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The Effectiveness of Online vs Face-to-Face Psychotherapy During the COVID-19 Pandemic in the United Arab Emirates

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Abstract
The COVID-19 pandemic caused an abrupt and immediate change to the way in which mental health services are delivered. To mitigate against lockdown protocols imposed on a global scale, many individuals seeking mental health services were obliged to use online mental health services in place of face-to-face services. The study reported here investigated the differences in individuals' experiences of online psychotherapy sessions compared to in-person psychotherapy services using a cross-sectional, within groups design. Forty-nine clients from a mental health clinic in the UAE, who received psychotherapy in both modalities, completed self-report questionnaires measuring satisfaction with therapy and working alliance. Results indicate that clients' satisfaction levels did not significantly differ between online and in-person therapy sessions. However, clients rated their perceived working alliance with their therapist for in-person therapy sessions significantly higher than for online therapy sessions. Implications for future research are discussed.

Keywords: Teletherapy, COVID-19, in-person therapy, therapeutic relationship, working alliance

Introduction
On January 30th, 2020 the World Health Organization (WHO) declared the 2019 SARS- Coronavirus (COVID-19) outbreak an international public health emergency. In addition to its high rate of infectivity and fatality, COVID-19 induced a universal psychosocial catastrophe (Dubey et al., 2020). Because of the pandemic, unanticipated and multidimensional changes in livelihood were imposed on a global scale (Humer & Probst, 2020). Other than fears of infection and further spreading of the virus, emotional distress was manifested in many ways that negatively impacted mental health. WHO defines mental health as an individual's state of emotional, psychological, and social wellbeing whereby they actualize their capability to confront normative stressors. Considering the pandemic, these components of mental health have become primary public health concerns throughout the world (Khan et al., 2020).

The disruption of daily habits and interpersonal relationships, unemployment, separation from work and social environments, economic hardship, and misinformation about the virus spread throughout the media, are just some of the consequences that people of all ages were forced to navigate (Savarese et al., 2020). The emotional turmoil resulting from the consequences of the pandemic included anger, anxiety, depression, paranoia, loneliness, stress, frustration, existential fears, irritability, and symptoms of posttraumatic stress disorder (Humer & Probst, 2020 ; Osofsky et al., 2020 ; Talevi et al., 2020). Indeed, research indicates that the countermeasures undertaken to combat the virus, including national lockdowns, social distancing, and quarantine protocols, together with frequent hand sanitization, are unfamiliar stressors that invoked numerous psychological burdens and exacerbated existing ones (Probst et al., 2020). Moreover, factors such as scarcity of basic supplies, loss of social identity, financial losses, involuntary confinement with family members, and unhealthy consumption of news and media, had a compounded effect on the overarching sense of unusual sadness, helplessness, and loss of control (Pfefferbaum & North, 2020). In some cases, maladaptive behavioural symptoms such as alcohol and drug abuse, self-harm or suicidal tendencies, together with increased rates of domestic violence, were also reported as outcomes of unsuccessful attempts in coping with feelings of severe distress (Kumar & Nayar, 2021).

While the outbreak of COVID-19 posed a variety of mental health challenges, it also created hindrances concerning access to mental health services such as psychotherapy (Humer & Probst, 2020). Considering the adversities that many individuals experienced, psychotherapy was seen as an essential response to the pandemic (Swartz, 2020), as psychotherapy places important emphasis on mental wellbeing such as resilience, social stability, finding meaning in life, and navigating significant life changes (Li et al., 2020 ; Osofsky et al., 2020).

To provide mental healthcare services whilst trying to reduce the risk of transmitting COVID-19 between clients and therapists, in-person therapy sessions were replaced by remote therapy sessions (Humer & Probst, 2020) using online platforms such as Skype, Zoom, and Facetime (Markowitz et al., 2020). Moreover, the adjustment of in-therapy to a remote platform increased its accessibility. Thus, providers were able to offer individuals a means for obtaining mental healthcare for concerns related to the pandemic (or otherwise), irrespective of either the therapists' or clients' geographical location. The adjustment to a remote platform also allowed for individuals to continue with their on-going treatment (Humer & Probst, 2020). Research indicates mixed consensus regarding the success of this change, which posed both challenges and benefits for those receiving therapy (Boldrini et al., 2020).

Firstly, where challenges are concerned, therapy sessions conducted online were perceived by some clients as an invasion of privacy (Crowe, 2020). Those concerned with their outward appearance had reservations in allowing their therapists to see them in their home environment. Research indicates that these include individuals who may be mistrustful or ashamed of their living situations, home interiors and even their families (Markowitz et al., 2020). Another aspect of client confidentiality includes discretion from people other than their therapist. For example, clients who lived with their families, or in other forms of shared living arrangements, often found it difficult to find a space free of interruptions or risk of being overheard (Crowe, 2020). Some individuals resorted to their cars whilst others used their bathrooms, corridors, and staircases to maintain discretion while discussing sensitive information with their therapists (Markowitz et al., 2020). Indeed, the concern of being overheard was prevalent even in cases where family members were aware and supportive of the therapy being undertaken (Burgoyne, 2020). On the contrary, online therapy can also improve session outcomes for client groups who find in-person sessions overwhelming. For example, individuals with anxiety-based disorders, such as social anxiety disorder, obsessive-compulsive disorder, and agoraphobia exhibited lower levels of arousal in the context of online therapy. This could be seen because of clients viewing teletherapy as less threatening, therefore providing a sense of safety and comfort compared to face-to-face therapy (Reynolds et al., 2013). Another observed negative consequence of online therapy was the elimination of the ritualistic preparation and processing elements that clients experience while commuting to and from their therapy sessions. Previously, the change of setting from their usual environment to the therapist's office would serve as an important transitional period where individuals could reflect on the content discussed during therapy sessions (Crowe, 2020).

The importance of therapeutic relationships has been well-grounded in the literature. It has been conceptualized and measured in many ways, with the most favored construct being the working alliance. Working alliance is defined as the collaboration and emotional connection that exists between a client and their therapist (Horvath & Luborsky, 1993).

According to (Bordin, 1979), working alliance consists of three elements: The Bond (the degree of mutual trust and acceptance), the Task (the agreement of treatment tasks) and the Goal (the agreement of therapeutic goals between the therapist and the client). Indeed, working alliance has been the construct most associated with positive outcomes in psychotherapy with client ratings of working alliance one of the most researched measures in psychotherapy (Horvath et al., 2011).

With issues concerning the establishment of the therapeutic relationship online (Knaevelsrud & Maercker, 2006), numerous empirical studies over the past two decades have attempted to understand the dynamic of the online working alliance compared to the traditional face-to-face working alliance. (Cook & Doyle, 2002), were amongst the first to evaluate this relationship and found ratings of the therapeutic alliance to be significantly higher for clients who received therapy online compared to those who received therapy face-to-face. However, (Preschl et al., 2011) reported no significant differences in alliance between online versus face-to-face therapy and concluded that online therapy was as effective as face-to-face therapy. On the contrary, (Rotger et al., 2022) found that treatments conducted face-to-face revealed significantly higher scores of therapeutic alliance compared to treatments conducted online. Research also indicates weaker scores of both, working alliance and online treatment satisfaction, although the sample of this study predominantly included Caucasian females, and therefore restricts its generalizability (Leibert et al., 2006). Additionally, results of study conducted by (Knaevelsrud & Maercker, 2006) indicate that although it is possible to establish a stable and positive therapeutic relationship online, working alliance is a less relevant predictor of the treatment outcome compared to in-person therapy sessions. Furthermore, a systemic review revealed that therapeutic alliance was directly associated with clinical outcomes in online CBT treatment for depression and anxiety disorders (Pihlaja et al., 2018). Similarly, a meta analysis by (Kaiser et al., 2021) found that therapeutic alliance was significantly related to clinical outcomes in teletherapy settings. More recently, and possibly more importantly, research on clients' views of therapy conducted during the pandemic in 2020 regarding working alliances revealed stronger associations for working alliance in online therapy compared to in-person therapy (Watts et al., 2020).

In the context of the COVID-19 pandemic, and considering the mixed results reported so far, research in the United Arab Emirates (hereafter UAE) specifically is scarce, there is a plausible need for empirical data on this issue considering the need for mental health support is increasing within the country. Research by (Thomas & Terry, 2022) conducted during the early months of lockdown in the UAE revealed high prevalence rates of mental illness, particularly symptoms of depression and anxiety disorders. Additionally, (Cheikh Ismail et al., 2021) highlighted the increase in demand for psychotherapy in the UAE by measuring negative mental health impacts, impacts on social and family support, and mental health related lifestyle changes because of the pandemic. Similarly, a lifetime prevalence for depression disorders of 2.8% and 10.3% for

males and females, respectively has been recorded in a UAE-based psychiatric survey of 1669 Emirati households (Abou-Saleh et al., 2001). Considering these prevalence rates and the challenges that online therapy can pose, investigating clients' experiences of online psychotherapy in the UAE is important in helping to recognize and tackle the barriers that online therapy holds for the future of mental health services.

Accordingly, the present study aimed to evaluate the differences between clients' experiences of online therapy sessions compared to in-person sessions, in the UAE. Specifically, the study will focus on clients' satisfaction and their perceived level of working alliance with their therapists. Because findings using therapy patients as participants in the UAE is scarce, the study reported here proposes the following hypotheses:

Hypothesis 1: Clients will express a lower level of satisfaction in online therapy sessions compared to in-person.

Hypothesis 2: Clients will report a lower score of perceived working alliance with their therapist, in online therapy sessions compared to in-person.

Hypothesis 3: Clients will rate a lower score of "bond" an element of working alliance, in online therapy sessions compared to in-person.

Method
Design
This study implemented a cross-sectional, within groups design with one independent variable with two levels: Mode of therapy (online/face to face), and two dependent variables: satisfaction of therapy, and perceived working alliance. Ethical approval for this study was granted by the School of Social Sciences Ethics Committee at a local university.

Participants
The sample consisted of ($N = 60$) clients from the Human Relations Institute and Clinics in the UAE. Three participants completed the questionnaire in person and while 54 participants completed the questionnaire online. Ten participants failed to complete the questionnaire and were excluded from the study and one participant was under-aged and data from these participants were excluded from the study. The final sample consisted of 49 participants ($n = 32$) were female, ($n = 16$) were male, and ($n = 1$) identified as non-binary.

Procedure
Participants received a link via email to the questionnaire that was created on SurveyMonkey. The questionnaire consisted of an information sheet and informed consent for the study. After consenting to the study by opting 'yes' on the informed consent page, participants were directed to the next page which consisted of the questionnaire. The questionnaire took a total of 15 minutes to complete. Upon completion, participants were directed to a debriefing page and thanked for their time. Participants who completed the questionnaire in-person were given hard copies of the questionnaire and asked to complete it

in a quiet room. Hard copies of the questionnaires had identifier numbers corresponding to those on the consent forms.

Materials
Demographics: All participants in the study were asked about their demographic details such as age, gender, and mode of receiving therapy.

Satisfaction with Therapy and Therapist Scale - Revised (Oei et al., 2008):
The 13-item questionnaire measures client's satisfaction with their therapeutic treatment and therapist and consists of two subscales: Satisfaction with Therapy (e.g., 'I am satisfied with the quality of the therapy I received') and Satisfaction with Therapist (e.g., 'The therapist listened to what I was trying to get across'). Responses used a 5-point Likert Scale ranging from 'Strongly Disagree' (1) to 'Strongly Agree' (5). Measures of reliability for both factors are high (for Satisfaction With Therapy, .90; for Satisfaction With Therapist, .89). Similarly, the Cronbach's alpha for the total scale ($\alpha = .93$) was high, which indicates good internal consistency of the combined subscales (Oei et al., 2008).

Working Alliance Inventory–Short Form Revised (Hatcher & Gillaspy, 2006):
This questionnaire was used to measure client's ratings of working alliance with their therapist. Items of the WAI-SRT are constructed so that four items correspond to quality of therapeutic bond (e.g. 5. 'My therapist and I respect each other.') and three items correspond to agreement on tasks (e.g. 'My therapist and I agree on what is important for me to work on.'), and agreement on goals (e.g. 'My therapist and I are working towards mutually agreed upon goals.') respectively. The WAI-SR was measured using a 5-point Likert scale ranging from 'Never' (1) to 'Always' (5). The WAI-SR revealed high internal consistency; Cronbach's alpha value of the subdomains ranges from $\alpha = .81$ to $\alpha = .90$, and Cronbach's alpha value of the total score is $\alpha = .95$ (Hatcher & Gillaspy, 2006).

Results
Descriptive statistics of clients' satisfaction level, their perceived working alliance with their therapist, and their bond score as an element of working alliance in both modes (in-person and online) are shown in Table 1.

Since we had a small sample size, determining the distribution of the 3 variables, clients' satisfaction level, their perceived working alliance with their therapist, and their bond score, was important for choosing an appropriate statistical method. Therefore, Shapiro-Wilk tests were performed and showed that the distribution of these variables departed significantly from normality $ps<0.05$.

Based on this outcome, a non-parametric Wilcoxon signed-rank tests was used to determine whether there were significant differences in the clients' satisfaction level, their perceived working alliance with their therapist, and their bond score

when clients were receiving online therapy compared to when receiving in-person therapy sessions.

The results showed that clients' satisfaction levels did not significantly differ in online and in-person therapy sessions ($Z = -0.808$, $p = 0.419$). The median of clients' satisfaction levels for online therapy was 57, and for in-person therapy sessions was 58.

Similarly, clients' bond scores did not significantly differ in online and in-person therapy sessions ($Z = -1.732$, $p = 0.083$), where the medians of clients' bond scores for both online and in-person were 4.

However, a significant difference between clients' perceived working alliance with their therapist in online and in-person therapy sessions ($Z = -4.376$, $p < 0.001$) was found. The median clients' perceived working alliance with their therapist for online therapy was 45 and for in-person therapy was 47.

	LQ	Median	Upper Quartile	Mode
In-person satisfaction	54.00	58.00	60.00	60.00
Online satisfaction	53.50	57.00	59.00	60.00
In-person Working Alliance	43.50	47.00	48.00	48.00
Online Working Alliance	41.50	45.00	47.50	48.00
In-person 'bond'	4.00	4.00	5.00	4.00
Online 'bond'	4.00	4.00	5.00	4.00

Table 1: For each variable, Lower Quartile (LQ), Median, Upper Quartile (UQ) and Mood are shown.

Discussion

This study evaluated the differences between clients' experiences of online therapy sessions compared to in-person sessions in the UAE and hypothesized that clients would express lower levels of satisfaction with online therapy sessions compared to in-person. The results of this study, however, do not support our hypothesis. Indeed, the findings reported here indicate similar levels of client satisfaction for both online and in-person therapy and lend support to the notion that online therapy is as effective as in-person therapy (Preschl et al., 2011) from a different cultural perspective and during a different period, specifically the Covid-19 pandemic. Indeed, the fact that this study was conducted during the pandemic in a new cultural context (UAE) may have influenced the results reported here. It may be that those requiring psychological support during the unprecedented time may have valued and been satisfied with psychotherapy regardless of its mode of delivery.

We also hypothesized that clients would report lower scores of perceived working alliance with their therapist for online therapy sessions compared to in-person therapy sessions. Our findings supported this hypothesis but are in contrast to previous research stating that online therapy sessions yield similar scores for working alliance to in-person therapy sessions (Preschl et al., 2011). One factor that may explain this result is the consideration that it may have been the first time that clients accessed mental health support in general, and the virtual nature of the therapy sessions might have made it more difficult for clients to engage with their therapist. This could have contributed to lower scores for working alliance for online clients.

We also hypothesized that the 'bond' element of the working alliance would have lower scores for online therapy sessions compared to in-person therapy sessions. This hypothesis was supported as results indicate that scores for the online bond did not differ significantly from scores for the in-person bond. This again contrasts with previous research that states a lack of emotional connection for online therapy sessions (Békés et al., 2020; Markowitz et al., 2020).

This study was amongst the first to report research on the difference between online and in-person psychotherapy in the UAE and contributes to the literature from a new cultural perspective. There were, however, a few limitations. Our sample size was relatively small compared to previously reported research that guided the study reported here. Our participants also included more females than males which may restrict the generalizability of the results to the male population. The research reported here could be built upon and by implementing a longitudinal design to observe changes in client satisfaction, working alliance and bond over time. Further research could also implement a qualitative approach to collect in-depth data and observe themes around the experience of online therapy compared to in-person therapy. Lastly, further research could compare results of clients' ratings with those of their therapists to observe whether levels of working alliance and satisfaction are consistent.

In conclusion, this study has evaluated the differences between clients' experiences who receive therapy online in contrast to those who received in-person therapy in the UAE. Findings revealed that clients showed higher levels of working alliance for in-person therapy than online therapy. Future research proposed undertaking a qualitative approach and comparing client ratings with those of their own therapist.

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