated the *convenience* of virtual sessions, with one patient stating: "I just set the alarm, and I don't need to worry so much…" (205). This streamlined process made it easier to dive directly into the therapeutic content, as one patient noted: "When you get online… I think that makes it easier because it's more direct and to the point" (232). Patients also valued the logistical advantages of virtual therapy, including flexible scheduling. One patient said: "Being a new mom… I'm valuing how easy it's been to make appointments and to fit it in my schedule virtually" (212). One of the main positives highlighted by patients was the elimination of the commute: "There's no need to account for commuting into an office… So, it's really convenient to kind of just, you know, drop everything and go into therapy and then, you know, just go back to my regular routine afterwards" (214). Eliminating the commute and flexible scheduling enabled some patients to attend sessions more frequently: "…it was more like putting out fires compared to like the proactive work as I might have wanted to do. So, because we were doing therapy more frequently, I could do more of the homework or like think more of like, okay, how do I solve this next time?" (211).

Positive effects on the therapeutic process

Beyond the practical benefits of virtual therapy, patients noted a variety of advantages to the therapeutic process. Patients valued the *comfort* afforded by virtual therapy, emphasizing the role of familiar surroundings: "Being in the comfort of my own home meant that I could have coffee or water or more easily take a bathroom break if needed. Just having my creature comforts around really helped"

Table 2. Summary of themes that emerged from thematic analysis and their descriptions.

Themes	Description
Positive experiences of virtual therapy	
Accessibility and convenience	
Accessibility	Greater access to therapy and a wider selection of service providers. Particularly salient for clients with mobility issues.
Convenience	Aspects of virtual therapy were convenient and streamlined, including flexibility of appointments and not commuting. Allowed patients to use therapy time more efficiently.
Therapeutic process	
Comfort	Felt comfortable working from their own physical environment which fostered a sense of closeness with the therapist.
Therapeutic presence	Felt calm, grounded, and in a good headspace in the moments prior to a session. Online therapy felt less stressful compared to in-person sessions enhancing reflective capacity.
Communication	An enhanced ability to communicate and discuss challenging topics with their therapist because of the virtual setting.
Physical separation from therapist	Some patients found the absence of physical presence positively impacted the therapeutic process. They felt less defensive and embarrassed during some therapeutic tasks.
Connection with therapist	Patients' connection with their therapist and the quality of the patient-therapist relationship improved because of the shared challenge of working online.
Negative experiences of virtual therapy	
Technology	Challenges related to the technology's characteristics like seeing the clock on the screen, unstable Internet connectivity.
Therapeutic space	Challenges with cultivating a therapeutic space both physically (in their environment) and mentally (their headspace).
Distractions	Felt distracted during online therapy, due to lack of separation between therapy and home or work life.
Privacy	Concerns that others in their environment might hear them during a session.
Psychological safety	Felt a lack of a sense of security in the virtual environment especially when feeling vulnerable.
Communication	Inhibited or holding back during virtual therapy due to limited non-verbal cues.
Disconnection	Disconnected from their therapist during virtual therapy, leading to impersonal feelings.
Absence of physical presence	Not having the therapist in the room lead to a sense of detachment. Some interventions felt limited or compromised. Body language could not be easily read.

(207). One patient speculated on the therapeutic benefits of a comfortable environment, saying: "I think it does bring a side of vulnerability when you're in your own space" (239). Some patients found reassurance in seeing their therapist from a comfortable setting, fostering a sense of closeness and connection.

Patients described virtual therapy's positive impact on their *therapeutic presence*, highlighting reduced stress. Patients valued moments alone before sessions to transition into the therapeutic space: "I always had these two minutes alone in front of my iPad where I could really kind of, you know, arrive" (237). The absence of external stressors, like traffic and parking, allowed patients to make the most of their therapy. One patient explained: "I show up to appointments a bit more present… There are fewer things on my mind right when I go in" (203). The online format mitigated concerns about discussing challenging topics, with one patient saying: "Sometimes I guess it can be easier to talk about shameful things when you don't have somebody watching you or staring at you" (240).

One of the perceived outcomes of this comfort was improved *communication*. Said one patient: "Yeah, I think it's helped me get through some issues that I wasn't getting through in person before" (239). Another patient affirmed: "I think [virtual therapy] breaks down a barrier, like it takes a layer away. It lets you be more candid" (236). For one patient, it led to a deep emotional experience: "I felt more comfortable crying. Like it was ugly cries. And I don't think I would have been as comfortable in her office… just sobbing like that" (216). For others, virtual therapy led to deeper introspection: "I was able to go a little bit deeper and be more reflective and make some more connections because I felt like I had a bit more space to do that" (216).

This deeper introspection was attributed to the *physical separation from the therapist*. One patient found being in separate spaces helped them feel less defensive during sessions: "When you're face-to-face with the person who's telling you something you don't like, you almost feel trapped. So, I think not being in the same room was kind of helpful because it felt a little less claustrophobic" (206).

Patients reflected on therapists' efforts to adapt to virtual sessions, which helped improve their sense of *connection with the therapist*. One patient said: "She was good at making sure that I still felt heard, that I still felt like there was still that connection. And not just like, I'm talking to the void" (206). Another explained: "She did tell me, you know, we're all kind of in the same boat with doing it online… I found we kind of connected over that" (206). Patients noted therapists' efforts created a safe space virtually: "Even though it was online, I felt safe. I do still feel safe in my sessions, and the mutual respect and the support are there, whether you're online or in person" (227).

Negative experiences of virtual therapy

Despite these positive experiences, many patients expressed reservations about online therapy, feeling it disrupted their flow and lacked the impact of in-person sessions. These negative experiences of virtual therapy were organized into themes of Technology, Therapeutic space, Distractions, Privacy, Psychological safety, Communication, Disconnection, and Physical presence.

Many patients encountered significant challenges with *technology* during their virtual therapy sessions. One patient highlighted the discomfort of prolonged screen time. Another patient noted that the visible clock on screen made them feel rushed: "I could see exactly how much time was left and then I'd start getting nervous…" (211). A recurring issue involved poor audio quality, which many patients said disrupted communication and weakened their connection with their therapist. Unstable internet connections and lagging or frozen video also disrupted many sessions. These issues were especially frustrating if they occurred in emotionally intense moments. One patient shared: "I had a straight-up meltdown one day because… every single time we tried to connect, … it would just cut out and crash and lag" (206). Despite these challenges, many patients acknowledged that the technology-related issues were manageable.

Patients found it challenging to create a distinct *therapeutic space*, both physically and mentally, during virtual therapy. Many patients missed the controlled, therapeutic environment of the office that helped them mentally transition into sessions. The responsibility of curating a therapeutic space fell to the patients during virtual sessions. One patient explained that virtual therapy required "more prep work in ensuring I had everything I needed nearby instead of just… going into their (therapist's) space, where they've already set up" (214). Several patients pointed out that being physically present in a therapist's office provided a sense of calm and separation from daily life that was difficult to replicate at home. For many, the merging of spaces in virtual therapy made it harder to transition into a therapeutic mindset. One patient described this struggle: "I was sitting in the room that I sleep in, work in, get dressed in, play with my cat in, and now go to therapy. And so, it was difficult to separate… it always felt like I couldn't leave work behind because there is a pile of it staring at me…" (206).

Challenges to creating a therapeutic space were also related to *distractions* during virtual sessions. Technological interruptions, like email notifications, were particularly challenging for patients with attentional difficulties. The temptation to multitask during sessions, such as browsing or attending to other devices, was another common challenge. A recurring issue was the distraction of seeing oneself on screen, which often led to self-consciousness, particularly during discussions about self-image: "I'm a bit more self-aware about seeing myself talking, and I think that's a bit distracting... because it's like you want to be in the present moment but I'm also like, my hair looks like this, my glasses look like this" (203).

Environmental and social distractions at home further disrupted the therapeutic process. One patient mentioned the challenge of isolating the therapy experience from household activity: "…at home, you know, as much as you try… you hear your kids in the background or like your husband walks by to get water… it's just really hard to segregate" (208).

Patients who lived with partners, family, or roommates struggled to maintain a sense of *privacy*, especially in instances where the subjects of a discussion with the therapist might inadvertently overhear sensitive conversations. One patient described anxiety that the lack of privacy caused them: "If I were talking about him, I kind of like would feel anxious for days, like 'did he overhear?' … that did impact like, what I felt comfortable saying in therapy" (211). To create privacy, patients adopted various strategies, from using better headphones to physically isolating themselves or entering a closet during sessions. Others would ask household members to leave the space, but this solution was not always possible.

A few patients disclosed concerns about *psychological safety* in virtual therapy sessions. One patient noted feeling more vulnerable during trauma work online compared to in-person sessions: "When you start to delve deeper into trauma work, it can be really frightening and really triggering. And when you're online… I didn't feel as safe as I would have or I did when I was in the same room as a therapist" (240).

In contrast to patients who found that virtual therapy improved communication with their therapist, others highlighted challenges in *communication,* including feeling inhibited or holding back during online sessions. Some patients felt that, compared to online therapy, face-to-face therapy encouraged greater openness and improved ability to address uncomfortable topics more directly. One patient

said: "I see the goal of talking to my therapist as having someone to like, challenge me to be more open and more vulnerable, so I think being in a physical space designed for that forced me to be more open and more vulnerable" (204). Some patients also noted the lack of non-verbal cues in virtual sessions as a limitation to communication, making it harder to gauge therapists' reactions.

Many patients missed their therapist's physical presence and expressed concerns about feeling *disconnected*. One patient observed: "There's a certain level of detachment when you're not in the physical presence of somebody else" (242). At the same time, another described the virtual interaction as feeling like "talking by yourself" (208).

Some patients also missed the "energetic aspect" of being *physically present* in the same room as their therapist. Several patients expressed concerns that certain therapeutic techniques, like body scanning, were less effective in the virtual environment. Patients struggled to read non-verbal cues through a screen, which might obscure important therapeutic signals: "It felt as though changes in my body language aren't being read… if my eyes welled up, that wasn't as easy to see." (207). Patients also cited the inability to handle physical materials, like worksheets, as another challenge of virtual therapy. For one patient, the process of sharing documents online felt "less personal, less intimate" (226). The result was that some patients felt online sessions were impersonal, lonely, detached, and less "real" and "authentic."

Recommendations suggested by patients

We prompted patients to reflect on ways to improve virtual therapy. Patients offered recommendations for therapists and for patients to improve service delivery and enhance their session experiences. Table 3 summarizes these recommendations. Patient participants recommended enhancing privacy by, where possible, finding a separate space for virtual sessions and using headphones. Patients also made several recommendations for therapists including, offering hybrid services (online and in-person when necessary, such as introductory sessions), preparing with patients a back-up plan in the case of technical difficulties (*e.g.*, phone call, text, or email), using a dedicated platform for virtual therapy, streamline processes to simplify access to the virtual platform such as sharing the link to the session well in advance, become familiar with online tools for document sharing, automate check-ins and appointment reminders, verbalize what would normally be communicated non-verbally, and reduce fees for online therapy due to lower operational expenses. For both patients and therapists, patient participants suggested adjusting camera placement to enhance non-verbal communication, prioritizing a stable, high-quality internet connection, and testing the technology before each session.

Discussion

The present study is situated within a small but growing body of literature that addresses patients' experiences with virtually delivered psychotherapy (Smith *et al.*, 2022). Virtual care has become a fixture in psychotherapy practice (Ferguson *et al.*, 2024). Patients' perspectives, such as their experiences of the therapeutic relationship (Norcross & Wampold, 2019), therapist presence (Geller *et al.*, 2010), and their preferences (Swift *et al.*, 2018), align with key common factors that predict outcomes and therapeutic processes (Wampold, 2015). The current thematic analysis of patient interviews provides insights into navigating the clinical and logistical challenges and enhancing therapeutic processes and relationships in virtually delivered psychotherapy.

The themes gleaned from patient interviews illustrate how introducing new communication technologies into psychotherapy can affect patients' experiences of the therapeutic relationship and of the therapist. Our results suggest that the office and virtual settings are not always experienced similarly. They represent two therapeutic ecologies, each bringing inherent factors that impact the therapy, for better and worse.

Changes in patient impressions of virtual care

Before receiving virtual care, patients believed they would experience virtual care differently from in-person therapy. Regarding practical and logistical factors, patients in our study generally pre-

Table 3. Patient recommendations to improve virtually delivered therapy.

Recommendation	Description
For patients	
Enhance privacy	Try to find a private space during virtual sessions. In shared living spaces, use headsets with microphones to increase a sense of privacy and comfort.
For therapists	
Offer hybrid services	Offer an in-person introductory session to establish a personal connection, especially for new patients starting virtual therapy. Consider occasional in-person sessions to provide a physical presence that supports the therapeutic relationship.
Plan for technical difficulties	Communicate in advance about backup procedures (phone, text, email) in case of internet disruptions to ensure continuity in sessions.
Use a dedicated platform	Use a platform dedicated to virtual therapy that ensures privacy.
Streamline processes	Simplify processes required for virtual therapy sessions to minimize confusion and enhance access for patients (*e.g.*, sharing the meeting link well in advance or having a single private link for all sessions).
Use interactive tools	Use interactive online tools for document sharing and joint work on materials during or after sessions.
Automate check-ins	Implement automated reminders for appointments, check-ins, or preparatory activities before and after sessions.
Reduce fees	Consider adjusting fees for online therapy to reflect lower operating expenses.
Be deliberate with non-verbal	Verbalize what may be normally communicated non-verbally. Coach patients to do the same.
For patients and therapists	
Optimize camera placement	Adjust the camera to show more of one's body during sessions to enhance non-verbal communication.
Ensure reliable technology	Prioritize a stable internet connection and high-quality video platforms to avoid interruptions and technical issues during sessions.
Test the technology	Test devices beforehand to minimize technical disruptions during the session.

dicted that the impacts of virtual care would be positive (*e.g.*, improved convenience, increased accessibility, more flexibility). Concurrently, many patients held negative preconceptions around technological challenges, physical separation, and emotional detachment from the therapist, and communication barriers arising between themselves and their therapist. These findings echo concerns described by patients in previous studies (Giordano *et al.*, 2022; Hajiheydari *et al.*, 2024; Nogami *et al.*, 2023). We found that engaging in virtual therapy ultimately changed the minds of most patients, and the virtual format proved acceptable to many, in some cases even preferable to in-person care.

The following sections discuss the findings of our thematic analysis. The findings reveal how virtual care influenced the logistics of care provision, interacted with patient characteristics, and both facilitated and hindered the patient's experiences of the therapeutic relationship and therapist factors like empathy and presence.

Logistical factors

Similar to findings reported by Hajiheydari and colleagues (2024), patients in our study praised virtual care for improving access to a broader selection of service providers, allowing patients with mobility challenges to engage in therapy, and overcoming geographic barriers to care. While these findings suggest that virtual care has the potential to make access to psychotherapy more equitable and inclusive, recent research indicates that this promise is yet to be realized, including for racialized individuals, those who are poorer, and those who do not live in urban areas (Olfson *et al.*, 2025).

Patients also reported that virtual care increased accessibility through shorter service wait times and greater appointment availability. Demands for psychological services have grown immensely, outstripping the capacity of clinics and providers, and leaving millions with unmet mental health needs (Tran, 2024). From patients' narratives about their virtual care experiences, it appears that some psychotherapists and organizations have adapted to these demands by establishing service delivery systems centred on virtual care.

Our findings are consistent with research demonstrating that virtual care offers increased convenience (Nogami *et al.*, 2023). Patients in our study described virtual care as more streamlined, as it eliminates the commute and minimizes pre-session preparation. They found that they were more able to integrate therapy into their day, their time was used more efficiently, they were less likely to cancel appointments, and they could engage in deeper work with their therapist.

Themes that emerged in our study identified numerous technology-related logistical factors that impeded virtual therapy (*e.g.*, seeing the clock on the screen, fatigue from prolonged screen time, poor audio quality, and unstable internet connectivity). Patients in our study reported that technology challenges made them feel uncomfortable and rushed, undermining their communication, emotional breakthroughs, and connection with their therapists. While patients felt they could manage these issues, they also felt they were preventable if therapists and patients dedicated more resources to quality internet connections and therapists created contingency plans for technical difficulties (see Table 3 for patient recommendations).

Similar to previous reports (Giordano *et al.*, 2022; Hajiheydari *et al.*, 2024), our patient participants reported that privacy concerns tested their ability to fully immerse themselves in virtual care. Patients expressed apprehension that others might overhear their conversations because creating a private therapeutic space in their homes is difficult. As a result, psychotherapists may need to be mindful of and help their patients troubleshoot distractions in their virtual and home environments and secure a private space to fully optimize virtual care.

Patients identified keeping their living space separate from the therapy space as a particularly salient challenge. In addition to concerns about therapeutic space, our participants also noted several virtual and environmental distractions that interfered with their psychotherapy (*e.g.*, social media, the temptation to browse online or use electronics, and seeing oneself on a screen). This adds to previous discussions on the unique distractions present during virtual psychotherapy (Giordano *et al.*, 2022).

Patient characteristics and circumstances

Patients identified characteristics and life circumstances that may influence their perception of the advantages and disadvantages of virtual care. Mental health status, disability, and parental responsibilities impacted virtual care preferences in our sample of patients. These are critical to understand, given the importance of patient factors in predicting mental health outcomes (Norcross & Wampold, 2019).

For some participants, the interaction between their characteristics and the virtually delivered therapy led to positive experiences with this modality. For example, patients with anxiety and related disorders experienced reduced distress because they did not need to leave their homes to receive therapy. However, a recent study of therapists' experiences with virtual care raised concerns among therapists about this modality enabling some patients' avoidance behaviours (Houle *et al.*, 2025). Furthermore, virtual care enhanced accessibility to treatment for patients with mobility impairments. Patients' life contexts also made virtual care a preferable option. Patients in our study with young children found the flexibility of virtual care worked well for their busy family schedules.

These benefits, however, were not realized by all patients. A participant with a trauma history felt unsafe managing their symptoms without the physical presence of the therapist. These concerns are not limited to patients. Song and Foster (2022) found therapists administering virtual care also expressed concerns about being unable to support patients with post-traumatic stress disorder during periods of dissociation. The experience of relational presence, which may be difficult during virtual therapy, may allow patients to weather the turmoil associated with the treatment of trauma-related problems (Lepak, 2022). The results also indicated that virtual care may challenge accessibility for some with attention-deficit/hyperactivity disorder (ADHD). One participant with ADHD found that virtual care increased the potential for distractions in both their virtual and physical spaces (*e.g.*, notifications, browsing the internet, and other devices).

Therapeutic relationship and processes

As we indicated previously, the therapeutic relationship, including the alliance, is a key common factor related to patient outcomes (Flückiger *et al.*, 2018; Norcross & Lambert, 2019; Wampold, 2015). The affective and relational bond between patient and therapist is one of the foundations of the alliance (Bordin, 1979). And so, patients' experiences of virtual therapy that affect the bond have important implications for their openness to engage in the therapy process and their experience of the therapist. Patient participants often found unexpected advantages to receiving virtual therapy, including increased vulnerability and candour and decreased defensiveness. Participants cited the comfort of their own space, physical separation from their therapist, and the ability to achieve greater presence within sessions as factors that led to these perceived benefits. The discrepancies between patients' predictions of what virtual

therapy might be like and their actual experiences, which we noted earlier, may be partly due to the unsubstantiated belief that the level of intimacy with the therapist afforded by a shared physical space is essential to the therapeutic process and cannot be achieved in a virtual context.

Although our results suggest that shared physical space may not always be required for successful treatment, this was not the case for all patient participants. After commencing virtual care, some participants reported experiencing serious therapy-interfering challenges such as a lack of psychological safety, increased feelings of inhibition, decreased vulnerability, emotional disconnection from their therapist, and feelings of loneliness and inauthenticity.

Recommendations based on the thematic analysis

Themes from patient interviews suggested that virtually delivered psychotherapy can offer benefits and challenges that vary with individual patient characteristics and life circumstances. This underscores the importance of clinicians having a clear understanding of these interactions to help guide patients toward selecting the modality that will be most beneficial. For example, therapists might consider patients' diagnoses or symptoms when providing virtual psychotherapy. Although patients in our study with anxiety disorders appreciated staying at home for therapy, therapists and patients need to discuss the extent to which this preference for virtual therapy may represent avoidance behaviours (Houle *et al.*, 2025). In cases where exposure to social situations is warranted, therapy sessions may switch from virtual to in-person to support the exposure work. Some patients with a history of trauma expressed a preference for in-person sessions to feel safe when engaged in emotionally challenging trauma work. Safety can also be enhanced for all patients by sharing contingencies for crisis management. Patients with attentional challenges and others may need coaching on how to manage notifications and other applications, hide the clock on their computer, and disable self-view on their screen.

The thematic analyses also indicated that providing psychotherapy virtually may impede a patient's ability to read a therapist's nonverbal communication. Consistent with this finding, research on therapists' experiences in providing virtual care suggested that their therapeutic presence may be challenged (Houle *et al.*, 2025), which may further complicate patients' ability to read such cues from their therapists. Thus, therapists could compensate by being more animated or verbalizing what is normally communicated nonverbally. Therapists must keep in mind that therapeutic presence (Geller *et al.*, 2010) and empathy (Elliott *et al.*, 2018) are key common factors that need special attention in the virtual environment.

Patients' recommendations for virtual practice

In addition to recommendations gleaned from the thematic analysis of interviews, patients were asked for their specific recommendations to improve the virtual therapy experience (see Table 3 for a list and description). Most of the patients' recommendations concerned enhancing privacy, offering hybrid services, addressing potential technical issues, and reducing fees due to lower overhead costs. These recommendations highlight patient concerns about practical issues. Therapists should address these issues with patients before offering virtual therapy, as they may represent specific client wishes, and research indicates patient preferences are associated with better outcomes (Swift *et al.*, 2018).

Therapists should consider their patients' unique logistical challenges, circumstances, and characteristics when discussing options for providing virtually delivered psychotherapy. Initial meetings may require a thorough discussion about whether the patient can secure a private space, given their living arrangements, and whether their internet connection and equipment are adequate. Therapists may also share written or video instructions on using the chosen platform. Backup plans, such as telephone contact, texting, or emailing, might be set up in advance in case connectivity problems arise. There should be a shared understanding of ethical issues that might arise when providing virtual care, consistent with local legislation and professional practice standards (Canadian Psychological Association, 2023).

Limitations and future directions

The primary strength of this study lies in its provision of one of the few in-depth explorations of patients' experiences with virtually delivered psychotherapy, achieved through a systematic thematic analysis of interview transcripts. Nevertheless, the study had some limitations. Our findings could be limited in transferability because our patient participants were Canadian adults receiving individual psychotherapy. Future studies that include a more diverse sample of participants from different cultures and ages, as well as within unique modes of virtual psychotherapy (*e.g.*, group, couples, family), could provide critical and nuanced insights into the contexts in which virtual therapy is most effective, feasible, and acceptable for patients. For example, there is evidence that ethnic minorities had significantly lower response rates to internet-based interventions (Karyotaki *et al.*, 2018), suggesting that this mode of treatment might require specific cultural adaptations (Soto *et al.*, 2018).

We acknowledge that the research team generally viewed virtually delivered psychotherapy as a means to increase access to mental health treatment, and this may have biased the findings. However, we took care to increase trustworthiness and fidelity by maintaining an audit trail, having independent team members review and modify the thematic structure, and having interviewers review the themes to ensure they accurately reflected the interview content. Despite our initial positive bias towards virtually delivered care, the thematic analysis led us to a deeper, more nuanced understanding of both positive and negative patient experiences, broadening our initial assumptions.

The current study can serve as a roadmap for future qualitative and quantitative research to help optimize virtual care for patients and inform studies on the impacts of various patient characteristics on virtual care. For example, it remains unclear whether perceived advantages, disadvantages, and recommendations affect therapeutic outcomes, a question that future quantitative and longitudinal analyses may address. Further research is necessary to understand how specific treatment modalities (*e.g.*, cognitive behavioural therapy, emotion-focused therapy, psychodynamic therapy) interact with patients' experiences of receiving virtually delivered therapy. While we uncovered key patient characteristics that affected patients' perceived advantages and disadvantages of virtual care, a more targeted investigation is needed to understand how these characteristics influence the processes and outcomes of virtual care.

Conclusions

Virtual and in-person psychotherapy give rise to inherent differences in therapy environments and in patients' experiences of their relationships with therapists and of their engagement with therapy. Therapists must be aware of these differences and discuss with patients the implications and how to leverage them to benefit both the patient and the therapeutic relationship. Themes of patients' positive experiences with virtual care included improved convenience and accessibility, as well as a stronger connection with their thera-

pists. Themes of negative experiences included technology-related challenges, perceived disconnection due to not being physically present with a therapist, concerns about safety, and privacy issues. These findings intersect with what we know about common factors in psychotherapy. Accommodating patient preferences (Swift *et al.*, 2018) for the conduct of therapy is known to improve outcomes. Patients' experience of therapist presence is associated with the therapeutic alliance (Geller *et al.*, 2010), which is a robust predictor of outcomes (Flückiger *et al.*, 2018). Our study outlines patients' perspectives on aspects of virtual care that work well and those that could benefit from further improvement for clinicians, researchers, and platform developers. Information about patients' preferences and experiences of emotional engagement and therapeutic presence with virtual care can be harnessed to improve virtual psychotherapy processes and outcomes.

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Online supplementary material:

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