

Psychotherapists' use of teletherapy during the second wave of the COVID-19 pandemic in Argentina

Uso de teleterapia por psicoterapeutas durante la segunda ola de la pandemia de COVID-19 en Argentina

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RESUMEN

La pandemia de COVID-19 y las medidas de aislamiento social para controlar la propagación de la enfermedad cambiaron las prácticas psicoterapéuticas en todo el mundo. Este estudio examinó el uso de la teleterapia durante la segunda ola de la pandemia de COVID-19 en Argentina desde la perspectiva de los psicoterapeutas. Entre junio y agosto de 2021, 573 psicoterapeutas participaron en una encuesta en línea. En total, 547 terapeutas utilizaron teleterapia, y 344 proporcionaron teleterapia a más de la mitad de sus pacientes. Las características del lugar de trabajo y las preferencias de los pacientes (teleterapia versus terapia presencial) están asociados con el nivel de uso de la teleterapia, pero no así el estrés ligado a la pandemia y las medidas de autocuidado. Es necesario realizar más estudios a efectos de comprender mejor los factores asociados a la elección de utilizar la teleterapia en la práctica habitual de la psicoterapia.

Palabras clave: Pandemia COVID-19, Teleterapia, Psicoterapia, Características del lugar de trabajo, Preferencias de pacientes.

ABSTRACT

The COVID-19 pandemic and the social isolation measures to control the spread of the disease changed the psychotherapeutic practices worldwide. This study examined the use of teletherapy during the second wave of the COVID-19 pandemic in Argentina from the perspective of the psychotherapists. Between June and August 2021, 573 psychotherapists participated in an online survey. Overall, 547 therapists used teletherapy, and 344 provided teletherapy to more than half of their patients. Workplace characteristics and patients' preferences (teletherapy versus face-to-face therapy) are associated with the level of teletherapy use, but pandemic stress and self-care are not. More studies are needed to further understand the factors associated with the choice of using teletherapy in routine psychotherapy practice.

Keywords: COVID-19, Pandemic, Teletherapy, Psychotherapy, Workplace Characteristics, Patient preferences.

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Introduction

COVID-19 Pandemic

In Argentina, the first COVID-19 case was reported in Buenos Aires on 3 March 2020 (Ministerio de Salud, 2020). Due to a rapid rise of the number of infections the government imposed a nationwide lockdown, the so called *Aislamiento Social Preventivo y Obligatorio* (ASPO; [Preventive and Obligatory Social Isolation]) on 20 March 2020. In its strictest form it applied for the whole country until 27 April 2020 (Decreto 408/2020). After that, depending on incidence rates of cities and provinces, the lockdown could be loosened.

The COVID-19 pandemic had a significant impact on mental health worldwide. In a survey in Argentina two months after the beginning of the lockdown, almost 40% of the participants stated that they needed psychotherapy. However, personal financial difficulties and a lack of psychotherapeutic services hindered access to treatment (Etchevers et al., 2021). Diminished access to mental health services might be partly explained by drastic changes in the psychotherapeutic practices during the pandemic and subsequent interruptions of treatment. While face-to-face therapy was no longer possible during strict lockdown, face-to-face therapy under hygiene measures in later phases of the pandemic was not widely used (Fontao et al., 2022).

Teletherapy

Teletherapy can use different mediums, such as traditional telephones, smartphones, internet video calls, online computer-mediated treatment programs (Markowitz et al., 2021). In this study, the term teletherapy refers to psychotherapy at a distance which is conducted synchronously via digital media (telephone and video calls) and thus, strongly resembles face-to-face psychotherapy. Neither self-therapy by the patient, asynchronous therapy nor online chatting as form of synchronous therapy is included. Empirical research on psychotherapy at a distance has been conducted in recent years, and there is a consensus about its effectiveness (Carlbring et al., 2018; Shigekawa et al., 2018).

Psychotherapy in times of COVID-19

Studies from several countries reported declining numbers of patients that were treated in personal contact at the beginning of the pandemic (Humer & Probst, 2020). Fontao et al. (2022) surveyed 978 psychotherapists between July and August 2020 in Argentina and found that the majority of therapists (62,6%) treated at least half of their patients via teletherapy. Interruptions of ongoing therapy were reported by the majority of the participants, and a large share of those who reported no interruptions at all treated 75 – 100% of their patients in a teletherapeutic setting. Although many therapists reported that they had admitted new patients after the beginning of the ASPO, it is unclear to what extent the demand for treatment has been attended. In this line, Probst et al. (2020) showed that teletherapy could not fully compensate the

decrease of face-to-face therapy.

Therapists hold different opinions about using teletherapy in the future and beyond the pandemic (Aafjes-van Doorn et al., 2020). According to McBeath et al. (2020), teletherapy would become a core business for two-thirds of the studied therapists. In the study of Shklarski et al. (2021a), therapists preferred teletherapy over face-to-face therapy with face masks. On the other hand, a survey carried out in April 2021 showed that most Austrian therapists had returned to face-to-face therapy, which was accompanied by a general increase in the number of patients treated (Humer et al., 2021).

The factors that influenced the therapists' decision to conduct teletherapy or face-to-face therapy during the pandemic included positive attitudes towards teletherapy, lack of vaccination, patient satisfaction, insurance reimbursement for teletherapy, negative attitudes towards wearing masks in the face-to-face setting, fear of infection in the face-to-face setting, and perceived effectiveness of teletherapy (Shklarski et al., 2021b). In the Argentinian study, weak associations were found between the use of teletherapy during the lockdown and the theoretical-clinical orientation (psychoanalytic / psychodynamic more teletherapy than systemic or humanistic), workplace (institution more than practice), work location (urban more than rural) and patient age (children and adults more than elderly; Fontao et al., 2022).

Aim of the study and research questions

In later phases of the pandemic, the social restrictions in Argentina were loosened and the vaccination campaign started. (At the time of data collection for this study [Mid-July 2021], 34% of the Argentinian population were partly vaccinated and only 11% were fully vaccinated; Ritchie et al., 2020). As the factors related to the use of teletherapy after the total lockdown may be different from those during the lockdown, this study aimed to investigate the use of teletherapy during the second wave of the COVID-19 pandemic from the perspective of the psychotherapists. The following research questions were investigated:

1. How many therapists used teletherapy during the second wave of the pandemic in Argentina?
2. Which factors (e.g., patient and therapist characteristics and attitudes, therapists' stress, and self-care) are related to the use of teletherapy?

Methods

Study design and survey

This cross-sectional, exploratory study is based on data collected by an online survey with psychotherapists in Argentina between the 21st of June 2021 and the 2nd of August 2021. The online survey was generated using the software SoSci Survey (version 3.2.23 and version 3.2.30; Leiner, 2021) and made available for participants via <https://www.soscisurvey.de>.

The survey consisted of 48 questions collecting

variables on therapist, patient, and work characteristics, attitudes towards and perceptions of the teletherapeutic and face-to-face setting as well as therapists' experienced stress and self-care (completion time: approximately 20 minutes). The questions were partly adopted from Fontao et al. (2022) and additionally created based on the literature on teletherapy during the COVID-19 pandemic. The target group of the study were psychologists and psychiatrists who regularly practise psychotherapy and continued doing so during the COVID-19 pandemic. Survey invitations were sent to the professional network of the project group and to professional institutions such as universities, chambers of psychologists, and professional associations (snowball sampling).

Ethical considerations

The project received a positive vote from the Ethical Committee of Scientific and Technical Research from CONICET Mendoza. In the first section of the survey, potential participants were informed about the aim and content of the study and about the processing of their personal data. The data were collected anonymously; withdrawing from participation was possible at any time. Only participants who agreed to participate and met the inclusion criteria were included in the study. The participants did not receive any kind of incentive for participating in the study.

Data Analysis

In total, 749 survey records were submitted. Participants who completed the survey twice as fast as the average, had more than 20% of missing data, or missed at least one out of six compulsory questions (in accordance with the participation requirements) were excluded of the sample. $N = 573$ observations were thus considered as valid cases.

All statistical analyses were performed using the statistical software R in the version 4.0.5 (R Core Team, 2021). The first research question that examines how many therapists conduct teletherapy was analysed by calculating absolute and relative frequencies of therapists that conducted teletherapy at the time of data collection. For the second research question, 55 variables representing factors potentially associated with the provision of teletherapy were analysed. The binary variable "provision of teletherapy" has the two response values "high provision" and "low provision of teletherapy". Thereby, high provision of teletherapy is defined as providing teletherapy for more than 50% of the patients ($> 50\%$) and low provision of teletherapy is defined as providing teletherapy for 50% or less of the patients ($\leq 50\%$). For these analyses, only those therapists who stated that they were allowed to provide face-to-face therapy at some point of the pandemic ($n = 508$) were considered. In doing so, only those therapists who could more likely choose between the teletherapeutic and face-to-face settings (versus those who were only allowed to offer teletherapy) were analysed. Due to missing values or filter questions, the sample size for the different analyses varies. Variables that are assigned to the category

"face-to-face therapy" include very few subjects compared to the other variables. This is because only therapists that exclusively provided face-to-face therapy during the COVID-19 pandemic answered these questions. Additionally, variables that are assigned to "Teletherapy" (except "future teletherapy") were only answered by therapists that provided teletherapy at least at some point during the pandemic. A similar rule applies for the variable "privacy of therapists". Only therapists who had worked from home could have answered this question, and therefore the sample size is smaller. All other variables could have been answered by all participants.

To investigate research question 2, contingency tables and percentages were calculated for the nominal and ordinal scaled variables. For the inference statistical analysis Chi-Squared tests were used (for cell frequencies below 5: Fisher's exact test). To calculate effect sizes and to measure the strength of the relationship between the independent variables and the provision of teletherapy, respectively, Cramer's V was used. It is interpreted according to Cohen (1988): $V = .10$ small, $V = .30$ moderate, $V = .50$ large. For the interval scaled variables descriptive statistics were calculated (*Mean, SD, Median*). For the variables that indicated how many patients from the respective age groups were treated, the overall sample mean has little informational value. Instead, of interest is how many patients from the respective age groups were treated per therapist in relation to the total number of patients of each therapist. Thus, the percentage of the respective age group treated per therapist was calculated and the mean of these figures were computed.

Except from patient number and the four age groups treated per therapist, therapist variables were collected by using visual analogue scales, which are classified as interval scaled variables (Reips & Funke, 2008). The visual analogue scales ranged from 1 to 101. For the variable patient satisfaction and the variables from the categories teletherapy, face-to-face therapy, pandemic stress, and self-care, the value 1 represented a very low expression of the respective variable, while the value 101 represented a very high expression. For the variable patient preference and the variables from the category comparison between both settings, the therapists were asked to compare teletherapy and face-to-face therapy directly. For these variables the value 1 corresponded to the teletherapeutic setting and the value 101 corresponded to the face-to-face setting.

Wilcoxon-Mann-Whitney tests were used as an alternative to the independent two samples t-test, as data were not normally distributed. The effect size r was calculated to measure the strength of the relationship and was interpreted according to Cohen (1988).

Results

Characteristics of the participants

A detailed summary of the absolute and relative frequencies of the sociodemographic characteristics of the participants can be found in the Supplementary materials (Table A1). Out of a total of $N = 573$ participants, $n = 512$ (89.35%) were female. The largest age subgroup was 30–39-year-old ($n = 194$, 33.86%). Almost all participants had a degree in psychology ($n = 566$, 98.8%), and the majority had a psychodynamic / psychoanalytic theoretical-clinical orientation ($n = 479$, 83.60%). Most surveyed therapists worked in the capital city (CABA, $n = 224$, 39.09%), followed by the province of Buenos Aires ($n = 192$, 33.51%).

Research Question 1

A total of $n = 547$ (95.46%) therapists provided teletherapy at the time of data collection, and $n = 22$ (3.84%) therapists did not provide teletherapy at this time but did so in the past (before or during the pandemic); $n = 4$ (0.70%) therapists never practised teletherapy. Thus, a total of $n = 569$ (99.30%) have ever performed teletherapy. On average, therapists treated $M = 71.3\%$ ($SD = 35.71$) of their patients in teletherapy ($Mdn = 100\%$). At the same time therapists treated $M = 28.7\%$ ($SD = 35.71$) of their patients in a face-to-face setting ($Mdn = 0$). Furthermore, of those therapists that stated that face-to-face therapy was allowed at their workplace at some point during the pandemic ($n = 508$), $n = 483$ (95.08%) therapists offered teletherapy at the time of data collection. This corresponds to 88.46% of all therapists who provide teletherapy and 84.29% of all therapists surveyed. Of these, $n = 344$ provided a high level of teletherapy (> 50%); this corresponds to 62.89% of all therapists that provide teletherapy at the time of data collection, to 67.72% of those therapists who provide teletherapy and who were allowed to do face-to-face therapy at some point during the pandemic and to 60.03% of all therapists surveyed.

Research Question 2

Research question 2 investigated the relationships between the provision of teletherapy and several variables in the categories: therapist, patient and work characteristics, attitudes towards and perceptions of the teletherapeutic and face-to-face setting, pandemic stress, and self-care. A maximum of $n = 508$ therapists were included in this analysis, representing those who stated that at some point of the pandemic face-to-face was allowed at their workplace. Of those, $n = 164$ (32.28%) provided teletherapy to a maximum of 50% of their patients (low provision) and $n = 344$ (67.72%) therapists provided teletherapy to more than 50% of their patients (high provision). Overall, a significant association between the provision of teletherapy and 37 variables was found. An overview of the results can be found in Table A2 and Table A3 in the Supplementary materials.

Therapist characteristics. There is a relationship of level of teletherapy provision with gender, as well as age; older therapists provide more teletherapy than younger therapists. Work experience is significantly related to teletherapy: Among therapist with less than 5 years of work experience, 76.28% ($n = 209$ out of $n = 274$) are in the high provision group. Another significant relationship was found between the theoretical-clinical orientation and the provision of teletherapy; whereas 73.86% of psychodynamic therapists are in the high provision group, 72.22% of the systemic therapists belong to the low provision group.

Patient characteristics. Caseload is related to the level of teletherapy provision. Therapists in the high provision group treat significantly less patients than those in the low provision group (moderate effect). Additionally, the proportion of each age group of patients who are treated by each therapist also differ significantly with respect to children, adolescents, and adults. The percentage of children treated by each therapist differ significantly between therapists in the high provision group and those in the low provision group. Therapists in the high provision group treat significantly fewer adolescents than those in the low provision group. By contrast, therapists in the high provision group treated significantly more adults than those in the low provision group.

Level of teletherapy is associated to therapist's perceived patient satisfaction with teletherapy: Therapists in the teletherapy provision group rate their patients' satisfaction with the teletherapeutic setting higher than therapists in the low provision group. Furthermore, the patient's preference for teletherapy or face-to-face therapy (from the therapist's perspective) is significantly related to the provision of teletherapy (moderate effect). Therapists in the high provision group state that their patients did not prefer one of the two settings, while therapists in the low provision group state that their patients prefer face-to-face therapy.

Workplace characteristics. The urban character of the workplace location is significantly related to the level of teletherapy provision. Many therapists working in an urban area are in the high teletherapy provision group ($n = 328$ out of $n = 466$; 70.39%). More therapists working in private institutions are in the high provision group compared to those working exclusively in private practices, public institutions or in both. This relationship between workplace and teletherapy is significant (moderate effect). The frequency of working in a multipersonal setting is significantly related to the provision of teletherapy. Among those who never work in a multipersonal setting, 81.17% ($n = 181$ out of $n = 223$) belong to the high teletherapy provision group. Furthermore, the frequency of cooperation with other professionals (e.g., therapists, physicians, social workers) or institutions is significantly associated with providing teletherapy. Among those therapists who never cooperate with other professional groups at work, 89.09% ($n = 49$ out of $n = 55$) are in the high teletherapy provision group.

Attitudes towards teletherapy. In the group of therapists who started working in the teletherapeutic setting at the beginning of the pandemic, 70.96% provide teletherapy on a high level (i.e., high provision group) at data collection; among those who had already used teletherapy before, 58.59% provide teletherapy on a high level. The frequency of the use of video conferencing in teletherapy is significantly related to the provision of teletherapy. Therapists who use video conferencing tools more frequently are more likely to provide more teletherapy. Among those who offer teletherapy in a home office setting, 326 out of 458 (71.18%) are in the high provision group. Of those who do not work at home, 13 out of 37 (35.14%) are in the high provision group. Thus, home office is significantly related to provision of teletherapy.

The dichotomously analysed variable of training, i.e. whether therapists received any training on teletherapy at all, is significantly related to the level of teletherapy provision. Thereby, more trained therapists are in the high provision group (73.10%) than untrained therapists (61.11%). A detailed analysis of the variable training also yielded significant results. Many therapists (89.04%) who had been trained by their institution or professional association are in the high provision group. They had also received significantly more information on teletherapy by their institution or professional association in comparison to the low provision group (moderate effect).

Both high and low teletherapy provision groups rate the disruption due to technical problems as very low. Concerning the privacy of therapists in teletherapeutic sessions when working from home, both groups say that keeping privacy is possible to a great extent.

Therapists in the high provision group consider continuing teletherapy after the pandemic as significantly more likely than therapists in the low provision group. Furthermore, therapists in the high provision teletherapy group experience significantly less discomfort in the teletherapeutic setting than therapists in the low provision group.

Attitudes towards face-to-face therapy. The therapists in the high teletherapy provision group experience significantly more discomfort working under hygiene protocol in face-to-face therapy than the low provision group.

Comparison between both settings. Considering the therapeutic relationship, therapists in the low provision group rate the relationship much better in the face-to-face setting, while therapists in the high teletherapy provision group rate it to be only slightly better in the face-to-face setting (moderate effect). Considering the emotional depth of the therapeutic work, similar results were found. Therapists in the low teletherapy provision group rate it much better in the face-to-face therapy and therapists in the high provision group rate it only slightly better in the face-to-face therapy (moderate effect). Additionally, therapists in the low teletherapy use group feel significantly more competent in a face-to-face setting than to those in the high teletherapy use group, who feel slightly more competent in a face-to-face setting (moderate effect). The

analysis of the variable therapist's sense of confidence yielded similar results. Therapists in the low provision group feel more confident in a face-to-face setting, while therapists in the high teletherapy provision group feel only slightly more confident in a face-to-face setting (moderate effect). As for the workload, therapists in the low provision group state that the workload is similar for both settings, while therapists of the high provision group state that the workload was slightly higher in the teletherapeutic setting. Both groups perceive face-to-face therapy as slightly more effective than teletherapy, but therapists in the low teletherapy provision group find face-to-face therapy a little more effective than therapists in the high provision group.

Pandemic stress. The high and low provision groups significantly differ in their concern about getting infected. Therapists in the low provision group are less concerned than those in the high provision group.

Self-care. Cultivating social contacts is related to teletherapy provision. Among the therapists that cultivate social contacts, 276 out of 388 (71.13%) are in the high provision group. Outdoor activities are also related to teletherapy provision, but the other way around. Therapists that do not do outdoor activities are more likely to provide teletherapy (75.54% in the high provision group) than those in the group that do outdoor activities (65.80%). Furthermore, taking therapy oneself is also significantly related to providing teletherapy. Among therapists that take own therapy, 71.05% are in the high provision group compared to 60.53% of therapists that do not take own therapy.

Discussion

After one year of pandemic, teletherapy was still widely used in Argentina. Almost all surveyed therapists used teletherapy to some degree. On average, the surveyed therapists treated nearly 75% of their patients in teletherapy. In the first wave of the COVID-19 pandemic in July/ August 2020, 46.3% of the surveyed therapists treated 75-100% of their patients in teletherapy (Fontao et al., 2022). In the second wave, despite the availability of vaccines and the fact that face-to-face therapy was partly allowed, 59.51% of the surveyed therapists treated the same proportion of patients in teletherapy. These figures seem to be specific for Argentina and differ from those reported in the international literature (e.g., Humer et al., 2021).

Therapist characteristics. Four therapist variables are significantly related to the provision of teletherapy. Psychodynamic oriented therapists offer teletherapy most frequently, whereas cognitive behavioural and systemic therapists offer teletherapy least frequently; the latter finding is also reported in previous work (Fontao et al., 2022). A possible explanation is that cognitive behavioural and systemic techniques apply fit less well into the teletherapeutic context. Systemic oriented therapists work more regularly in multipersonal settings, which

might be more difficult to translate to the teletherapy setting. This is supported by the finding that therapists who frequently work in multipersonal settings are less likely to provide much teletherapy. International research on the relationship between teletherapy use and theoretical-clinical orientation during the COVID-19 pandemic is inconclusive. The study by Humer et al. (2020) found that psychodynamic and humanistic psychotherapists find teletherapy delivered by telephones more comparable to face-to-face setting than behavioural and systemic therapists. According to Békés and Aafjes-van Doorn (2020), behavioural therapists had more positive attitudes towards teletherapy delivered by video. Probst et al. (2020) found no influence of theoretical-clinical orientation on the provision of teletherapy in an early phase of the pandemic at all. Beyond the COVID-19 pandemic, teletherapy is expected to remain a valuable tool in the psychotherapy practice (Fernández-Álvarez & Fernández-Álvarez, 2021). Hence, the development of methods that facilitate a sound transfer of different theoretical-clinical orientations and settings (individual and multi-person therapy) to teletherapy is a crucial task in future research in psychotherapy.

Work experience, gender and age are associated with the provision of teletherapy, but the effects are small. Therapists that have the shortest work experience use teletherapy most frequently, followed by those that have the longest work experience. In general, therapists who are over 50 years old use teletherapy more often than younger therapists. This could be related to the higher risk of a severe course of a COVID-19 infection among older people and might also explain the positive association of teletherapy use with work experience, which is also related to age. These results are partly in line with the association between a high level of work experience and a positive attitude towards teletherapy reported by Békés and Aafjes-van Doorn (2020). These results do not necessarily contradict each other, but the current study found no positive linear relationship between level of work experience and provision of teletherapy. Beyond the COVID-19 pandemic, teletherapy can be a valuable resource for psychotherapists and patients at a higher health risk. Therefore, barriers for the implementation of teletherapy, such as preconceptions, lack of clinical training or technical shortcomings should be reduced across age and work experience groups.

This study failed to replicate the relationship between provision of teletherapy and protection against COVID-19 through vaccination/ recovery reported by Shklarski et al. (2021b), with those therapists that were not protected providing teletherapy more often. Because of the implications of this relationship for risk management at work, these phenomena should be further explored in future work.

Patient characteristics. Six patient variables rated by the surveyed therapists have a significant relationship with the provision of teletherapy. The largest effect is the patients' preference for face-to-face or teletherapy. In line with Shklarski et al. (2021b), these findings may indicate

that patient satisfaction (as perceived by the therapist) influence therapists' decision to provide teletherapy. However, caution is needed, because these results raise the question of whether therapists choose the therapeutic modality (face-to-face or teletherapy) according to their patients' preference or satisfaction, or whether the patients' preference/ satisfaction is influenced by the therapist' choice.

Caseload is also associated with the use of teletherapy. Therapists in the high provision group treat overall fewer patients than therapists who offer less or no teletherapy at all. This is an interesting finding, because of the shortage of therapeutic services during the pandemic reported in previous studies (Etchevers et al., 2021; Probst et al., 2020), as well as the general increase in patients treated observed by Humer et al. (2021) as therapists returned to face-to-face therapy. Future research could help clarify the link between case load for psychotherapists and teletherapy in comparison to face-to-face therapy.

The average percentage of children and adolescents treated per therapist show that therapists in the low teletherapy provision group treat more children and adolescents in relation to the total number of patients than those in the high provision group. These results may indicate that, at least during the pandemic, the implementation of teletherapy with children and adolescents was more challenging. The specific techniques (e.g., play) and characteristics of the interaction (e.g., therapist being more active in session) in these patient populations may require more adaptations than those used with adult patients, i.e., mostly verbal techniques (Bate & Malberg, 2020; Burgoyne & Cohn, 2020).

Workplace characteristics. Workplace location shows an association with teletherapy use. By interpreting these results, it should be kept in mind that most of the participants work in CABA or the province of Buenos Aires. Almost all therapists working in CABA use teletherapy with more than 50% of their patients. Moreover, only in urban regions a majority of therapists offer teletherapy to more than 50% of their patients, while therapists working in suburban or rural areas reported lower teletherapy use. Because of the small subsamples of suburban and rural therapists, these results should be interpreted with caution. National and international studies reported similar results (Author et al., 2022; Pierce et al., 2020). In rural regions, teletherapy use is generally low. Structural deficits (lack of stable internet connection, technical equipment, as well as private rooms etc.) may hinder the implementation of teletherapy, but also a lower COVID-19 incidence or patients' and therapists' preferences could explain these results. Further research with therapists and patients in suburban and rural areas is needed to reveal underlying reasons for low teletherapy use. This is especially important because access to therapy is generally difficult in rural areas, and teletherapy could help to fill this gap.

The workplace has a moderate influence on the provision of teletherapy, which is in line with previous studies (Fontao et al., 2022; Humer et al., 2020; Shklarski et

al., 2021b). Therapists who work in private institutions (alone or in combination with private practice) use more teletherapy than those who work in public institutions (alone or in combination) or in private practice alone. A possible explanation is that the general conditions for teletherapy (e.g., technical equipment, training) are better in private institutions than in public institutions. But it is also possible that the choice of face-to-face or teletherapy reflects different preferences and needs of patients in public or private institutions, and in private practices. With regard to training on teletherapy, therapists who work in private institutions (alone or in combination with private practice), receive training from the institution more often than therapists in public institutions. Conducting teletherapy at home is positively associated with high teletherapy provision (small effect). This finding of therapists working from home instead from office may reflect a major change in psychotherapy practices beyond the pandemic and should be further investigated.

Working in multipersonal settings is associated with low provision of teletherapy. Because using teletherapy in sessions with many persons may have several advantages (e.g., when family members live in different locations; Lovejoy et al., 2009), this relationship should be explored in future studies, in order to remove possible obstacles to couple, family and group teletherapy. Therapists who often cooperate with other professionals or institutions treat fewer patients in teletherapy. This finding is consistent with the results of in-depth interviews with Argentinean psychotherapists, who stated that teletherapy is very challenging when a close cooperation with different professionals or departments is needed (König et al., 2023).

Attitudes towards teletherapy. A moderately strong relationship was found between the amount of information therapists received about teletherapy from their institution or professional association and teletherapy use. Training on teletherapy is also positively associated with provision of teletherapy (small effect). These results are in line with those reported in Pierce et al. (2020). To promote teletherapy in routine psychotherapy practice and as an additional tool when social distancing is needed, psychotherapy training programmes should include courses in teletherapy.

In accordance with international research (Boldrini et al., 2020; Humer et al., 2020), the provision of teletherapy is positively associated with the predominant use of video conferencing in teletherapy. This makes sense, because video calls resemble the face-to-face therapy most strongly (Fernández-Álvarez & Fernández-Álvarez, 2021). Technical problems are weakly associated with low provision of teletherapy, which makes sense and replicates previous findings on barriers for teletherapy (Olwill et al. [2021]) for telephone therapy, Shklarski et al. ([2021a] for video therapy).

In accordance with several studies that reported negative attitudes for teletherapy when therapists felt more exhausted, tired, or stressed in teletherapy (Békés & Aafjes-van Doorn, 2020; McBeath et al., 2020), in this study a higher level of perceived discomfort in the

teletherapeutic session was associated with low provision of teletherapy, although the level of discomfort was generally low. If teletherapy is to become part of clinical training and routine mental health practice, it would be interesting to further research the reasons why some therapists feel more stressed in teletherapy than others, and to develop resources for therapists to effectively cope with stress.

Using teletherapy prior to the pandemic is negatively associated with the degree of teletherapy use since the beginning of the pandemic. This result is somewhat counterintuitive and is not in line with those reported by Békés and Aafjes-van Doorn (2020) and Boldrini et al. (2020). Of note, it is unclear to what degree therapists had provided teletherapy before the pandemic. Because since the beginning of the pandemic the vast majority of psychotherapists in Argentina became acquainted (even in different degrees) with teletherapy, teletherapy experiences previous to the pandemic have now little or no predictive value for teletherapy use in the future. Therapists in the high and low provision group had rather negative to neutral attitudes towards teletherapy before the pandemic, and this was not associated with provision of teletherapy. This is in line with the current state of research, which shows that therapists were skeptical of teletherapy before the pandemic (Gaebel et al., 2020). However, many studies report a shift from rather negative before the pandemic to rather positive attitudes towards teletherapy during the pandemic (e.g., Shklarski et al., 2021b). This shift can be explained by the gain of experience on teletherapy, as therapists were forced to provide it at the beginning of the pandemic, since in-person therapy was mostly not allowed (Humer et al., 2020).

Furthermore, a relationship between a high provision of teletherapy and future plans to provide teletherapy was found, although those therapists who provide fewer teletherapy stated that they are likely to use teletherapy in the future as well. This is in line with results of McBeath et al. (2020), who found that two-thirds of surveyed therapists planned to use teletherapy frequently in the future. Although Aafjes-van Doorn et al. (2020) found different opinions between therapists on whether to use it in the future, we can possibly expect a trend towards more teletherapy, even after the exceptional pandemic situation (Fernández-Álvarez & Fernández-Álvarez, 2021).

Attitudes towards face-to-face therapy. On average, the surveyed therapists that at some point during the pandemic had provided face-to-face therapy stated that hygiene protocols can be implemented well in practice and have only moderate influence on therapeutic work. These results suggest that treatment integrity could be assured even under these circumstances, and that hygiene protocols are a valuable option to teletherapy during the pandemic and maybe beyond it (e.g., when patients or therapists have health risks). The therapists in the high teletherapy use group reported slightly more discomfort with the hygiene protocol. Thus, even if the mandatory use of hygiene protocols cannot fully explain why some therapists chose either face-to-face or teletherapy, person-

al well-being at work could have influenced this choice. For instance, Shklarski et al. (2021b) found that negative attitudes towards wearing masks were associated with plans to continue teletherapy rather than returning to face-to-face therapy.

Comparison between both settings. A direct comparison of the two studied settings showed that six variables were related to the provision of teletherapy. The sense of competence and self-confidence as well as the experienced emotional depth in the therapy sessions and the therapeutic relationship as reported by the therapists are associated with teletherapy use (moderate effect). Therapy effectiveness and workload are also associated with teletherapy use. The therapists in the high teletherapy provision group rated the therapeutic relationship and emotional depth as slightly higher in face-to-face therapy. They rated the experienced competence, self-confidence, and effectiveness as almost equally high in both modalities; only the workload was considered to be higher in teletherapy. In comparison, the therapists who offered less teletherapy rated all variables as significantly higher in the face-to-face setting, except for workload, which they considered fairly similar in both settings. This could mean that the therapists that see clear shortcomings in teletherapy are more likely to use face-to-face therapy. However, it is also possible that the frequency of providing therapy in either setting has an influence on the perception of therapist variables (e.g., competence, self-confidence, and effectiveness). Further research with different methodological approaches (e.g., quasi-experimental studies) are needed to draw definite conclusions.

As there are only a few studies that have directly compared face-to-face therapy with teletherapy, the conclusions are tentative. Aafjes-van Doorn et al. (2020) found that the therapists that provided teletherapy during the pandemic rated the therapeutic relationship similarly good to that in pre-pandemic face-to-face therapy. In contrast, in the current study the therapists in the high provision group rated the therapeutic relationship somewhat higher in the face-to-face setting. In line with this, Olwill et al. (2021) found that therapists who provided teletherapy by phone experienced more difficulty in establishing a good therapeutic relationship compared to the face-to-face setting. To our knowledge, previous studies did not directly compare workload and emotional depth in teletherapy and face-to-face therapy. In a clinical report, Thompson-de Benoit and Kramer (2020) stated that deepening emotions represented a challenge in teletherapy, which is not fully in line with the results in this study. In conclusion, therapists that provide more teletherapy (high provision group) seem to perceive both settings as more comparable than therapists who provide teletherapy on a lower level.

Stress. One form of stress was assigned to the categories “teletherapeutic setting” and “face-to-face setting” and represents the discomfort in either setting. These forms of stress were each rated relatively low, with the group working less frequently in each setting rating the discomfort higher. Pandemic related stress, which

included general pandemic stress and concerns about catching the SARS-CoV-2 virus, was rated much higher in both groups. The latter are related to the provision of teletherapy, with therapists in the high provision group experiencing more concerns (small effect).

Self-care. As for (overall high) stress levels, both groups of therapists did not differ in the level of self-care that they exhibit. Both groups stated that they have increased their emphasis on self-care since the beginning of the pandemic, which seems reasonable to counteract the high stress levels and which has been reported by other studies (McBeath et al., 2020; Shklarski et al., 2021a). Both groups rated self-care activities quite similar, but some differences emerged: Therapists that relied on own therapy and socialising provided teletherapy more often than those that did not, while those that did not rely on spending time outside provided more teletherapy than those that did.

Limitations of the study

The study participants were not recruited randomly out of all psychotherapists in Argentina (snowball sampling), and the sample cannot be considered representative. A general problem of this study field is the unclear definition of teletherapy (e.g., telephone or videoconferencing alone or in combination, synchronous or asynchronous, professional or self-help therapy), which make direct comparisons between studies difficult.

For research question 2, only those therapists were included who stated that at some point in the pandemic face-to-face therapy was allowed at their work location, but it is unclear if this was the case at the time of data collection. Therefore, it is possible that a part or all of the 238 participants who provided teletherapy to 100% of their patients at the time of data collection did not have the choice between face-to-face or teletherapy, but between teletherapy and no therapy at all. At the beginning of July 2021, CABA and the provinces of Buenos Aires and Mendoza showed high to very high incidence rates, and 208 of 238 therapists (87.39%) that conducted only teletherapy worked in CABA and the province of Buenos Aires. Therefore, the permission to conduct face-to-face therapy in the workplace location is a non-negligible confounding factor. Some subgroups (e.g., humanistic theoretical-clinical orientation, older patients and therapists, rural areas, etc.) were small, and some findings must be interpreted with caution. Due to the explorative character of this study and its cross-sectional design, the direction of the relationship between the analysed variables and the level of provision of teletherapy is not clear. While it is possible that many of the studied patient, therapist and workplace variables had an impact on the decision to provide teletherapy, it cannot be ruled out that the decision of providing teletherapy actually had an impact on these variables. Therefore, it would be interesting to conduct longitudinal and (quasi-)experimental studies to understand factors that causally affect the use of teletherapy.

Patients' preferences and satisfaction, and the thera-

peutic relationship were rated by the therapists, and the ratings were not patient-related, but global. The therapeutic alliance in teletherapy from the patients' perspective has also been investigated (Casari & Stefanini, 2020), and because patients' and therapists' ratings not always match, future studies should collect patients' and therapists' data on these process variables.

The variable level of teletherapy provision was dichotomized (more than 50% of the patients in teletherapy: high teletherapy provision; 50% or less of the patients: low teletherapy provision), which simplified the statistical analysis and the presentation of results. However, dichotomizing may lead to information loss, and to a reduction of statistical power to detect a relationship between the investigated variables (Altman & Royston, 2006). To answer the research question 2, correlations between the level of teletherapy provision and possibly associated variables were tested. Due to the explorative character of the study, no correction method for dealing with multiple testing was applied. This might have resulted in an inflation of the type I error.

Outlook and Conclusion

Despite these limitations, this study makes an important contribution to describe and understand the psychotherapeutic practice and in particular the use of teletherapy during the COVID-19 pandemic in Argentina. Different factors associated with the provision of teletherapy were described. A set of variables from four of the six explored categories (therapist characteristics, patient characteristics, workplace characteristics, and attitudes towards and perceptions of therapeutic modalities) were significantly related to the provision of teletherapy. These exploratory findings provide a good foundation for exploring more specific questions.

Even before the pandemic, psychotherapy researchers predicted a growing use of teletherapy increase in the forthcoming years (e.g., Norcross et al., 2013). Because of its tremendous increase during the pandemic, teletherapy is expected to remain in routine psychotherapeutic practice (Fernández-Álvarez & Fernández-Álvarez, 2021). This expected development is confirmed by findings of the current study. This trend makes sense, not only for times of crisis, but also for regions and groups of people for whom the availability of psychotherapy is limited even at regular times. In this context, mixed approaches are also conceivable, in which teletherapy is combined with face-to-face therapy. The allocation of resources to therapist training in teletherapy and to the provision of high-quality teletherapy in routine practice is crucial. To this end, further research on the specific challenges and advantages of teletherapy should be encouraged and supported.

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Appendix

Table A1
Sociodemographic characteristics of the participants

| Variable | n | % |
|---|-----|-------|
| Gender | | |
| Female | 512 | 89.35 |
| Male | 57 | 9.95 |
| Non-binary | 4 | 0.7 |
| Age | | |
| 20 to 29 years | 113 | 19.72 |
| 30 to 39 years | 194 | 33.86 |
| 40 to 49 years | 116 | 20.24 |
| 50 to 59 years | 99 | 17.28 |
| 60 to 69 years | 46 | 8.03 |
| > 70 years | 5 | 0.87 |
| Degree | | |
| Psychology | 566 | 98.8 |
| Medicine | 7 | 1.22 |
| Work Location | | |
| CABA | 224 | 39.10 |
| Buenos Aires | 192 | 33.51 |
| Catamarca | 2 | 0.35 |
| Chaco | 2 | 0.35 |
| Chubut | 3 | 0.52 |
| Córdoba | 17 | 2.97 |
| Corrientes | 3 | 0.52 |
| Entre Ríos | 2 | 0.35 |
| Formosa | 8 | 1.40 |
| Jujuy | 1 | 0.17 |
| La Pampa | 1 | 0.17 |
| La Rioja | 0 | 0 |
| Mendoza | 39 | 6.81 |
| Misiones | 5 | 0.87 |
| Neuquén | 25 | 4.36 |
| Río Negro | 4 | 0.70 |
| Salta | 3 | 0.52 |
| San Juan | 4 | 0.70 |
| San Luis | 24 | 4.19 |
| Santa Fe | 10 | 1.74 |
| Santiago del Estero | 1 | 0.17 |
| Tierra del Fuego, Antártida e Islas del Atlántico Sur | 1 | 0.17 |
| Tucumán | 0 | 0 |
| Not answered | 2 | 0.35 |
| Theoretical-clinical orientation | | |
| Cognitive behavioural | 34 | 5.93 |
| Psychodynamic | 479 | 83.60 |
| Systemic | 18 | 3.14 |
| Humanistic | 8 | 1.40 |
| Integrative/ eclectic | 31 | 5.41 |
| Other | 3 | 0.52 |

Note. Sample size (n) varies due to missing values and/or filter questions.

Table A2
Absolute frequencies, relative frequencies and Chi-Square test/ Fisher's Exact test of provision of teletherapy by nominal/ ordinal scaled study variables

| Variable | Low Provision | | High Provision | | n | X ² | df | p | V |
|--|---------------|-------|----------------|--------|-----|----------------|----|---------|-----|
| | n | % | n | % | | | | | |
| Therapist characteristics | | | | | | | | | |
| Gender^a | | | | | | | | | |
| Female | 138 | 30.67 | 312 | 69.33 | 508 | | | .040* | .16 |
| Male | 23 | 42.59 | 31 | 57.41 | | | | | |
| Non-binary | 3 | 75.00 | 1 | 25.00 | | | | | |
| Age^a | | | | | | | | | |
| 20 to 29 years | 31 | 30.69 | 70 | 69.31 | 508 | | | .036* | .16 |
| 30 to 39 years | 74 | 40.66 | 108 | 59.34 | | | | | |
| 40 to 49 years | 31 | 30.69 | 70 | 69.31 | | | | | |
| 50 to 59 years | 20 | 24.39 | 62 | 75.61 | | | | | |
| 60 to 69 years | 8 | 21.05 | 30 | 78.95 | | | | | |
| > 70 years | 0 | 0.00 | 4 | 100.00 | | | | | |
| Degree^a | | | | | | | | | |
| Psychology | 163 | 32.47 | 339 | 67.53 | 508 | | | .669 | .04 |
| Medicine | 1 | 16.67 | 5 | 83.33 | | | | | |
| Work experience | | | | | | | | | |
| < 5 years | 65 | 23.72 | 209 | 76.28 | 508 | 24.76 | 4 | .000*** | .22 |
| 6 to 10 years | 46 | 47.92 | 50 | 52.08 | | | | | |
| 11 to 15 years | 15 | 40.54 | 22 | 59.46 | | | | | |
| 16 to 20 years | 15 | 48.39 | 16 | 51.61 | | | | | |
| > 20 years | 23 | 32.86 | 47 | 67.14 | | | | | |
| Protection | | | | | | | | | |
| No | 12 | 29.27 | 29 | 70.73 | 508 | 0.711 | 2 | .701 | .04 |
| Partially | 47 | 30.32 | 108 | 69.68 | | | | | |
| Yes | 105 | 33.65 | 207 | 66.35 | | | | | |
| Orientation^a | | | | | | | | | |
| Cognitive behavioural | 22 | 66.67 | 11 | 33.33 | 505 | | | .000*** | .29 |
| Psychodynamic | 109 | 26.14 | 308 | 73.86 | | | | | |
| Systemic | 13 | 72.22 | 5 | 27.78 | | | | | |
| Humanistic | 3 | 37.50 | 5 | 62.50 | | | | | |
| Integrative/ eclectic | 15 | 51.72 | 14 | 48.28 | | | | | |
| Patient characteristics | | | | | | | | | |
| Severity of pathology^a | | | | | | | | | |
| Minor | 55 | 34.59 | 104 | 65.41 | 507 | | | .106 | .10 |
| Moderate | 102 | 30.18 | 236 | 69.82 | | | | | |
| Major | 6 | 60.00 | 4 | 40.00 | | | | | |
| Treated Children^{a,b} | | | | | | | | | |
| 0-25% | 131 | 29.98 | 306 | 70.02 | 505 | | | .041* | .13 |
| 26-50% | 20 | 47.62 | 22 | 52.38 | | | | | |
| 51-75% | 9 | 47.37 | 10 | 52.63 | | | | | |
| 76-100% | 3 | 42.86 | 4 | 57.14 | | | | | |
| Treated Adolescents^{a,b} | | | | | | | | | |
| 0-25% | 121 | 30.48 | 276 | 69.52 | 507 | | | .019* | .14 |
| 26-50% | 37 | 43.02 | 49 | 56.98 | | | | | |
| 51.75% | 5 | 33.33 | 10 | 66.67 | | | | | |
| 76-100% | 0 | 0.00 | 9 | 100.00 | | | | | |
| Treated adults^b | | | | | | | | | |
| 0-25% | 25 | 37.88 | 41 | 62.12 | 508 | 34.099 | 3 | .000*** | .26 |
| 26-50% | 31 | 64.58 | 17 | 35.42 | | | | | |
| 51-75% | 46 | 35.66 | 83 | 64.34 | | | | | |
| 76-100% | 62 | 23.40 | 203 | 64.34 | | | | | |

continue

Table A3
*Means, Standard Deviations, Medians and Wilcoxon-Mann-Whitney tests
 of provision of teletherapy by interval scaled study variables*

| Variable | Low Provision | | | High Provision | | | n | U | p | r |
|---|---------------|-------|-------|----------------|-------|-------|-----|--------|---------|-----|
| | M | SD | Mdn | M | SD | Mdn | | | | |
| Patient characteristics | | | | | | | | | | |
| Patient number | 21.75 | 11.76 | 20 | 14.67 | 10.20 | 12 | 508 | 39260 | .000*** | .32 |
| Treated children ^a | 13.77 | 21.10 | 0 | 7.59 | 17.58 | 0 | 505 | 34131 | .000*** | .22 |
| Treated adolescents ^a | 18.30 | 16.35 | 16.67 | 14.69 | 20.41 | 8.00 | 507 | 33708 | .001*** | .17 |
| Treated adults ^a | 62.76 | 29.26 | 66.67 | 73.68 | 30.03 | 80.63 | 508 | 21120 | .000*** | .21 |
| Treated elderly patients ^a | 5.43 | 13.07 | 0 | 4.10 | 9.10 | 0 | 505 | 28404 | .62 | .02 |
| Patient satisfaction ^b | 75.50 | 19.88 | 78 | 80.13 | 20.49 | 84 | 493 | 22084 | .004** | .13 |
| Patient preference ^c | 76.95 | 22.59 | 81 | 47.63 | 25.18 | 50 | 486 | 40.658 | .000*** | .48 |
| Attitudes towards and perception of therapeutic settings | | | | | | | | | | |
| <i>Teletherapy^b</i> | | | | | | | | | | |
| Attitude | 40.16 | 28.53 | 40 | 42.12 | 29.83 | 37 | 485 | 24158 | .422 | .04 |
| Information | 38.98 | 34.38 | 29 | 61.80 | 33.96 | 69 | 487 | 16362 | .000*** | .30 |
| Ethics | 63.74 | 32.34 | 68.0 | 64.67 | 32.95 | 70.5 | 489 | 25100 | .588 | .02 |
| Technical issues | 21.75 | 11.76 | 20 | 14.67 | 10.20 | 12 | 508 | 29184 | .043* | .09 |
| Privacy therapist | 92.48 | 15.34 | 101 | 96.46 | 9.71 | 101 | 447 | 17910 | .017* | .11 |
| Privacy patients | 73.65 | 25.33 | 77 | 78.20 | 21.12 | 81 | 485 | 23298 | .141 | .07 |
| Future teletherapy | 68.53 | 32.87 | 79 | 86.11 | 20.32 | 94 | 484 | 17524 | .000*** | .25 |
| Discomfort | 35.78 | 28.54 | 33.5 | 20.49 | 23.61 | 12.0 | 493 | 34684 | .000*** | .26 |
| <i>Face-to-face therapy^b</i> | | | | | | | | | | |
| Hygiene | 88.55 | 16.48 | 97 | 85.53 | 20.38 | 94 | 266 | 9392 | .3 | .06 |
| Hygiene influence | 52.25 | 33.74 | 51.5 | 54.08 | 32.60 | 55 | 268 | 8582 | .638 | .03 |
| Hygiene discomfort | 32.07 | 28.07 | 23.5 | 40.59 | 30.48 | 34 | 268 | 7389 | .018* | .14 |
| <i>Comparison between both settings^c</i> | | | | | | | | | | |
| Therapeutic relationship | 80.96 | 20.80 | 88.5 | 65.36 | 21.19 | 57.5 | 492 | 35992 | .000*** | .31 |
| Emotional depth | 75.92 | 21.39 | 78 | 59.10 | 20.82 | 53.0 | 493 | 37119 | .000*** | .33 |
| Competence | 73.80 | 21.62 | 71 | 55.81 | 20.93 | 55.81 | 494 | 38161 | .000*** | .36 |
| Confidence | 72.30 | 23.01 | 69 | 54.97 | 21.98 | 52 | 492 | 36434 | .000*** | .32 |
| Workload | 51.64 | 34.10 | 50 | 42.64 | 31.44 | 48 | 493 | 30210 | .008** | .12 |
| Effectiveness | 67.59 | 20.99 | 57 | 58.24 | 18.53 | 52 | 491 | 31920 | .000*** | .18 |
| Pandemic Stress^b | | | | | | | | | | |
| Pandemic stress | 69.26 | 25.46 | 70 | 66.83 | 24.40 | 70 | 487 | 27130 | .273 | .05 |
| Concern COVID-19 | 56.38 | 29.51 | 56 | 62.46 | 27.01 | 65 | 486 | 22503 | .039* | .09 |
| Self-care^b | | | | | | | | | | |
| Self-care | 79.90 | 22.56 | 86 | 80.86 | 21.98 | 87.0 | 484 | 24990 | .816 | .01 |
| Self-care pandemic | 84.34 | 18.86 | 92 | 85.43 | 0.99 | 92 | 485 | 24846 | .698 | .02 |

Note. Sample size (n) varies due to missing values and/ or filter questions.

^a The figures represent the proportion (%) of the respective age groups treated per therapist. ^b The rating scale ranged from 1 to 101. The value 1 represents a very low expression of the variable and the value 101 represents a very high expression. ^c The rating scale ranged from 1 to 101. The value 1 represents teletherapy and the value 101 represents face-to-face therapy.

*p < .05 **p < .01 ***p < .001