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Published in:
International Journal of Developmental Disabilities

DOI:
[10.1080/20473869.2021.1967078](https://doi.org/10.1080/20473869.2021.1967078)

Publication date:
2022

Document Version
Publisher's PDF, also known as Version of record

[Link to publication in Tilburg University Research Portal](#)

Citation for published version (APA):
Oudshoorn-Smit, C., Frielink, N., Riper, H., & Embregts, P. (2022). Experiences of therapists conducting psychological assessments and video conferencing therapy sessions with people with mild intellectual disabilities during the COVID-19 pandemic. *International Journal of Developmental Disabilities*. <https://doi.org/10.1080/20473869.2021.1967078>

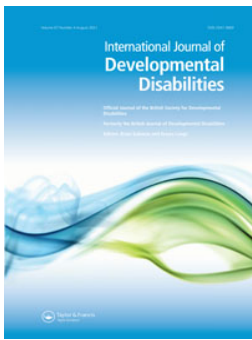
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To cite this article: Cathelijan E. M. Oudshoorn, Noud Frielink, Heleen Riper & Petri J. C. M. Embregts (2021): Experiences of therapists conducting psychological assessments and video conferencing therapy sessions with people with mild intellectual disabilities during the COVID-19 pandemic, *International Journal of Developmental Disabilities*, DOI: [10.1080/20473869.2021.1967078](https://doi.org/10.1080/20473869.2021.1967078)

To link to this article: <https://doi.org/10.1080/20473869.2021.1967078>



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Published online: 02 Sep 2021.



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Experiences of therapists conducting psychological assessments and video conferencing therapy sessions with people with mild intellectual disabilities during the COVID-19 pandemic

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Background. Due to the restrictive measures introduced to tackle the COVID-19 pandemic, therapists working with people with mild intellectual disabilities have had to use video conferencing to continue to conduct their psychological assessments and therapy sessions. This qualitative study explored therapists' experiences of using video conferencing during the initial lockdown period in the Netherlands.

Method. In total, seven therapists working at a service organisation supporting people with intellectual disabilities participated in this qualitative study ($M = 34.4$ years; $SD = 6.0$, range: 26-42). The therapists documented their experiences via audio recordings, which were subsequently analysed using thematic analysis.

Results. Five themes emerged: 1) An immediate transition to virtual working; 2) Developing virtual ways to support service users in both coping with COVID-19 related stress and with continuing therapy; 3) Lacking the appropriate equipment; 4) Limitations in virtually attuning to people with mild intellectual disabilities; and 5) Unforeseen opportunities for distance-based psychological assessments and therapy.

Conclusions. This study provides valuable insights into the experiences of therapists using video conferencing to support people with mild intellectual disabilities during the COVID-19 pandemic. These insights can help inform clinical practice with respect to the use of video conferencing for psychological assessment and therapy with people with mild intellectual disabilities.

Keywords: Intellectual disabilities; COVID-19; therapists' experiences; assessment; therapy

Healthcare professionals across the globe are increasingly using eHealth within the field of intellectual disabilities (Oudshoorn *et al.* 2020), a trend which has been accelerated even further by the ongoing COVID-19 pandemic (Courtenay and Perera 2020). On March 11 2020, the World Health Organisation declared the COVID-19 outbreak, a coronavirus causing infections of respiratory with serious risks for people with a vulnerable health status and elderly, a pandemic (Moreno

et al. 2020, Rose *et al.* 2020, World Health Organisation 2020a). Governments worldwide took manifold preventive measures in an attempt to reduce the risk of infection based on the announcements of the WHO, such as to keep social distance, the closure of public places (e.g. schools, restaurants, churches/mosques, museums, and theatres), and the instruction to leave the house only for essential necessities (e.g. food and medication) (World Health Organisation 2020b). In response to the pandemic, a series of restrictions were also introduced by the Dutch government, including maintaining physical and social distance, staying and working at home as much as possible as well as the closure of public facilities such as schools. These measurements had a profound impact on the daily lives of

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many citizens, particularly the elderly, people with intellectual disabilities and people with mental health problems (Dutch Government 2020, Embregts *et al.* 2020). Some of the common negative consequences of social isolation reported by people with mild intellectual disabilities include, amongst other things, loneliness, difficulty in maintaining structure in daily life and increased stress as a result of the closure of day and work services, the loss of formal and informal support and misunderstanding of information about the COVID-19 virus (Embregts *et al.* 2020).

Service organisations for people with intellectual disabilities have introduced strict measures regarding engaging in face-to-face contact with relatives and healthcare professionals other than the direct support staff working in residential group settings. Professionals working in the community had to either postpone or move their face-to-face contact with service users with intellectual disabilities online within a very short space of time. In order to continue to conduct psychological assessments and therapy sessions, health care professionals, and therapists in particular, have begun to use video conferencing (Békés and Aafjes-van Doorn 2020, Embregts *et al.* 2021a). Studies evaluating the effectiveness of video conferencing for conducting psychological assessments and therapy amongst the general population have reported promising results, concluding that video conferencing is feasible for both neuropsychological assessment (Marra *et al.* 2020) and diagnosing an autism spectrum disorder (Alfuraydan *et al.* 2020). Furthermore, video conferencing has been found to produce similar outcomes as in-person interventions for anxiety, depression and post-traumatic stress disorder, achieving sufficient to good user-satisfaction (Backhaus *et al.* 2012, Blake Berryhill *et al.* 2019a; Blake Berryhill *et al.* 2019b; Turgoose *et al.* 2017). Conversely, technical problems, lack of on-site support as well as the severity and complexity of a person's problems prior to therapy have been found to negatively impact the effectiveness of video conferencing (e.g. Poletti *et al.* 2020). However, there is a relative dearth of research assessing the feasibility and effectiveness of video conferencing amongst people with mild intellectual disabilities (Oudshoorn *et al.* 2021). Recently, in a small-scale mixed-methods study, Rawlings *et al.* (2020) explored the accessibility and acceptability of using video conferencing for psychological interventions for anxiety, low mood and anger amongst people with intellectual disabilities, and found that only a minority of service users accepted therapy being conducted in this way. Given that professionals play a key role in the acceptance and implementation of interventions delivered by a broad range of eHealth applications, such as video conferencing (Henneman *et al.* 2017), it is important to also explore their perspectives. To the best of our knowledge, the perspective of

professionals providing psychological interventions to people with intellectual disabilities via video conferencing has hitherto not been explored. Although people with intellectual disabilities are a very heterogeneous group with a wide variety of support needs, this study reported on the experiences of therapists working with people with mild intellectual disabilities (IQ 50-70 and significant deficits in adaptive functioning) and high support needs due to mental health problems (Schalock *et al.* 2021).

Recently, Embregts *et al.* (2021b) explored the general experiences of five psychologists working online with people with intellectual disabilities during the initial lockdown in the Netherlands. These psychologists reported difficulties with picking up non-verbal cues and discussing sensitive topics, alongside technical difficulties associated with the lack of secure internet connections and devices at group homes, which undermined the ability of service users and staff to use video conferencing. Although Embregts *et al.*'s (2021b) study provides interesting insights into video conferencing from the perspective of psychologists, who experienced challenges in terms of both discussing sensitive topics with service users and keeping in contact with support staff in group homes, it would be noteworthy to specifically explore the experiences of therapists using video conferencing to conduct psychological assessments and therapy amongst people with mild intellectual disabilities. This is because therapists play a key role in terms of both the acceptance and implementation of a broad range of eHealth applications, including video conferencing (Henneman *et al.* 2017). Moreover, their attitude towards using video conferencing is a strong predictor of its actual use (e.g. Békés and Aafjes-van Doorn 2020, Feijt *et al.* 2018). Therefore, the rationale for the present study is that exploring their perspectives will enhance knowledge concerning the role of therapists working with people with mild intellectual disabilities. Hence, the present exploratory qualitative study is underpinned by the following research question: what are the experiences of therapists conducting psychological assessments and video conferencing therapy sessions with people with mild intellectual disabilities during the initial COVID-19 lockdown?

Methods

Study design

A phenomenological qualitative study design was adopted in order to capture the experiences of therapists conducting psychological assessments and video conferencing therapy sessions with people with mild intellectual disabilities during the initial COVID-19 lockdown in the Netherlands. Phenomenological studies are qualitative studies focusing on the lived experiences of a

specific group sharing common features with a phenomenon or context (Creswell 2014, Neubauer *et al.* 2019, Yarimkaya and Töman 2021). To capture the experiences of a group of therapists, they were invited to self-record their experiences on their smartphone. This form of data collection has been used effectively more often during the COVID-19 pandemic (e.g. Embregts *et al.* 2021a, 2021b; Nind *et al.* 2020). Some brief topics (e.g. positive and negative experiences, factors that either facilitated or served as barriers to using video conferencing, and what went well and what problems they encountered when using video conferencing), based on their clinical expertise, served as a guideline for the therapists to reflect upon. This method of data collection was deemed to be convenient for this group of participants who were already exceptionally busy during the COVID-19 pandemic, as they were able to determine for themselves when to record their audio messages. Although posing follow-up questions was not possible due to the use of audio recordings, the participating therapists were clearly instructed in advance to describe as many details and feelings as possible in their audio messages.

Participants

This study was conducted in a large service organisation in the Netherlands that provides support and treatment from more than 5,000 professionals to nearly 6,000 people with intellectual disabilities. In total, seven therapists (all female) participated in the study. The mean age of the therapists (five psychologists, one art-based therapist, and one psychomotor therapist) was 34.4 years ($SD = 6.0$, range: 26-42). On average, they had worked with people with intellectual disabilities for 10.7 years ($SD = 6.4$ years; range: 1-17), and had 3.7 years ($SD = 2.2$; range: 1-8) of experience in their current position. Both additional demographic features of the participants and a brief description of the specific support needs of service users are presented in Table 1. They conducted individual psychological assessments ($n = 7$) and provided psychological therapy ($n = 6$) to both children and adults with mild intellectual disabilities, mental health problems (e.g. anxiety, attachment, depression, trauma) and/or who exhibited challenging behaviour (e.g. aggressive or sexually deviant behaviour), who were either living independently in the community and receiving outpatient support or living in residential care facilities. The therapists delivered individual psychological therapy, systemic therapy, experience-based therapy, and applied Eye Movement Desensitisation Reprocessing (EMDR) therapy, in conjunction with different elements from Cognitive Behavioural Therapy (CBT), Competitive Memory Training (COMET), and Solution-Focused therapy (SFT). The experience-based therapists (i.e. art and psychomotor) provided psychological therapies in tandem

with a psychologist. The psychological assessments focused on diagnosing an intellectual disability, attachment disorder and autism spectrum disorder. The service organisation provided the therapists with an account for the simple and safe video conferencing apps Vicasa™ and Microsoft Teams™. None of the therapists were trained beforehand in how to use video conferencing to conduct psychological assessments and therapy.

Procedures

The participants were recruited via convenience sampling. We used this particular sampling method because these participants were both easy to contact and willing to participate during the lockdown period. A team manager in the service organisation was contacted by the first author. Eligible therapists had to be working with people with mild intellectual disabilities with extensive support needs as well as conducting individual psychological assessments and/or providing psychological therapy. With their consent, the team manager provided the names of seven therapists to the first author, who subsequently contacted these potential participants by phone. After outlining the purpose and nature of the study, all seven therapists voluntarily agreed to participate in the study and provided written informed consent. The Ethics Review Board of Tilburg University approved this study (RP179).

Materials

The therapists were asked to reflect upon their experiences of conducting assessments and providing therapy through video conferencing during the first two months of the initial lockdown period in the Netherlands, which lasted from 16th March to 15th May, 2020. Similar to Embregts *et al.*'s (2021a, 2021b) study, the participants self-recorded their experiences on their smartphone and sent the audio recording (mean duration for each participant: 12.8 min; $SD = 5.3$; range: 6.12-16.32) to the first author. When recording the audio message, the participants were offered the following topics to reflect on: 1) positive and negative experiences of using video conferencing, 2) factors that either facilitated or served as barriers to using video conferencing, and 3) what went well and what problems they encountered when using video conferencing. Two therapists preferred to share their experiences in written form, simply because they felt more comfortable expressing themselves in this way than talking to a device.

Data analysis

Themes were identified by deploying an inductive thematic analysis method (Braun and Clarke 2006). Given of the novelty of the topic being studied, the analytic process was undertaken without prior theories or assumptions. The analytic process followed the six-

Table 1. Demographical characteristics of the participants (all female).

Pseudonym	Age	Position	Working experience people with intellectual disabilities	Working in current position	Content of work	Support needs of service users*	eHealth use before March 2020
Eleonor	42	psychologist, systemic therapist	17 years	8 years	psychological and systemic assessment, individual and family therapy	Assessment: emotional functioning, intellectual and adaptive functioning, needs assessment Therapy: family dysfunctioning and crisis, complex trauma	Incidental
Irene	26	art-based therapist	3 years	2 years	individual and group (forensic) therapy and observation in individual assessment	Assessment: observation differential diagnosis ASD, attachment and trauma Therapy: trauma, self-esteem problems, emotion regulation problems, unsafety and risk of domestic violence,	Incidental
Lisa	27	psycho-motor therapist	1 year	1 year	individual and group therapy and observation in individual assessment	Therapy: anxiety and stress management problems, emotion recognition and management problems, self-esteem problems, anxiety disorder	Regular base (chat, online assignment)
Nathalie	38	psychologist	11 years	4 years	psychological and systemic assessment, individual and family therapy	Assessment: ASD, emotional functioning, sexual development, sexual trauma, complex trauma Therapy: anxiety and panic, problematic partner-relationship and domestic violence, obsessive compulsive disorder, psychosis, resilience empowerment	Regular base (chat, online assignment, video modeling), incidental Virtual Reality
Tessa	34	psychologist	16 years	4 years	individual assessment	Assessment: sexuality and defiant sexual behaviour, personal and developmental history interviews, attachment, ADHD, ASD	Incidental
Susan	37	psychologist	16 years	4 years	psychological and systemic assessment, individual therapy	Assessment: personal and developmental history interviews, social-emotional functioning. Therapy: complex trauma, mood disorder, obsessive-compulsive disorder	Incidental
Wilma	37	psychologist	11 years	3 years	psychological and systemic assessment and individual and family therapy	Assessment: intellectual and adaptive functioning, attachment, trauma, ASD, ADHD. Therapy: depression, suicidal thoughts, families with children with challenging behaviour and high risk of maltreatment	Incidental

ADHD = attention deficit hyperactivity disorder; ASD = autism spectrum disorder; PWID = people with intellectual disabilities.

*Features of assessment/therapies in period March-May 2020.

phases delineated by Braun and Clarke (2006). First, the first author transcribed verbatim the verbal data from the recorded audio files into written data. The verbatim texts were read carefully at length together with the second author for the purpose of familiarisation with the content of the data. Second, the first author inductively generated codes based on phrases of clear relevance to the present study. The second author checked

all codes, which were subsequently discussed with the first author until a consensus was established. Third, all codes were clustered into potential themes. To both ensure consistency within each theme and maintain the differences between themes, the potential themes were then discussed by all the authors in the fourth phase. As the original verbatim texts were in Dutch, the coding and clustering was also conducted in Dutch, while the

Table 2. Overview of the identified themes and descriptions.

Themes	Description
An immediate transition to virtual working	Flexibility and new skills needed due to an adapted workflow of using video conferencing within a very short space of time
Developing virtual ways to support service users in both coping with COVID-19 related stress and with continuing therapy	Adapting to supporting service users who were overwhelmed by feelings of stress because of the impact of COVID-19 on their daily lives at a distance by video conferencing as well as continuing to provide current therapies despite the restrictive measures in place
Lacking the appropriate equipment	The importance of the availability of proper equipment for all users involved in video conferencing sessions
Limitations in virtually attuning to people with intellectual disabilities	The impression of how video conferencing affected both people with mild intellectual disabilities and the therapist as well as missing the support of members of the formal and informal network of a service user who were usually involved in person
Unforeseen opportunities for distance-based psychological assessments and therapy	The surprise advantages of video conferencing experienced by therapists that allowed them to continue their work (assessment and therapy) with service users and gain a better picture of their personal circumstances

findings were subsequently translated into English by a professional native speaker. Finally, the themes were defined and named by the first two authors in the fifth phase, before a narrative structure with accompanying descriptions was then established by all authors in the final stage. Two checks of trustworthiness and credibility were carried out in order to ensure the quality of the study. First, the second coder checked the coding to ascertain the consistency and clarity of the codes identified by the first coder. Second, extensive discussions of the codes and proposed themes took place between the coders and all of the authors to ensure both the coherence of the codes within each theme and that there was a clear distinction between themes.

Results

Based on a total of 317 codes, the thematic analysis identified five main themes: 1) An immediate transition to virtual working (65 codes; 7 therapists); 2) Developing virtual ways to support service users in both coping with COVID-19 related stress and with continuing therapy (41 codes; 5 therapists); 3) Lacking the appropriate equipment (61 codes; 7 therapists); 4) Limitations in virtually attuning to people with mild intellectual disabilities (71 codes; 6 therapists); and 5) Unforeseen opportunities for distance-based psychological assessments and therapy (73 codes; 7 therapists). Six codes were assigned to a miscellaneous category as these codes were very general and broad (e.g. lack of safety at home). Table 2 presents an overview of the identified themes and corresponding description.

An immediate transition to virtual working

Due to the restrictive measures introduced in the initial lockdown period, therapists were not allowed to conduct psychological assessments and therapy in-person. The therapists experienced this situation as unreal and strange, insofar as they had to immediately transition to

remote contact by telephone and video conferencing in order to continue with their work.

... that very first day was kind of surreal due to the fact that I was not actually allowed to see service users. ... so I began to quickly arrange all requests for Vicasa™ [name of video conferencing application] in the first week ... [Nathalie]

At the beginning of the lockdown, therapists experienced their own digital skills as insufficient, and thus had to spend time and effort learning the necessary skills. Moreover, they were confronted with various new tasks, such as arranging a working account for service users, and instructing both them and their relatives how to install and activate the secure video conferencing app and to create a password. For example, they had to search for personal data in the electronic health records system, where they occasionally found that the up-to-date data on service users that was needed to create a working account was missing. The sudden change and rapid adaptation necessitated by the pandemic proved to be demanding for all of the therapists and tested their flexibility.

Developing virtual ways to support service users in both coping with COVID-19 related stress and continuing with therapy

During the initial weeks of the lockdown, therapists primarily helped service users to cope with stress that stemmed from both difficulties in understanding the measures and a fear that they or their loved ones would contract the COVID-19 virus. Therapists had to pay attention to the profound impact of the measures on service users and focus on how to cope with the stressful situation, by, for example, guiding them through relaxation exercises and pointing towards finding helpful ways of thinking and performing activities at home. In so doing, the therapists were exploring methods to convert their normal work into the virtual realm. For example, some therapists noticed that it was helpful to send materials (e.g. workbooks, questionnaires, paints,

or clay) to service users prior to a session. In addition, therapists were hesitant to use video conferencing for therapy with complex families, due to difficulties in observing the interpersonal interactions between family members on the same screen, which left therapists feeling unable to intervene adequately. In the case of emotionally unstable people, therapists experienced difficulties in helping these people to deal with and channel their overwhelming feelings at a distance.

[I] have to explain and clarify things more and question what is actually happening to someone else. ... a man began to cry very loudly and actually disappeared out of sight [moved away from the screen]. Urgh, that felt very unpleasant because [I] couldn't do anything at that moment, I didn't know where the other person was and [I was] really at a distance. [Eleonor]

Not being in the same room as the service user, forced the therapists to consider the feasibility of video conferencing for a particular session with a sensitive topic to discuss or making appointments with service users beforehand on how to cope with stress or a crisis situation during a video conferencing session. So therapists had to prepare a video conferencing session more intentionally compared to a face-to-face session.

Lacking the appropriate equipment

Therapists were also confronted with technical challenges that hampered their ability to do their work. Specifically, unstable internet connections, overly small screens that resulted in uncomfortable sitting positions, and a dependency on third parties to restart interrupted sessions were routinely cited as barriers.

... a verbal consultation in which the connection is broken off ... those kinds of things are not very pleasant at all, and then [I] you miss [I] simply miss the ability to restart the session quickly ... when someone gets emotional and the connection is broken, yes, it is more difficult to engage in a good conversation. [Tessa]

In the case of video conferencing via a smartphone, a broken connection was often the consequence of an incoming call. In addition, therapists reported that inappropriate equipment (e.g. as a result of organisational policy only smartphones or private equipment could be used) made it difficult for them to provide adequate psychological therapy, because nonverbal cues were barely visible on small screens, which, in turn, had a negative effect on the session. Further, both therapists and service users lacked the appropriate tools to engage in therapy via video conferencing, which caused difficulties in terms of contact and communication. These experiences underscore the importance of the availability of proper devices for both therapists and service users.

Limitations in virtually attuning to people with mild intellectual disabilities

The therapists reported on the difficulties that service users experienced with planning and attending their

sessions. Service users were often too late or took part in the session while they were driving or at the shops. Hence, therapists had to support service users by speaking to them specifically about their attendance. Explaining the objectives and expectations was found to lead to improvements in the video conferencing therapy sessions. In comparison to face-to-face therapy, therapists reported that several service users were less serious during therapy via video conferencing. For example, therapists routinely observed service users checking their smartphones instead of actively participating in the session. Moreover, service users were more likely to request to reschedule the therapy session at the last moment, often when the session was about to start. In addition, therapists cited difficulties in remotely contacting service users with complex needs, such as service users who were in a crisis situation, who either avoided questions or simply did not answer when a therapist attempted to call them.

Therapists reported that conducting assessments or therapy without the presence of important stakeholders (e.g. partners, parents, support staff) led them to take on a different inflection. Participants experienced notable differences when comparing working with and without the support of staff or parents during assessments and therapy sessions. Specifically, they reported that meetings without the help of stakeholders were more difficult. They felt inconvenienced and missed the regular support of stakeholders, who provide either technical or practical on-site support (e.g. practicing exercises at home or organising a private space), and instead had to support service users at a distance.

... they could not find the e-mail [to activate the video conferencing app] and actually had little help from [persons in] the environment to support them. This was because both outpatient and family support were less present because of Corona, so it was hard to rely on them for support with service users. [Lisa]

Finally, the therapists indicated that solely working online meant that they were unable to illustrate relevant themes for service users, either by drawing or showing pictures or using tangible materials (e.g. little dolls). This is problematic, because they reported that video conferencing is heavily reliant on verbal communication skills, which they judged to be difficult for people with mild intellectual disabilities.

. a lot of people had difficulties with engaging in long conversations, as well as difficulties with expressing what they felt and experienced. [Lisa]

These experiences clearly testify to the fact that therapists were largely unaware of the possibilities presented by video conferencing tools, and, as such, were actively searching for the best ways to optimise their sessions and attune them to the specific needs of service users, such as, for example, by providing support in the case of stress or through visualising.

Unforeseen opportunities for distance-based psychological assessments and therapy

Despite the fact that some therapists felt insecure about delivering certain types of therapy (e.g. Psycho Motor Therapy, EMDR for complex trauma) and reported that it was too complex to establish a therapeutic alliance with service users with more complex problems, they also recounted positive experiences of using video conferencing and noted that it produced comparable results to face-to-face sessions for the majority of service users, particularly with regard to reduced tension and enhanced ability to cope with stress, improved self-awareness, higher self-esteem and less problems with marital partners. Over time, therapists felt more adept at using video conferencing and reported greater satisfaction with their efforts.

My experience of online treatment is that I came to the conclusion that there were far more possibilities than I had originally expected. I do not think that I will go back to exclusively working face-to-face [with service users]. [Susan]

In the case of psychological assessments, for example, relatives were found to be useful in terms of both making it easier to arrange interviews in the first place and for helping service users when they joined interviews virtually. Prior to the COVID-19 pandemic, relatives had less opportunity to support their family members in person because of other responsibilities and duties. In particular, the fact that relatives were home due to the restrictive measures created positive opportunities for therapists to invite relatives to engage in the online therapy sessions. The use of video conferencing thus enabled virtual insight into the personal lives of service users. Another unforeseen advantage of online sessions was that some service users were more relaxed at home, which, in turn, resulted in an increased frankness in their discussions. At the same time, therapists cited that they needed to pay greater attention to observations about unsafe environments now that they were virtually present in the living situation of service users. Another unforeseen positive finding was the opportunity to immediately be able to implement the content of the therapy session into service users' personal context, due to the fact that exercises could be completed in the targeted context (e.g. controlling compulsive behaviour). Finally, reduced travel time and greater opportunity to engage in quick online consultations with other professionals were also cited as saving time. Hence, one can conclude that the therapists were surprised by the opportunities, and sometimes advantages, associated with conducting assessments and providing therapy via video conferencing, which, in turn, resulted in them gaining a more nuanced picture of how video conferencing could be used in their work.

Discussion

The restrictive measures introduced during the initial lockdown period in the Netherlands led to a pronounced

transition in terms of how therapists conduct diagnostic assessments and provide psychological therapy to people with mild intellectual disabilities. Conducting a thematic analysis of their experiences led to the identification of five themes: 1) An immediate transition to virtual working; 2) Developing virtual ways to support service users in both coping with COVID-19 related stress and with continuing therapy; 3) Lacking the appropriate equipment; 4) Limitations in virtually attuning to people with mild intellectual disabilities; and 5) Unforeseen opportunities for distance-based psychological assessments and therapy.

The lockdown period forced therapists to immediately have to engage in a series of new tasks, such as instructing service users at a distance how to use video conferencing and developing virtual ways to continue to carry out their work. Therapists were able to provide mental health support to service users who were trying to cope with the restrictive measures. The period of lockdown from March to May 2020 was a stressful time for both service users and therapists (Embregts et al. 2020, 2021b). Anxiety levels increased due to the fear of infection, the loss of loved ones and the prevailing feeling of uncertainty. Changes in daily life routines and the loss of informal and formal support caused increased levels of stress for service users, but also for families of people with intellectual disabilities (Embregts et al. 2021a; Zaagsma et al. 2020). The COVID-19 pandemic signalled a profound turning point for the virtual delivery of mental health services with therapists rushing to implement remote care. Over time, the therapists adapted to video conferencing and came to experience it as both positive and as adding value to their work. Specifically, therapists cited time efficiency, easier access to service users and important stakeholders, and working directly in service users' living environment as key benefits of working online. Barriers such as technological problems, lack of proper equipment, insecurity and worries over their digital competence as well as the lack of on-site support for service users were also cited. Therapists missed the option of visualising things for their clients, such as by drawing a picture as part of psycho-education, and worried about the level of verbal communication required in video conferencing. This derived from a lack of awareness about the various possibilities offered by video conferencing programs. These results underline the importance of training professionals to both feel more skilled in using all of the options provided by a tool such as Microsoft Teams™ and to become more self-confident in using video conferencing for diagnostic and therapeutic objectives. Therapists noted service users' difficulties in both organising their attendance and maintaining their focus during video conferencing sessions. Moreover, the present study clarified the important role played by relatives and support staff as practical and emotional

resources, both during and in between the online sessions. This finding is in line with previous recommendations that posit that face-to-face therapy for people with intellectual disabilities should seek to involve relatives or support staff (e.g. Jahoda *et al.* 2017, Scott *et al.* 2019).

To the best of our knowledge, this study is the first to have explored the experiences of therapists using video conferencing for conducting psychological assessments and therapy amongst service users with mild intellectual disabilities. Although the evidence on the use of video conferencing to conduct psychological assessments and therapy amongst the general population is promising (Alfuraydan *et al.* 2020, Marra *et al.* 2020), studies involving people with mild intellectual disabilities are scarce. Temple *et al.* (2010) concluded that administering both the Wechsler Adults Intelligence Scale and the Beery-Buktenica Test of Visual-Motor Integration for adults with mild intellectual disabilities is possible via video conferencing, provided there is on-site support from staff, while Zaagsma *et al.* (2019) reported promising results for the use of video conferencing in remote support. Despite these aforesaid studies, video conferencing remains an underdeveloped opportunity vis-à-vis providing mental health support to people with intellectual disabilities (e.g. Rose *et al.* 2020, Sheenan *et al.* 2020).

There are several limitations of this study that need to be discussed. First, only seven participants from one service organisation shared their personal experiences of using video conferencing to continue their work, which prevents us from generalising these findings to all people with mild intellectual disabilities. Second, as a consequence of convenience sampling, only female participants were included in the study. Consequently, further research is required with a larger group of therapists, including male therapists. Moreover, given the small number of participants, it is possible that other themes or subthemes might have emerged if there had been additional participants. Based on the data of the participating therapists, we are unable to draw conclusions about the differences between adults and children or the specific issues these two groups face. This could be a relevant topic for future research. The method used for data collection also had some limitations in terms of gaining more in-depth experiences from therapists, but was convenient during such a demanding lockdown period.

Despite these aforementioned limitations, a notable strength of this study is that it provides important insights into how therapists experience the use of video conferencing to conduct assessments and therapy amongst people with mild intellectual disabilities. Gaining insights from a larger group of therapists inspired by the results of the present exploratory study is thus important, especially given that remote care and

support is expected to remain in the near future (Wind *et al.* 2020). In this study, we specifically focused on the experiences of therapists. However, the experiences of service users are also important to explore. Understanding their views on being interviewed in the context of receiving either a psychological assessment or therapy via video conferencing is of paramount importance for gaining a more nuanced picture of the opportunities presented by eHealth.

Acknowledgements

The authors would like to thank the participants and ASVZ for their efforts in this study.

Disclosure statement

No potential conflict of interest was reported by the authors.

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