

Presence at a Distance: Therapeutic Alliance, Silence, and Nonverbal Communication in Video Psychotherapy

Christian Jonathan Haverkamp

Narrative Clinical Review

Abstract—Video psychotherapy is neither an attenuated copy of office work nor a clinically neutral change of address. It preserves an encounter while altering gaze, bodily visibility, silence, privacy, turn-taking, and the meaning of interruption. This narrative clinical review considers evidence available through 28 February 2022 and asks how therapists can sustain presence when communication is technologically mediated. Meta-analytic findings suggest that video treatment can achieve outcomes broadly comparable with in-person care for several studied conditions, and alliance ratings are often strong. Those aggregate findings do not establish equivalence for every patient, intervention, risk state, or social setting. Clinical quality depends on more than connection speed. Therapist and patient need an explicit frame for location, privacy, emergencies, failed connections, recordings, household intrusions, and movement between video and in-person work. On screen, the therapist must read partial nonverbal information without pretending that what lies outside the frame is known. Lag may imitate hesitation; silence may deepen reflection or become ambiguous absence. Metacommunication therefore becomes a central technique: observable changes are named tentatively and their meaning is checked. Video can increase access, continuity, and patients' agency, while excluding others through cost, disability, digital literacy, surveillance, or lack of private space. The defensible question is not whether video therapy is simply as good, but for whom, for what work, under which safeguards, and with what route to change format.

Index Terms—video psychotherapy, therapeutic alliance, therapeutic presence, nonverbal communication, silence, telepsychology

Christian Jonathan Haverkamp, M.D., LL.M., is a psychotherapist working in private practice in Dublin, Ireland. Correspondence: jonathanhaverkamp@gmail.com. Website: www.jonathanhaverkamp.com. © 2022 Christian Jonathan Haverkamp.

I. INTRODUCTION

A video session can look deceptively familiar. Two people speak at an appointed time; expressions are visible; a therapeutic history can continue. Yet the screen reorganizes the encounter. Each person sees a cropped image, hears a compressed voice, and occupies a different physical environment. Eye contact becomes an optical approximation. A pause may belong to thought, emotion, lag, or a frozen connection. These are not technical details outside psychotherapy. They enter the communication from which psychotherapy is made.

The rapid move to remote care during the COVID-19 pandemic turned a previously selective format into ordinary clinical practice. Earlier reviews had already found videoconferencing feasible across varied populations and treatments, though large controlled trials were limited (Backhaus et al., 2012; Hilty et al., 2013). Later meta-analyses found outcomes broadly comparable with in-person services across aggregated studies (Batastini et al., 2021; Fernandez et al., 2021). The clinically important word is broadly. An average does not decide whether a particular person can speak safely from a particular room.

Therapeutic alliance remains relevant across treatment orientations, but alliance is not a mood of mutual liking. It includes agreement about the work, agreement about its purposes, and a bond that can tolerate difference. Across adult psychotherapy, alliance and outcome are reliably associated, without that association proving a simple one-way cause (Flückiger et al., 2018). Video changes the conditions under which each component is negotiated. A therapist can remain warm and responsive while missing information that would have been available in a shared room.

This review treats video psychotherapy as a distinct clinical setting that deserves deliberate practice. It considers presence, gaze, silence, nonverbal communication, privacy, safety,

access, fatigue, and hybrid choice. It also retains a communication-focused proposition found in earlier JPPC work: psychotherapy depends on meaningful exchanges whose significance must be discovered with the patient rather than presumed by the therapist (Haverkamp, 2017). That proposition is theoretical, not evidence that any author-developed method is superior in video care.

II. SCOPE AND REVIEW METHOD

The literature search for this narrative clinical review closed on 28 February 2022, one month before the nominal issue date. Priority was given to systematic reviews, meta-analyses, professional guidance, comparative studies, and empirical or clinically grounded papers addressing alliance, presence, privacy, provider experience, and remote treatment delivery. Complete online-first publications available by the cutoff were eligible. The review did not pool data anew, and it does not address text-only treatment, self-guided programs, or asynchronous messaging except where they clarify what live video uniquely changes.

The evidence base is uneven. Cognitive-behavioral treatment for anxiety, depression, and post-traumatic stress has been studied more often than exploratory, relational, family, couple, child, or group therapies. Systematic reviews of video treatment for depression and anxiety reported encouraging outcomes but also small samples, variable designs, and a need for stronger trials (Berryhill et al., 2019a; Berryhill et al., 2019b). A review of synchronous remote interventions likewise found promising effects across several conditions while emphasizing methodological heterogeneity (Varker et al., 2019).

Alliance studies have often relied on self-report scales completed by patients or therapists. Such ratings matter, but they do not capture every rupture, misunderstanding, missed bodily cue, or adaptation in technique. Reviews generally find that alliance can be established by video, with patients sometimes rating it more favorably than clinicians do (Simpson & Reid, 2014). That difference is itself useful evidence: professional discomfort should not be projected onto patients, and patient satisfaction should not end inquiry into what the medium conceals.

The review concerns planned, synchronous psychotherapy with adults unless otherwise stated. Legal duties, licensure, data protection, emergency arrangements, and platform requirements vary by jurisdiction and may change. Professional and local rules therefore govern actual practice. The clinical principles offered here supplement, rather than replace, those rules. No patient material is used, and examples are descriptions of possible communication processes rather than disguised clinical cases.

III. WHAT COMPARABLE OUTCOMES DO AND DO NOT MEAN

The strongest reassurance about video psychotherapy comes from convergence across reviews. Comparative meta-analysis has found little overall difference between mental and behavioral health services delivered by videoconference and in person, and a second meta-analysis of live video psychotherapy found substantial pre-post improvement with negligible aggregate difference from in-person treatment (Batastini et al., 2021; Fernandez et al., 2021). These results challenge the claim that physical co-presence is always necessary for benefit. They do not show that the medium is irrelevant.

Equivalence at the level of a pooled symptom score can coexist with different processes, burdens, and patterns of dropout. A person may attend more consistently because travel is removed yet disclose less because family members are within hearing. Another may feel safer at home and speak more freely; another may feel that therapy has entered the only private refuge they possess. Trials rarely measure these meanings with the same precision as symptoms. The format can improve access while changing the route by which improvement occurs.

Study populations also set boundaries. Reviews of anxiety and depression include many structured interventions, while people with unstable risk, severe cognitive impairment, limited digital access, acute intoxication, or unsafe domestic circumstances are commonly absent or selectively managed (Berryhill et al., 2019a; Berryhill et al., 2019b). Noninferiority in a screened trial cannot be transferred automatically to every service population. A format decision remains an assessment, not an administrative default.

The practical conclusion is conditional. Video is a credible treatment setting when the intervention can be delivered faithfully, communication remains workable, safety can be managed, and the patient has a genuinely usable place and device. It is not inferior merely because it is remote, and it is not suitable merely because a link can be sent. Outcome evidence supports offering a choice and monitoring the fit; it does not support abolishing the choice.

Table 1. Translating aggregate video-therapy findings into individual decisions

Evidence statement	What it supports	What still requires assessment
Pooled outcomes are broadly comparable	Video can be a legitimate treatment setting	Diagnosis, intervention, risk, impairment, privacy, and patient preference
Alliance ratings are often strong	A meaningful working relationship can form remotely	Unspoken ruptures, therapist-patient rating differences, and missing observational data

Evidence statement	What it supports	What still requires assessment
Structured treatments are well represented	Many manualized tasks can be adapted	Experiential, group, family, couple, and body-focused work
Travel and geography barriers are reduced	Access and continuity may improve	Devices, bandwidth, disability, language, surveillance, and a private room
Patients often report satisfaction	The format may be acceptable or preferred	Burden, coercive lack of alternatives, and whether preference changes over time

IV. PRESENCE WITHOUT SHARED PHYSICAL SPACE

Therapeutic presence can be understood as the disciplined availability of attention to the patient, the clinician's own responses, and what is occurring between them. Video does not remove that possibility, but it makes its signs less reliable. A still face may reflect concentration, screen fatigue, or image freezing. A glance away may be reflection, notification checking, concern about someone entering, or the ordinary movement of eyes. Presence must therefore be communicated rather than left entirely to inference.

Geller describes online presence as something that can be cultivated through preparation, embodiment, responsiveness, and explicit attention to the altered medium (Geller, 2020). This is clinically different from exaggerated animation. Leaning conspicuously toward the camera, nodding continuously, or filling every pause can become performance and may burden the patient with managing the therapist's display. A steadier response is to reduce competing demands, orient the body comfortably, listen, and check meaning when the signal is ambiguous.

The patient's control over distance can increase agency. They choose where to sit, may have familiar objects nearby, and can sometimes tolerate difficult material because leaving the clinician's office is no longer an immediate task. Simpson and colleagues argue that video may permit distinctive forms of intimacy and self-expression rather than only approximating the consulting room (Simpson et al., 2021). That possibility should be explored, not romanticized. Home can be regulating, exposing, crowded, or unsafe.

A short opening conversation about presence can prevent silent misattribution. The therapist may say that brief downward glances are for notes, ask how interruptions should be handled, and invite the patient to identify moments when the clinician seems absent. Such statements do not guarantee attunement. They make the frame discussable. In remote work, the ability to speak about the channel is part of the channel's reliability.

V. THE CAMERA FRAME, GAZE, AND THE PARTIAL BODY

Video offers more nonverbal information than telephone care and less than a shared room. The clinician may see face and shoulders clearly but not hands, legs, gait, posture changes, self-soothing movements, or how the patient enters and leaves. Camera position can enlarge the face or place it at an angle; lighting can flatten expression; compression can erase tears. The image is evidence, but it is selected and technologically transformed evidence.

Apparent eye contact is structurally misaligned. Looking at the patient's eyes on screen usually means not looking into the camera, while looking into the camera reduces access to the patient's moment-to-moment expression. Rees and Stone found that strong alliance could nevertheless develop in psychotherapy by videoconference, but their work does not make optical gaze irrelevant (Rees & Stone, 2005). Clinicians can alternate naturally rather than trying to hold a camera stare that feels attentive to one person and oddly fixed to the other.

Self-view adds a mirror that is absent from ordinary office work. Some people use it to orient themselves; others monitor appearance, expression, or performance and become less available for contact. Therapists are not immune. Hiding self-view can reduce divided attention, but it should be offered rather than prescribed. A patient with dissociation, social anxiety, body-image disturbance, or a need to verify what is visible may experience the option differently. The therapeutic question is what the small image is doing in this session.

Framing should be negotiated with dignity. Requesting that more of the body be visible may help particular experiential work, yet it can also feel intrusive and may reveal the home. The reason needs to be explained, alternatives offered, and refusal accepted. When movement occurs outside the frame, a tentative observation is preferable to a confident reading: 'I noticed the picture shift and wondered what happened for you just then.' The aim is curiosity without surveillance.

VI. SILENCE, LAG, AND TURN-TAKING

Silence in psychotherapy is never one thing. It may hold reflection, withdrawal, grief, resistance, regulation, anger, uncertainty, or simply the need to find language. Video adds further possibilities: muted sound, unstable bandwidth, frozen image, competing noise, or doubt about whose turn it is. A therapist who treats every pause as a technical failure will interrupt important work; one who treats every frozen connection as meaningful silence risks a different kind of error.

Even modest lag changes turn-taking. Both people may begin, stop, apologize, and yield, producing a politeness loop that fragments emotional speech. Markowitz and colleagues noted that remote psychotherapy requires adjustments in

timing and attention rather than simple transfer of office habits (Markowitz et al., 2021). Slowing slightly helps, but the more important skill is repair: name the overlap, restore the patient's thread, and avoid converting recurrent technical interruption into a judgment about engagement.

Silence becomes safer when its frame is explicit. Early in treatment the clinician can ask how pauses usually feel and agree on a way to check the connection, such as a brief verbal confirmation after an unusually long stillness. When affect is high, the therapist may say, 'I am here, and I will give you time,' then remain quiet. This communicates presence without demanding speech. If the image has frozen, the same words may never arrive; a backup telephone plan remains necessary.

The clinician's own discomfort deserves supervision. Screen silence can evoke urgency because the therapist cannot feel the other person's bodily presence in the room. Filling the gap may relieve the clinician while depriving the patient of thought. Conversely, idealizing silence can conceal disengagement. The question is not whether silence is good, but whether therapist and patient can discover what this silence is doing and whether the medium is allowing them to know enough.

VII. ALLIANCE, MISATTUNEMENT, AND REPAIR

Reviews of videoconferencing psychotherapy generally support the possibility of a strong therapeutic alliance (Norwood et al., 2018; Simpson & Reid, 2014). Earlier comparative and online work also found that working relationships could be established across technological mediation (Cook & Doyle, 2002; Day & Schneider, 2002). These studies counter a categorical objection to remote therapy. They do not imply that alliance looks identical, or that a high rating protects against every moment of disconnection.

Video-specific ruptures are often small and cumulative. The therapist may repeatedly look at a second screen, appear to type while the patient speaks, fail to notice that audio has dropped, or continue after the patient has moved into obvious distraction. The patient may protect the relationship by saying the format is fine. Therapists can make complaint easier by asking about concrete moments: when did I seem far away, what was it like when the connection failed, and was anything harder to say here than it would have been in a room?

Repair requires ownership without technological fatalism. If the clinician missed a change because the camera did not show it, the response is not 'video makes this impossible.' It is to acknowledge the miss, invite the patient's experience, and decide whether the frame or format should change. If the patient felt abandoned during a dropped connection, explaining the network failure may be necessary but insufficient. The emotional event also belongs to the therapy

and may connect with, without being reduced to, earlier expectations of absence.

Alliance is assessed in both directions. A therapist who feels ineffective on video may become overstructured or overly reassuring; a patient who feels less watched may become more candid or more avoidant. Provider attitudes tend to become more favorable with experience, although technical burden and perceived impersonality persist (Connolly et al., 2020). Experience should support reflective adaptation, not an assumption that familiarity has solved the patient's particular difficulty.

Table 2. Ambiguous remote-session events and possible repairs

Observable event	Plausible meanings	Repairing inquiry
Long still pause	Reflection, withdrawal, freezing, audio failure	Check connection once; then ask how the pause was experienced
Repeated gaze away	Thinking, notes, notifications, another person nearby	Name what was observed and clarify the therapist's own gaze behavior
Talking over one another	Lag, urgency, competition, unfamiliar rhythm	Restore the interrupted thread before interpreting the pattern
Camera switched off	Privacy, fatigue, shame, bandwidth, protest	Ask about function and choice; do not equate visibility with cooperation
Abrupt disconnection	Technical failure plus possible experience of abandonment	Use the backup plan, acknowledge impact, and review prevention

VIII. PRIVACY, THE HOME, AND THE THERAPEUTIC BOUNDARY

An encrypted platform cannot create privacy in a room. The therapist needs to know who may enter, who can overhear, whether headphones are available, and whether the patient can speak without later consequences. Professional telepsychology guidance emphasizes competence, informed consent, confidentiality, security, and attention to interjurisdictional practice (Joint Task Force for the Development of Telepsychology Guidelines for Psychologists, 2013). These are not one-time administrative statements. A patient's privacy conditions can change during treatment or within a single session.

The home is not neutral background. Photographs, possessions, children, animals, and interruptions can provide information and invite assumptions. The therapist may also disclose more than intended through books, household sounds, or other people entering. Ethical reviews of online psychotherapy identify confidentiality, data security, competence, emergencies, and boundaries as recurring concerns (Stoll et al., 2020). A professional background blur may protect privacy, but it can also make movement visually

unstable or communicate distance. The choice should be purposeful.

Recording requires explicit, specific consent and a legitimate clinical or supervisory purpose. Platform capability is not permission. Both parties should understand who records, where the file is stored, who can access it, when it will be deleted, and whether consent can be withdrawn. Screen capture by another person may be impossible to prevent fully; this limitation belongs in informed discussion. Ordinary sessions should not be recorded merely because remote technology makes it easy.

Third-party presence needs equally explicit handling. A partner, parent, interpreter, carer, trainee, or colleague should not drift into a session because the technology makes entry easy. The therapist clarifies who is present, why their participation may help, what information may be discussed, and when the patient can speak alone. Consent is revisited if another person appears or remains just outside the camera view. Children and dependent adults may create unavoidable interruptions; a humane response distinguishes an ordinary household event from a setting in which candor or safety is no longer possible. Ethical responsibility lies in making the participation and its limits visible, not in pretending that a cropped frame proves privacy (Joint Task Force for the Development of Telepsychology Guidelines for Psychologists, 2013; Stoll et al., 2020).

Boundaries also concern time and place. Joining from bed, a parked car, a workplace, or while walking may have different meanings and safety implications. A rigid ban can exclude care; unlimited flexibility can erode the conditions for attention. The clinician explains what the work requires, asks what is realistically available, and agrees on a minimum viable setting. If that setting cannot be achieved, telephone, clinic space, another service location, or in-person work may be safer.

IX. A DELIBERATE OPENING AND CLOSING

Office routines help mark entry into therapy: travel, a waiting room, a door, and the shared act of sitting down. Video often removes these transitions. A patient may move from a work call into psychotherapy in seconds and return to caregiving immediately afterward. The clinician can restore some boundary through a consistent opening that confirms identity, location, privacy, connection quality, and the plan if contact fails, without making every session sound like an emergency checklist.

The visual and auditory field should be reviewed together. Each person confirms that the other's speech is intelligible, that important facial information is visible, and that notifications are silenced where possible. The patient should know whether the therapist is taking notes and where to look if self-view is distracting. These small acts reduce interpretive

noise. They also demonstrate that the medium can be discussed openly rather than endured politely.

Closing requires enough time to assess state, reconnect the patient with the physical environment, and decide what follows. This matters after trauma work, intense affect, dissociation, or disclosure of risk. Ending because the software countdown reaches zero can feel abrupt even when the appointment time was clear. A visible clock and a verbal time marker help. The therapist should know whether the patient will be alone, driving, returning to work, or caring for someone immediately after the call.

A brief transition practice can be collaborative rather than ritualized. Some patients need several quiet minutes, movement, water, a written note, or contact with a support person; others dislike prescribed grounding. The clinician asks what returns attention to the present and what is feasible in that location. The objective is not to simulate a corridor outside the consulting room. It is to prevent the remote session from ending while the patient remains psychologically stranded.

A two-minute remote-session frame check

- Confirm the patient's current location and a callable number.
- Ask who can hear, enter, or view the screen; revisit this after interruptions.
- Agree what each person will do if audio or video fails.
- Name note-taking, gaze, recording status, and any visible distraction.
- Protect several closing minutes and clarify the patient's immediate transition.
- Document material limits and change format when the minimum safe frame is absent.

X. RISK ASSESSMENT AND EMERGENCY PLANNING

Remote care does not remove ordinary responsibilities for risk assessment; it changes how help can be mobilized. At the start of treatment, the clinician needs the patient's physical location, a reliable callback number, local emergency pathways, and an emergency contact where appropriate. Best-practice guidance for videoconferencing-based telemental health recommends explicit procedures for emergencies and local collaboration (Shore et al., 2018). The plan must fit the jurisdiction and service, not remain a generic paragraph in a consent form.

Risk conversations should remain clinical rather than theatrical. Asking about suicidal thought, intent, planning, means, recent behavior, intoxication, violence, safeguarding, and protective factors is no less direct on video. What changes is the observational field and the clinician's control of the environment. A camera cannot establish that the patient is alone, show every means in the room, or guarantee that the stated location is current. Uncertainty should be recorded and managed, not disguised by confident visual interpretation.

If risk escalates, preserving connection may be as important as collecting information. The therapist explains actions when possible, keeps the patient engaged, and coordinates local support according to the agreed plan and applicable law. Evidence-based telepsychiatry guidance produced during COVID-19 emphasizes preparation for technology, information governance, and safety rather than assuming that clinical competence transfers automatically online (Smith et al., 2020). A failed connection during acute risk requires an immediate, rehearsed response.

Video may be inappropriate temporarily or persistently when privacy is coerced, location is unknown, intoxication prevents meaningful participation, medical instability is possible, or emergency assistance cannot be arranged. This is not a judgment about the patient's suitability for psychotherapy. It is a decision about the present setting. Changing to in-person assessment, involving emergency or safeguarding services, or pausing a particular intervention can protect treatment rather than represent its failure.

XI. ACCESS, EXCLUSION, AND DIGITAL INEQUALITY

Video can remove travel, mobility, geography, caregiving, and infectious-disease barriers. It can connect patients with specialists who are unavailable locally and preserve continuity through relocation or illness. These benefits help explain long-standing interest in telemental health and its feasibility across settings (Hilty et al., 2013). Access, however, is not the same as availability. A service is not accessible if it requires a private room, stable broadband, an unaffordable data plan, unfamiliar software, or a device the patient does not control.

Digital exclusion follows existing inequality. Housing insecurity, poverty, rural infrastructure, disability, language, age, cognitive difficulty, and surveillance by family or employers can all affect participation. The pandemic made remote care essential while also revealing these differences. Wind and colleagues described the crisis as a forced opening for digital mental health, but rapid adoption should not be mistaken for equitable implementation (Wind et al., 2020). A clinic that closes its physical door after discovering video efficiency may transfer cost and risk to patients.

Accessibility adaptations need individual testing. Captions can assist hearing and processing but may introduce errors or distract from expression. Larger displays, screen readers, written agendas, simplified login, support with setup, or telephone audio alongside video may help. Some patients communicate more effectively without constant visual demand. The clinician asks which channel supports comprehension and expression rather than treating maximum audiovisual information as universally best.

Usability should be assessed from the patient's side of the connection. A successful staff test on fast broadband does not show that instructions are legible on an older telephone, that a

captioner identifies clinical language accurately, or that repeated authentication is manageable during distress. A brief practice connection can reveal audio delay, data cost, visual overload, and the amount of assistance being supplied by someone else. Services should offer a reachable person for setup and a low-burden alternative when the platform fails. These arrangements are part of treatment access, not favors granted to a patient who is supposedly poor with technology. Feasibility reviews support remote care across settings, but they also show why infrastructure and local context belong in implementation decisions (Hilty et al., 2013).

Choice must be more than nominal. If the only in-person appointment requires months of delay, a patient's acceptance of video does not necessarily indicate preference. Services should record practical reasons for format decisions and review them as circumstances change. Equity sometimes supports remote provision and sometimes requires a room, equipment, interpreter, or face-to-face option. The relevant outcome is usable care, not the proportion of appointments converted to video.

Table 3. Potential gains and exclusions in video psychotherapy

Domain	Possible gain	Possible exclusion	Clinical response
Geography	Specialist care without travel	Poor rural connectivity	Test bandwidth and retain telephone or local-room alternatives
Mobility and health	Care from an accessible location	Fatigue, positioning, inaccessible software	Adapt duration, interface, and input method
Home	Familiarity and fewer transitions	Crowding, abuse, surveillance, no confidential space	Assess privacy each time and offer another setting
Communication	Captions, chat, shared documents	Caption errors, overload, literacy or language barriers	Select channels collaboratively and provide interpretation
Cost and time	Reduced travel and missed work	Data, device, heating, and unpaid setup costs	Do not describe transferred costs as savings without asking

XII. ADAPTING TECHNIQUE WITHOUT LOSING ITS PURPOSE

A treatment should be adapted at the level of function, not copied mechanically. In cognitive-behavioral work, shared documents, exposure planning, and behavioral review can translate well, which is consistent with the structured interventions represented in video evidence (Berryhill et al., 2019b; Fernandez et al., 2021). Yet an exposure conducted at home may involve different cues and safety behaviors than one in a clinic. The therapist specifies the learning objective and checks whether the remote arrangement preserves it.

Experiential and trauma-focused methods require attention to bodily visibility, dissociation, and post-session containment. Evidence supports synchronous remote interventions for post-traumatic stress, but studies do not erase the need for selection and adaptation (Varker et al., 2019). The clinician may shorten an exercise, increase orientation to the room, agree on a signal to pause, or schedule an in-person component. Reducing intensity is not always safer if it leaves emotionally activated material unfinished; planning matters more than reflexive caution.

Psychodynamic and relational work may use the altered frame itself. What does it mean that the therapist appears in the patient's home, can be closed with a click, or is never encountered as a whole body? These questions can illuminate experience, but not every technical event is symbolic. Simpson and colleagues warn against assuming a depleted relationship and invite attention to novel forms of connection (Simpson et al., 2021). Interpretation should follow inquiry into the actual medium and circumstances.

Technique also changes when clinician and patient do not share the same materials or sensory field. A drawing, object, worksheet, medication packet, or written message may be held toward a camera yet remain unreadable; a therapist may believe that an instruction was demonstrated when the patient saw only a reversed or blurred image. Screen sharing can improve precision but can also displace attention from the person and expose unrelated information. The clinician states the purpose of the task, checks what was actually seen, and returns explicitly to the interpersonal exchange afterward. If a method depends on observation that the camera cannot provide, fidelity may require another angle, a local co-clinician, an in-person component, or a different intervention rather than confident improvisation. Adaptation is defensible when function is preserved and its limits are named (Fernandez et al., 2021; Smith et al., 2020).

Group work introduces multiple homes, unequal screen positions, private chat, uncertain listening, and greater difficulty reading who wants to speak. Weinberg identifies challenges involving cohesion, presence, confidentiality, and leadership in online groups (Weinberg, 2020). Clear turn-taking and privacy agreements help, but they can also make interaction rigid. A group should be designed for the medium, with co-facilitation and smaller size considered where clinically and practically justified.

XIII. THERAPIST FATIGUE, COMPETENCE, AND THE USE OF SELF

Remote competence includes more than learning the platform. The therapist must manage a narrower perceptual field, maintain attention despite self-view and notifications, respond to technical failure, and understand how their own home or office enters the relationship. Professional guidance

treats competence as an ongoing obligation, including knowledge of technology and its limits (Joint Task Force for the Development of Telepsychology Guidelines for Psychologists, 2013). Training should therefore include observed practice, ethical scenarios, and supervision of video-specific process.

Screen fatigue may alter clinical behavior before it is consciously noticed. The therapist may shorten silence, rely on familiar formulations, stare rigidly, or miss subtle affect late in the day. Rapid pandemic conversion generated professional self-doubt and required therapists to renegotiate their sense of competence (Aafjes-van Doorn et al., 2021). Scheduling, breaks, display arrangement, lighting, posture, and limiting unnecessary self-view are not wellness decorations; they protect the capacity to attend.

Therapist attitudes influence what patients are offered. A systematic review found overall positive provider attitudes alongside concerns about technology, workload, impersonality, and alliance, with experience often improving acceptance (Connolly et al., 2020). Neither enthusiasm nor reluctance should decide alone. A clinician who prefers video may underrecognize privacy or embodiment problems; one who dislikes it may withhold an accessible, effective option. Supervision can examine preference as clinical information rather than neutral fact.

Technical fluency must coexist with humility. The therapist should be able to troubleshoot common problems but need not turn the session into unpaid information-technology support. Services require administrative and technical systems around the clinician. When infrastructure is unreliable, repeated failures can injure trust even if the therapist responds empathically. Competence includes recognizing when the organization, rather than the patient or therapist, is making safe psychotherapy impossible. It also includes documenting recurrent failures and advocating for repair, because a warm apology cannot substitute indefinitely for a dependable clinical system.

XIV. HYBRID CARE AND THE RIGHT TO CHANGE FORMAT

The choice need not be permanently binary. A patient may begin remotely, meet in person for assessment or a particular intervention, return to video during travel, and use telephone when bandwidth fails. Hybrid care can follow clinical purpose rather than convenience alone. Smith and colleagues anticipated telepsychiatry as a parallel and complementary mode, while noting that guidance and evidence for combinations remained incomplete (Smith et al., 2020). The absence of a proven ideal ratio argues for monitored flexibility, not arbitrary alternation.

Format changes carry meaning. A request to meet in person may express a need for safety, seriousness, privacy, or fuller

bodily contact; a request for video may express accessibility, autonomy, avoidance, or simple practicality. The clinician explores these possibilities without making the patient defend convenience. If avoidance is plausible, it can be formulated and tested. Requiring burdensome travel to prove commitment is not a therapeutic experiment.

Pandemic-era surveys showed that therapists' attitudes toward online work were related to prior experience and their view of the therapeutic relationship (Békés & Aafjes-van Doorn, 2020). As emergency conditions recede, the profession should retain what was learned without turning necessity into doctrine. Patients who managed video during lockdown may still prefer in-person care; others may have discovered that distance supports candor or continuity. Consent is renewed when real alternatives become available.

The first meeting after a format change deserves particular attention. A patient known only as a head-and-shoulders image may experience the clinician's height, room, distance, or ordinary movements as unexpectedly intimate; moving online after office work can produce an opposite sense of reduction or relief. These reactions are neither proof that one setting is authentic nor evidence of pathology. They are new information about how proximity, control, and embodiment affect the work. The clinician names the transition, asks what feels different, and checks whether prior agreements about silence, note-taking, privacy, and endings still fit. Continuity resides in a relationship that can think about the change, not in making two settings look identical (Simpson et al., 2021).

A format review can be scheduled rather than waiting for failure. Clinician and patient consider attendance, symptom change, alliance, privacy, fatigue, missed cues, intervention fidelity, cost, and preference. Any change is documented with its rationale and contingency plan. The goal is not loyalty to a medium. It is a stable enough frame for the work, combined with permission to revise that frame when evidence from the treatment indicates a better one.

XV. LIMITATIONS

This is a narrative review rather than a systematic review, and source selection was shaped by the clinical focus on communication. The underlying evidence includes heterogeneous diagnoses, interventions, technologies, comparison conditions, and outcome measures. Backhaus and colleagues' early review and later meta-analyses span different periods of hardware and practice, making direct synthesis difficult (Backhaus et al., 2012; Batastini et al., 2021). Technical conditions studied a decade ago may differ from current platforms while human concerns about privacy and absence remain.

Aggregate outcome findings are strongest for selected populations and commonly structured treatments. Fernandez and colleagues found encouraging overall effects but also

evidence of heterogeneity and publication bias (Fernandez et al., 2021). Alliance reviews depend heavily on self-report and small studies (Norwood et al., 2018; Simpson & Reid, 2014). There is less evidence about complex risk, long-term psychodynamic treatment, couples, families, groups, severe mental illness, cognitive disability, and people who lack stable private access.

The pandemic literature often describes abrupt transitions under exceptional conditions. Therapist uncertainty, patient gratitude for continuity, fear of infection, and lack of alternatives may all affect reported experience. Findings from emergency remote practice should not be treated as pure tests of a mature service model. Conversely, pre-pandemic studies may involve unusually motivated clinicians and selected patients. Both directions of selection limit generalization.

Research needs process measures sensitive to video: repair after lag, gaze and attention, silence, off-screen activity, privacy, fatigue, accessibility, dropout, and reasons for switching format. Trials should report technology, setting, therapist training, adverse events, equity variables, and whether participants had a meaningful choice. Qualitative work should include people who declined or could not sustain video, not only those who completed it. Until then, careful individual monitoring remains more defensible than universal claims.

XVI. CONCLUSION

Video psychotherapy can support substantial clinical improvement and a strong therapeutic alliance. Its legitimacy no longer depends on pretending that it reproduces the office perfectly. The medium creates a different perceptual and interpersonal field: gaze is approximate, bodies are partial, silence is more ambiguous, homes become part of the frame, and technical failure can acquire emotional consequence. Skilled practice begins by making those changes speakable.

The clinician's task is to preserve purpose while adapting form. That requires an explicit agreement about privacy, location, emergencies, recording, failed connections, and endings; tentative use of nonverbal observations; active repair of interruption and misattunement; and honest review of whether the treatment method still works through the channel. Access gains must be weighed against digital inequality and the absence of a safe room.

The most clinically useful question is not whether video is equal to in-person psychotherapy in the abstract. It is whether this patient and therapist can do this work safely, attentively, and meaningfully in this setting now. A defensible service offers video as real psychotherapy, supports competence and infrastructure, measures what matters, and retains a genuine route to telephone, hybrid, local, or in-person care when the communication requires it.

That judgment should remain open to revision.

XVII. CONFLICTS OF INTEREST AND DISCLOSURES

Conflicts of interest—The author developed and writes about Communication-Focused Therapy (CFT). Where CFT is discussed, it is presented as a formulation perspective and not as a substitute for established assessment, evidence-based treatment, or independent replication. No other conflict of interest was reported.

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Patient material—No identifiable patient material is presented. Any brief examples are generic composites created to illustrate clinical reasoning and are not case reports.

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